Quality Assurance & Performance Improvement Work Plan

FY 2020-2021

Health & Human Services Department
Behavioral Health and Recovery Services Division
Jei Africa, PsyD, MSCP, CATC-V, Behavioral Health Director

Quality Management Program Description

The Marin Mental Health Plan's (MHP) Quality Management (QM) program is responsible for monitoring the MHP's effectiveness and for providing support to all areas of MHP operations by conducting performance monitoring activities which include, but are not be limited to: utilization management, utilization review, provider appeals, credentialing and monitoring, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes. The QM program's activities are guided by the relevant sections of federal and state regulations, including Title 42 of the Code of Federal Regulations, California Code of Regulations Title 9, California Welfare and Institutions Code, as well as the MHP's performance contract with the California Department of Health Care Services (DHCS). The QM program is embedded in the Behavioral Health and Recovery Services Division (BHRS) within the Health and Human Services Department (HHS) of the County of Marin.

The QM program consists of seven licensed staff, including the Quality Improvement Coordinator (1 FTE), the Quality Management Unit Supervisor (1 FTE), and five Utilization Review Specialists (serving mental health and substance use treatment programs) (4.5 FTEs). The QM program also includes two data analysts (2.5 FTE), two administrative staff (2 FTE) and a .25 FTE consulting contractor. The QM program is overseen by a licensed QM Division Director (1 FTE), who is additionally responsible for Access and Information Technology, for a total workforce of 11.75 FTEs. The QM Division Director position has been vacant since February 2020. QM staff carry out their job responsibilities as defined by their individual professional disciplines and scopes of practice. The Information Technology Team (3 FTE dedicated to BHRS) participates in the data reporting and analysis functions of QM and provides essential technical support services to the entire BHRS Division.

An array of teams and committees within and affiliated with the QM program provide structure for the quality management and oversight responsibilities of the organization.

The **Utilization Management (UM) Team** is a component of the QM program. The UM Team, led by the Quality Improvement Coordinator, assures that beneficiaries have appropriate access to specialty mental health and substance use treatment services. Program activities include: the evaluation of medical necessity determinations, and continuous monitoring of the appropriateness and efficiency of services.

The **Administrative Operations Committee** is led by QM, Fiscal, Administrative, and Information Technology representatives. The BHRS Administrative Services Manager (ASM), Assistant Chief Fiscal Officer (CFO), IT Supervisor, and Quality Management Unit Supervisor take primary responsibility for setting the agendas and sponsoring the work of the committee, whose additional members include QM, IT, Fiscal, Program, Administrative and Compliance leads. During committee meetings, stakeholders identify and problem-solve issues across the BHRS system that relate to the Electronic Health Record (EHR) system, the practice management system, policies and procedures, documentation processing, credentialing and onboarding of new staff and contractors and other administrative tasks that are essential to the integrity of BHRS operations.

Quality Improvement Team:

The Quality Improvement Team, led by the Quality Management Unit Supervisor, monitors the overall service delivery system with the aim of improving care provision and increasing consumer and family member satisfaction and outcomes. QI is also responsible for the ongoing implementation of the Federal Managed Care Final Rule, including the Provider Directory, the Network Adequacy submissions and other related documents.

The **Quality Improvement Committee** (QIC) is a combined mental health (MH) and substance use services (SUS) committee, and is comprised of a diverse group of stakeholders, including representatives from MH and SUS administration and clinical programs, the Mental Health Board, peers/family members, the Patient Rights Advocate, and contractors/community partners from both MH and SUS agencies. QM staff are responsible for facilitating a quarterly QIC meeting to review findings from a range of compliance and quality improvement activities, including specified DMC-ODS data elements, and to obtain input into these and other areas for improvement.

The **Incidence and Grievance Subcommittee** of the QIC is attended by the Medical Director, QI Coordinator, QM Division Director, Adult Services Division Director, Youth and Family Division Directors, Program Manager Crisis Continuum of Care, Program Manager Adult Services and on ad hoc basis Program Supervisors. It is a standing group that meets quarterly to evaluate and analyze trends of grievances, appeals, fair hearings, and unusual occurrences to identify issues or trends that require implementation of system changes. It also makes improvement recommendations to the system such as additional trainings policies, workflows and operational changes. The subcommittee is led by the QI Coordinator. Findings from this meeting are presented to the QIC stakeholders as required.

The **Policy and Procedure Subcommittee meets** monthly to draft and/or update new or existing policies and procedures as needed.

The MHP has an active **Cultural Competency Advisory Board (CCAB)** which is comprised of BHRS management and staff, contract agency providers, consumer advocates, consumers, community leaders and stakeholders. There are working subcommittees within the Board responsible for discrete content areas such as training, policies, and access. The 20+-member board is tasked to analyze data, review existing improvement plans, examine practice approaches and make recommendations related to policy, service delivery, staffing and training needs, and system improvements. QM staff provide data for the CCAB, and there is shared participation in both the QIC and CCAB on the management, staff and consumer level.

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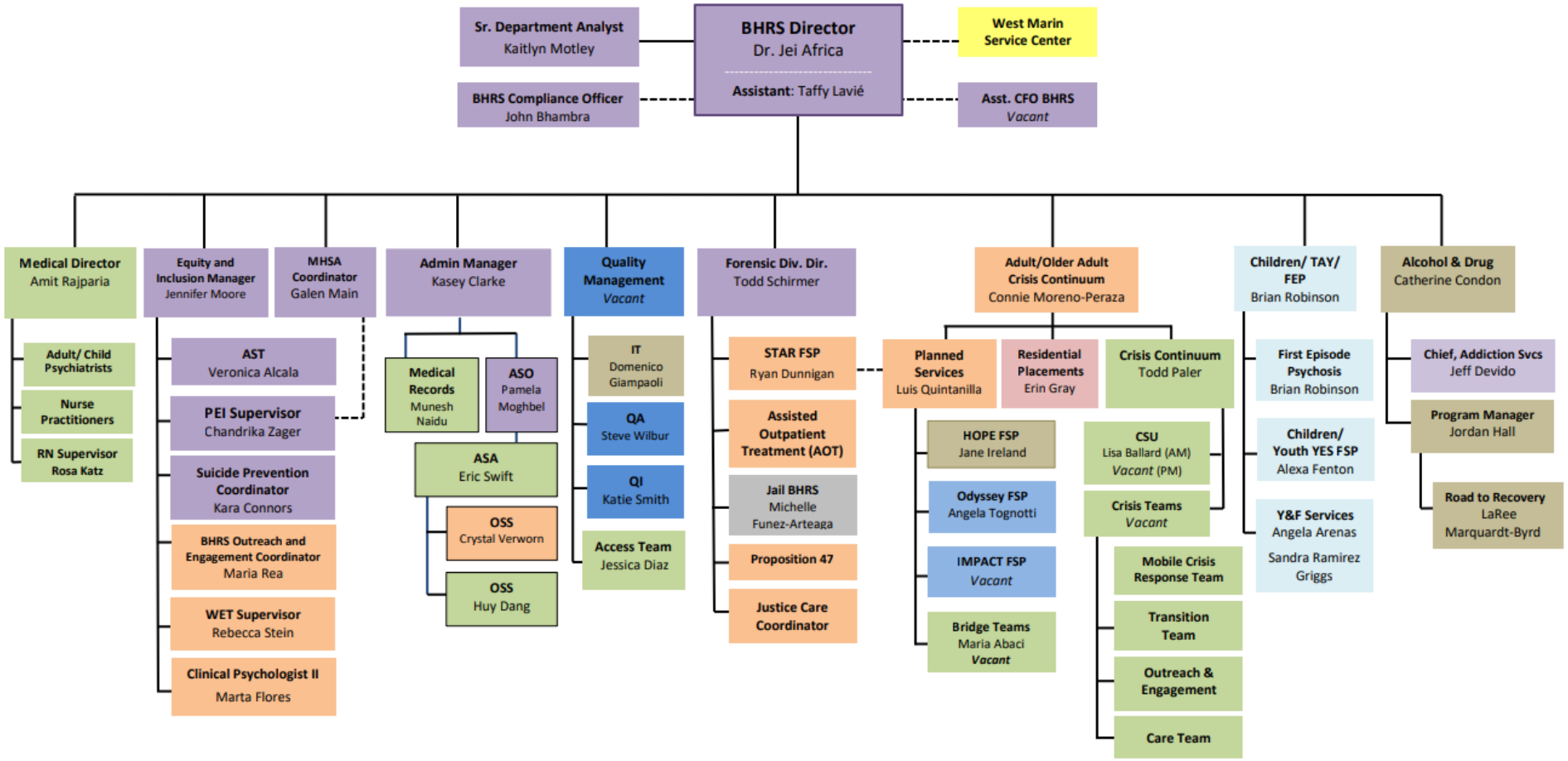
Behavioral Health & Recovery Services System of Care



Last updated 11/9/2020

Quality Assessment and Performance Improvement Work Plan

The intent of the Quality Assessment and Performance Improvement (QAPI) Work Plan is to create systems whereby data relevant to the performance of the MHP is available in an easily interpretable and actionable form. This year's plan continues the work of the previous plan's work of improving the capture, analysis and use of data to support contractual compliance, performance management and decision making. Performance improvement activities focus on improving provider network adequacy, accessibility, timeliness and outcomes of services and serve to enhance the MHP's daily work of supporting the recovery and resiliency of the consumers and family members in our community.

The QAPI Work Plan is evaluated and updated annually. The elements of this QAPI Work Plan are informed by the quality improvement requirements of the Marin MHP - DHCS contract as well as feedback received from the CalEQRO review and DHCS Triennial audit findings and recommendations. This fiscal year, all QAPI Work Plan goals are specific, measurable, achievable, and time-bound (SMART) to facilitate ongoing monitoring and year-end progress evaluation. All goals have a target completion date of June 30th, 2021. Accompanying each goal are a list of objectives toward achieving the goal. SMART goal development, monitoring, and evaluation is consistent with the Marin County Health and Human Services Department, Strategic Performance Management initiative.

Quality Assurance& Performance Improvement Work Plan FY20-21

I. Access To Care

Goal	Objectives	Baseline
1. Provider Network Adequacy **Marin MHP will maintain and monitor a network of providers that is sufficient to provide adequate access to specialty mental health services.**	1. BHRS will provide county programs and contracted agencies with a tool to track changes/additions to the provider network monthly. This is currently manual and time-consuming process. BHRS will implement a mechanism to help to automate the process which will result in smoother and more timely tracking. 2. BHRS will update Provider Directory monthly per DHCS requirement. 3. BHRS will create a feedback loop to communicate with county and network providers regarding fulfillment of required criteria. 4. In order to address the needs of beneficiaries requesting psychotherapy, the MHP will increase the number of available clinicians who can provide psychotherapy, and decrease the number of clients on the psychotherapy waitlist. By March 1, 2021, the MHP will complete an analysis of the current psychotherapy waiting list and the determine the baseline and goal for expanding the network and/or utilizing current resources differently to meet the needs of the clients. The MHP will stratify the data by race/ethnicity in order to determine if disparities exist and how they can be addressed.	Provider network adequacy – As of October 1, 2020, Marin County MHP was placed on NACT CAP due to lack of mechanisms to track CSI Timeliness data. DHCS accepted the BHRS CAP response in December 2020. Currently, BHRS has continued to meet the requirements for provider ratios. The MHP currently has a waitlist for psychotherapy. Data Source(s): NACT submission (July 2020); Provider Directory (November 2020)

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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>2. Provider Linguistic Capacity

Ensure services are provided in the client's preferred language by utilizing bilingual staff and/or qualified interpreters, when preferred by the client, as documented in the medical record 100% of the time.</td>
<td>1. Continue to ensure that when preferred by client, interpretation or bilingual staff was utilized to provide services in the client's preferred language (or if not preferred, client declined offer of interpretation/service in preferred language) and this is documented in the medical record) 100% of the time.

2. BHRS will run a monthly report to identify data errors related to client service language and provide feedback to responsible parties in order to improve accurate recording this information.</td>
<td>Provider linguistic capacity – 94.1% of clients served during FY19-20 had services provided in their preferred language, as documented in the EMR.

<table>
<tr><th>Encounters (n=71,939 rendered svcs)</th><th>% Encounters</th></tr>
<tr><td>Rendered in Clt's Preferred Language (includes the use of interpreter/language line)</td><td>94.1%</td></tr>
<tr><td>Language Provision Not Recorded</td><td>0%*</td></tr>
<tr><td>Services Not Provided in Clt's Preferred Language</td><td>5.9%**</td></tr>
</table>
*** CG does not allow any services to be Finalized without a Language, therefore 0%
** Data quality issues contribute to this variable
n = 71,939 svcs

<table>
<tr><th>Preferred Language</th><th>% Active Clients</th></tr>
<tr><td>English</td><td>86%</td></tr>
<tr><td>Spanish</td><td>9%</td></tr>
<tr><td>Vietnamese</td><td>1%</td></tr>
<tr><td>Other Languages</td><td>4%</td></tr>
<tr><td>Not Captured</td><td>N/A</td></tr>
</table>
Preferred language, as documented in the EMR, is Spanish for 9% of clients served (Marin's threshold language) and 5% Vietnamese and other languages.
Data Source(s): ShareCare (SC) Scheduler, Clinician's Gateway (CG) EMR progress notes, ShareCare Admissions</td>
</tr>
</table>

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>3. Cultural Competency of Service Providers

Improve cultural humility and sensitivity within the delivery system and increase awareness of disparities for populations based on race/ethnicity and sexual orientation and gender identity (SOGI).</td>
<td>1. At least 80% of Marin MHP providers will complete a minimum of four hours of cultural competency training annually.

2. Monitor cultural competency training hours completed monthly to ensure that all providers are in compliance with this requirement and inform supervisors of their direct reports' status throughout the year.

3. BHRS will increase cultural competency training opportunities for staff and contract providers from the previous year and consider on- demand options for training through use of Talent Quest or other media in response to the COVID-19 pandemic, and in order to attain the 80% goal.

4. For FY 20-21, BHRS will focus cultural competence trainings on the top three populations identified in the 2019 WET survey by BHRS employees as the populations they believe they need more training to effectively treat.

5. By June 30, 2021, incorporate updated race/ethnicity and SOGI categories on the admission form and in ShareCare in order to improve data equity.</td>
<td>Provider cultural competency – Out of 184 BHRS staff tracked during FY19-20, 30% completed a minimum four hours of cultural competency training, which down from the last FY. Cultural competency training data was not available for contract providers during FY19-20.

<table>
<tr><th>Cultural Competence Training</th><th># Employees</th><th>% Completed</th></tr>
<tr><td>Completed at least 4 hours</td><td>55</td><td>30%</td></tr>
<tr><td>Did not complete 4-hour CCT</td><td>129</td><td>70%</td></tr>
<tr><td>Total</td><td colspan="2">184</td></tr>
</table>

Data Source(s): BHRS Cultural Competency Training Tracking Log, SC-Provider View database</td>
</tr>
</table>

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>4. Change of Provider Requests

Ensure change of provider requests are resolved by oral or written response to the beneficiary.</td>
<td>1. Continue to track and trend change of provider requests (as reported orally or in writing on Change of Provider Request form and report to QIC and management annually.

2. QM will log the request and provide one of the following responses to the beneficiary:

a. Provider will be changed as requested by client;
b. Change of provider request will be denied and client will be notified of the reason for denial.

3. QM will complete NOABD's and send to clients when their requests are denied, QM will keep a log of NOABD's.</td>
<td><u>Change of provider requests</u> – For FY19-20, 38 change of provider requests were received; 29 pertaining to medical staff and 9 pertaining to non-medical staff. 22 out of 38 requests were approved; 1 was denied. 15 requests were withdrawn by the client during the processing period. No significant trends were noted. Timeliness of change of provider resolution was not tracked during 19-20.
<table>
<tr><th>Type of Provider</th><th># Requests</th><th>Approved</th><th>Withdrawn</th><th>Denied</th><th>Pending</th></tr>
<tr><td>Medical Staff</td><td>29</td><td>15</td><td>13</td><td>1</td><td>0</td></tr>
<tr><td>Non-Medical Staff</td><td>9</td><td>7</td><td>2</td><td>0</td><td>0</td></tr>
</table>
Data Source(s): Change of Provider Log</td>
</tr>
</table>

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>5. Access to SMHS – 24/7 Phone Line

Marin MHP will conduct 12 test calls per quarter, during and after business hours, a minimum of 2 conducted in a language other than English. Test calls will be appropriately logged 100% of the time.</td>
<td>1. Conduct 12 test calls per quarter using test call scripts/worksheets that capture all required elements.

2. Ensure at least two test calls per quarter are conducted in a language other than English to test capacity to link beneficiaries with an interpreter as needed.

3. Ensure that test calls are conducted during and after business hours in order to assess both the Access team and the after hours contractor, Optum.

4. Review adherence to test call requirements on a quarterly basis (including appropriate logging of test calls) and provide feedback and training to Access Team and Optum at least one time per year.</td>
<td>
<table>
<tr><th>MEASURE</th><th>GOAL</th><th>FY 19/20 OUTCOME</th></tr>
<tr><td>Total test calls placed</td><td>12 calls/ quarter</td><td>12 calls/ quarter</td></tr>
<tr><td>Test call logging %</td><td>100%</td><td>86%</td></tr>
<tr><td>Test calls in a language other than English</td><td>1 call/ quarter</td><td>3.25 calls/ quarter</td></tr>
</table>
<u>24/7 Access line</u> –

An average of 12 test calls were conducted per quarter, 3.25of which were conducted in a language other than English.

Data Source(s): Quarterly data for FY19/20 (based on 24/7 Test Call Quarterly Update Report Forms submitted to DHCS)
</td>
</tr>
</table>

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>6. Timely Access to Services

Monitor quarterly, the MHP's ability to meet statewide timeliness standards and achieve compliance with all standards (a-d) for adult, children/youth and foster youth beneficiaries.</td>
<td>1. Monitor wait times between initial request and first appointment for adults, children/youth and foster youth using the following standards:

a. Initial request to first offered assessment appointment – 10 business days

b. Screening to completed assessment – 10 business days

c. Initial request (completed assessment) to psychiatry appointment – 15 business days

d. Service request for urgent appointment to actual encounter – 48 hrs. (no prior authorization required) / 96 hours (prior authorization required)

2. The MHP will develop mechanisms by which to monitor the wait times between initial request and first appointments for non-psychiatric providers and contactors.

3. Develop or utilize existing information systems to create a tracking process which is less manual for county operated programs.</td>
<td>Timely access to requested services –For FY 19-20, the timeliness standards for criteria a-d were met in every category with the exception of criteria c for children/youth and foster youth to receive a psychiatric appointment within 15 business days. Instead it took an average of 20.9 days for children/youth and 21 days for foster youth. The average wait-time from BH Screening to Completed Initial Assessment for both adults, children/youth, and foster youth are well below the requirement of 10 days.
Average wait times for FY 19-20
<table>
<tr><th>Timeliness – FY19-20</th><th>Goals</th><th>Adults (Business days)</th><th>Children/Youth (Business days)</th><th>Foster Youth</th></tr>
<tr><td>a) Initial request to first offered assessment appointment*</td><td>10 Business days</td><td>1.44 days</td><td>1.45 days</td><td>n/a</td></tr>
<tr><td>b) Screening to completed assessment*</td><td>10 Business days</td><td>2.9 days</td><td>4.4 days</td><td>1 day (n=9)</td></tr>
<tr><td>c) Completed assessment to psychiatry appointment</td><td>15 Business days</td><td>12.2 days</td><td>20.9 days</td><td>21 days (n=3)</td></tr>
<tr><td>d) Service request for urgent appointment to actual encounter **</td><td>48 hrs. (no prior authorization required) / 96 hours (prior authorization required)</td><td>1.5 hrs.</td><td>1.2 hrs</td><td>0.3hrs. (n=2)</td></tr>
</table>
Data Source(s): ShareCare (SC) Scheduler, Clinician's Gateway (CG) EMR progress notes, ShareCare Admissions, Access Log, Transition Team Log, Mobile Crisis Response Team (MCRT) Log, YFS Medication Evaluation Referral Tracking Log.</td>
</tr>
</table>

II. Timeliness

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>7. Post-psychiatric Hospitalization Follow-Up

Provide post-psychiatric hospitalization follow-up appointment within 7 days of discharge. Achieve performance rate of 10% or less readmission rates within 30 days of discharge.</td>
<td>1. Monitor:
a. Post-psychiatric hospitalization follow-up – 7 days after discharge
b. Psychiatric inpatient readmission rates within 30 days – ≤10%

2. Partner with the Adult and Older Adult System of Care to identify root causes of 30 day recidivism rate and implement strategies to ameliorate.

3. By June 30, 2021, complete an analysis to determine if there is a correlation between declining post-hospitalization follow-up and crisis and repeated admissions to the hospital. Stratify data by race/ethnicity.</td>
<td>Follow-up appointment post-psychiatric hospitalization – FY19/20
<table>
<tr><td>Adults</td><td>3.1 days</td></tr>
<tr><td>Children/Youth</td><td>4.6 days</td></tr>
<tr><td>Foster Youth (n=3) *</td><td>0.2 days</td></tr>
</table>
* 3 foster clients during FY 19-20 with a hospitalization

Post-psychiatric hospitalization readmission within 30 days – FY19/20
<table>
<tr><td>Adults</td><td>15%</td></tr>
<tr><td>Children/Youth</td><td>9%</td></tr>
<tr><td>Foster Youth (n=4) *</td><td>25%**</td></tr>
</table>
* 4 inpatient admissions for the 3 foster clients
**1 re-admission for 3 foster clients

Data Source(s): ShareCare (SC) and Hospital Inpatient Tracking Log</td>
</tr>
</table>

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>8. Client Engagement with SMHS – No Show Rates

Achieve or maintain less than or equal to 10% no-show rates to psychiatry and non-psychiatry scheduled SMHS appointments for adults, children/youth and foster youth.</td>
<td>1. Monitor no-show rates to scheduled SMHS appointments and achieve rates of 10% or less

a. No Show appointment rates – psychiatry appointments – ≤10%

b. No show appointment rates – non-psychiatry SMHS appointments – ≤10%

2. Improve ability to capture no show appointment rates for non-psychiatry SMHS by implementing a calendaring enhancement in Clinician's Gateway.

3. Work with contract provider, Side by Side TAY Medication providers to implement reliable practices for tracking no show appointments. This may include training by BHRS staff.</td>
<td><u>Average No-show rates</u> to scheduled SMHS appointments:

a. During FY19/20, the MHP was able to keep psychiatric no-show rates to ≤10% for children/youth and foster youth. Unfortunately, the MHP was not able to keep adult psychiatric no-show rates at ≤10% but was close to meeting the goal at 11.5% which also represents a slight decrease compared to FY18/19.

b. The MHP kept no-show rates for non-psychiatric appointment to ≤10%.

<table>
<tr><th>FY 18/19</th><th>Psychiatry</th><th>Other SMHS</th></tr>
<tr><td>Adults</td><td>11.5%</td><td>2.6%</td></tr>
<tr><td>Children/Youth</td><td>7.3%</td><td>5.8%</td></tr>
<tr><td>Foster Youth</td><td>1.9%</td><td>4.0%</td></tr>
</table>

Data Source(s): ShareCare (SC) Scheduler, Clinician's Gateway (CG) EMR progress notes.</td>
</tr>
</table>

III. Beneficiary Progress/Outcomes

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>9. Utilization Review – Clinical Documentation

Improve quality of clinical documentation as evidenced by < 5% disallowance rates for 70% of programs reviewed during FY20-21</td>
<td>1. Provide clinical documentation training to all new clinical staff within six months after hire. Staff will be required to remain on documentation review by their supervisors until they have completed a documentation training.

2. Provide at least two authorization and clinical documentation trainings for network contractors annually.

3. Offer clinical documentation trainings for staff/contractor participation on an ongoing basis, at least 4x per year, that address all current documentation standards. BHRS will adapt trainings to systematically target most common reasons for disallowance (e.g. missing signatures on client plans).

4. Due to the complications caused by the COVID-19 pandemic, BHRS will offer live virtual trainings by 12/31/2020.

5. Decrease UR disallowance rate for programs with a prior disallowance rate > 5% to < 5% by conducting re-reviews and/or training for those programs/providers within 6 to 9 months from the date the initial report is disseminated. Continue to offer to meet with programs after reviews for Q&A at least annually.</td>
<td>UR disallowance rate was < 5% for 21 out of 45, or 47% of programs reviewed during FY19-20. This is a large increase from 7% in FY 18-19. The number of programs with disallowance rates >5% remained the same at 24. However, the percentage decreased from 92% in FY18-19 to 53% in FY 19-20 due to overall increase in the number of programs reviewed.

<table>
<tr><td>DISALLOWANCE RATE FY 18/19</td><td>> 5%</td><td>< or equal to 5%</td></tr>
<tr><td># Programs Reviewed</td><td>24 (53%)</td><td>21 (47%)</td></tr>
</table>

Total programs reviewed during FY19/20 = 45

Data Source: UR Tracking Log 2015 to Present

Before the Shelter-in-Place order, there were a total of 9 in-person Documentation trainings completed which are available to BHRS internal staff and contractors. Since April 2020, the video training is available, and it currently shows 139 views. The in-person trainings took place on the following dates: July 29, 2019, Aug. 7, 2019, Sep. 13, 2019, Oct. 18, 2019, Jan. 31, 2020, Feb. 3, 2020, Feb. 6, 2020, March 4, 2020, and lastly on April 7, 2020</td>
</tr>
</table>

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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>10. Utilization Review – Frequency and rate of review

Review a minimum of 5% of medical records from every BHRS program and contract provider program reviewed annually and provide UR results to provider within 30 calendar days.</td>
<td>1. Continue to review a minimum of 5% of medical records.

2. Conduct re-reviews of programs that have high disallowance rates (>5%) following UR review (>5%) within 12 mos.

3. Provide completed reports to programs within 30 calendar days of the utilization review.</td>
<td>During FY 19-20, the UR team had an average completion time of 33 days from UR to issuance of a completed report to the program reviewed.
<table>
<tr><th>FY18/19</th><th># UR Reports</th><th>Time to Report (calendar days)</th></tr>
<tr><td>Q1</td><td>16</td><td>39</td></tr>
<tr><td>Q2</td><td>9</td><td>24</td></tr>
<tr><td>Q3</td><td>8</td><td>14</td></tr>
<tr><td>Q4</td><td>12</td><td>44</td></tr>
</table>
Average = 33 days
Data Source: UR Tracking Log 2015 to present</td>
</tr>
</table>

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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>11. Utilization Management – Monitor Safe and Effective Medication Practices

Ensure that all clients who are prescribed medication have a current, signed medication consent form on file, including all required elements (and any required JV-220 forms), 100% of the time.</td>
<td>1. QM staff and Medical Director or designee will continue to conduct medication monitoring reviews for 5% of the medical records, including review of required consent forms and any JV-220 forms, if applicable.

2. QM staff/Medical Director will support corrective action activities as required and report to Senior Management annually.</td>
<td>
<table>
<tr><th></th><th># Reviews</th></tr>
<tr><td>Q1</td><td>6</td></tr>
<tr><td>Q2</td><td>2</td></tr>
<tr><td>Q3</td><td>3</td></tr>
<tr><td>Q4</td><td>5</td></tr>
</table>
- During FY19/20, a total of 16 medication monitoring reviews were conducting, with at least 2 reviews completed per quarter. As required, the Medical Director took corrective actions to address review findings.
- There were no records indicating whether JV-220 forms were reviewed during these reviews, nor if they were applicable in the sample.
</td>
</tr>
</table>

Goal	Objectives	Baseline
12. Outcomes- Improve data collection and reporting for the ASOC, OASOC, and CSOC. **Select and implement a universal tool for measuring outcomes for the Adult and Older Adult Systems of Care. Additionally, implement a mechanism to improve CANS reporting for the Children's System of Care.**	1. Select and implement a universal tool to capture outcome measurements for the Adult and Older Adult Systems of Care. 2. Improve CANS reporting for the Children's System of Care by loading the CANS forms into Clinicians Gateway. This will eliminate the need for manual entry of data into the State tool and will provide simple graphics which will bring awareness to what the focus of work should be. 3. By June 30, 2021, update ongoing care notes in Clinician's Gateway to capture metrics identified by the Outcomes Tracking Project Team. 4. By June 30, 2021, begin tracking and trending HEDIS measures for Katie A./foster youth.	Currently there is not a universal tool in place for the measurement of adult and older adult outcomes. The Children's System of Care currently utilizes the CANS – 90. Due to the system that is being used (Advanced Metrics), data has to be manually entered into the State tool in order to be current. The MHP does not currently track and trend HEDIS measures.

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<table>
<tr><th>Goal(s)</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>13. Beneficiary/Family Satisfaction – Performance Outcomes and Quality Improvement (POQI) based on Consumer Perception Survey Completion

Report POQI results back to the programs in a timely manner, twice yearly and support programs in selecting improvement goals.</td>
<td>1. Performance Outcomes and Quality Improvement (POQI) data will be collected using the applicable consumer satisfaction survey (MHSIP Consumer Survey for adults, Youth Services Survey for youth 13-17 years, Youth and Youth Services Survey for Families, for parents of youth under 18 years) per DHCS schedule.

2. Report POQI results to county staff, contractors, and clients 2x annually as the surveys occur.

3. Determine consistent process for POQI administration so that the MHP can complete analysis of survey data to inform quality improvement goals.

4. Pilot a program to include one Adult System of Care program and one Children's System of Care program to identify an improvement goal based on the POQI responses.

5. BHRS will participate on the Client Experience Action Team which is developing a Client Satisfaction Survey meant to capture and learn about client experience based on race/ethnicity and SOGI. Once implemented, Report on outcomes from these surveys quarterly.</td>
<td>During POQI data collection week in November FY 19-20, an average of 45% of expected client respondents (clients served during the data collection weeks) participated in completing surveys.

Client participation rate was unavailable for the POQI data collection week in June 2020 due to the online format as a result of the COVID-19 pandemic

<table>
<tr><th>FY 18/19</th><th>MAY 2019 %</th><th>NOV 2019 %</th><th>June 2020 %*</th></tr>
<tr><td>Adult</td><td>44.1%</td><td>45.7%</td><td>n/a</td></tr>
<tr><td>Youth</td><td>50.3%</td><td>42.3%</td><td>n/a</td></tr>
<tr><td>Total</td><td>45.3%</td><td>45%</td><td>n/a</td></tr>
</table>

See overall POQI response results on the next page</td>
</tr>
</table>

	May-19				Nov-19				Jun-20			
Adult (N=285)	**Positive**	**Neutral**	**Negative**		**Adult (N=362)**	**Positive**	**Neutral**	**Negative**	**Adult (N=315)**	**Positive**	**Neutral**	**Negative**
General Satisfaction	85.5%	8.5%	4.4%		**General Satisfaction**	88.4%	7.6%	2.6%	**General Satisfaction**	87.7%	7.2%	3.0%
Perception of Access	79.6%	11.7%	4.7%		**Perception of Access**	83.0%	10.1%	4.0%	**Perception of Access**	83.9%	8.4%	3.5%
Quality & Appropriateness	79.5%	11.5%	3.2%		**Quality & Appropriateness**	73.6%	12.4%	2.8%	**Quality & Appropriateness**	81.6%	8.8%	4.3%
Participation in Tx Planning	80.7%	11.1%	4.4%		**Participation in Tx Planning**	80.9%	12.2%	2.6%	**Participation in Tx Planning**	83.3%	10.0%	4.6%
Outcome of Services	66.3%	15.8%	4.6%		**Outcome of Services**	69.5%	14.6%	5.1%	**Outcome of Services**	68.8%	16.5%	3.9%
Functioning	68.9%	15.6%	3.9%		**Functioning**	74.4%	13.8%	5.6%	**Functioning**	74.6%	15.2%	3.7%
Social Connectedness	68.3%	14.8%	5.6%		**Social Connectedness**	71.0%	15.4%	6.5%	**Social Connectedness**	70.1%	16.3%	6.5%
Youth & Family (N=77)	**Positive**	**Neutral**	**Negative**		**Youth & Family (N=83)**	**Positive**	**Neutral**	**Negative**	**Youth & Family (N=22)**	**Positive**	**Neutral**	**Negative**
General Satisfaction	92.0%	5.3%	2.7%		**General Satisfaction**	88.0%	3.6%	4.8%	**General Satisfaction**	77.3%	4.5%	13.6%
Perception of Access	80.4%	8.4%	6.7%		**Perception of Access**	81.9%	5.6%	4.0%	**Perception of Access**	75.8%	1.5%	10.6%
Quality & Appropriateness	86.7%	4.9%	3.8%		**Quality & Appropriateness**	82.7%	3.6%	2.4%	**Quality & Appropriateness**	76.5%	2.3%	9.8%
Participation in Tx Planning	82.4%	7.7%	8.0%		**Participation in Tx Planning**	83.1%	5.1%	6.5%	**Participation in Tx Planning**	78.2%	2.7%	11.8%
Outcome of Services	69.6%	11.7%	10.4%		**Outcome of Services**	67.7%	17.3%	7.5%	**Outcome of Services**	60.0%	5.5%	15.5%
Functioning	66.7%	20.0%	8.0%		**Functioning**	66.3%	19.3%	7.8%	**Functioning**	59.1%	6.8%	9.1%
Social Connectedness	82.7%	9.3%	2.7%		**Social Connectedness**	83.4%	7.8%	2.7%	**Social Connectedness**	84.1%	1.1%	3.4%