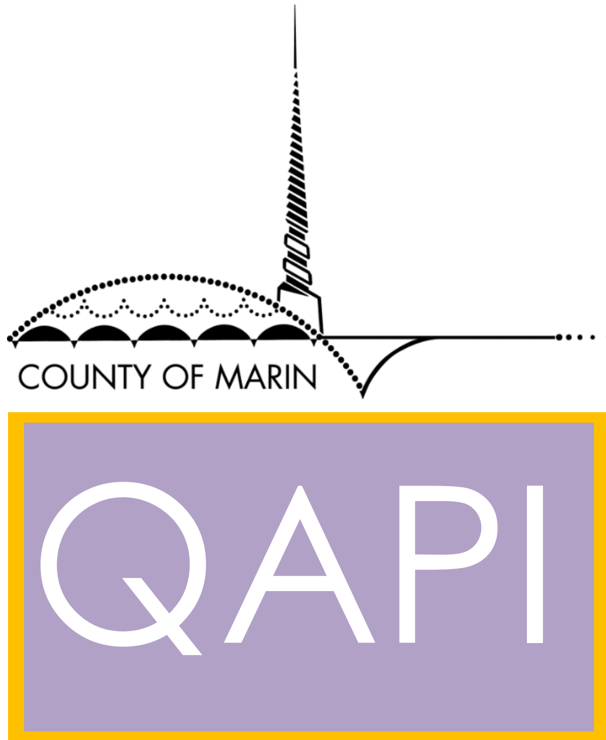


Quality Assurance & Performance Improvement Work Plan

FY 2019-2020

Health & Human Services Department
Behavioral Health and Recovery Services Division
Jei Africa, PsyD, MSCP, CATC-V, Behavioral Health Director
Dawn Kaiser, LCSW, CPHQ, Quality Manager

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. 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.

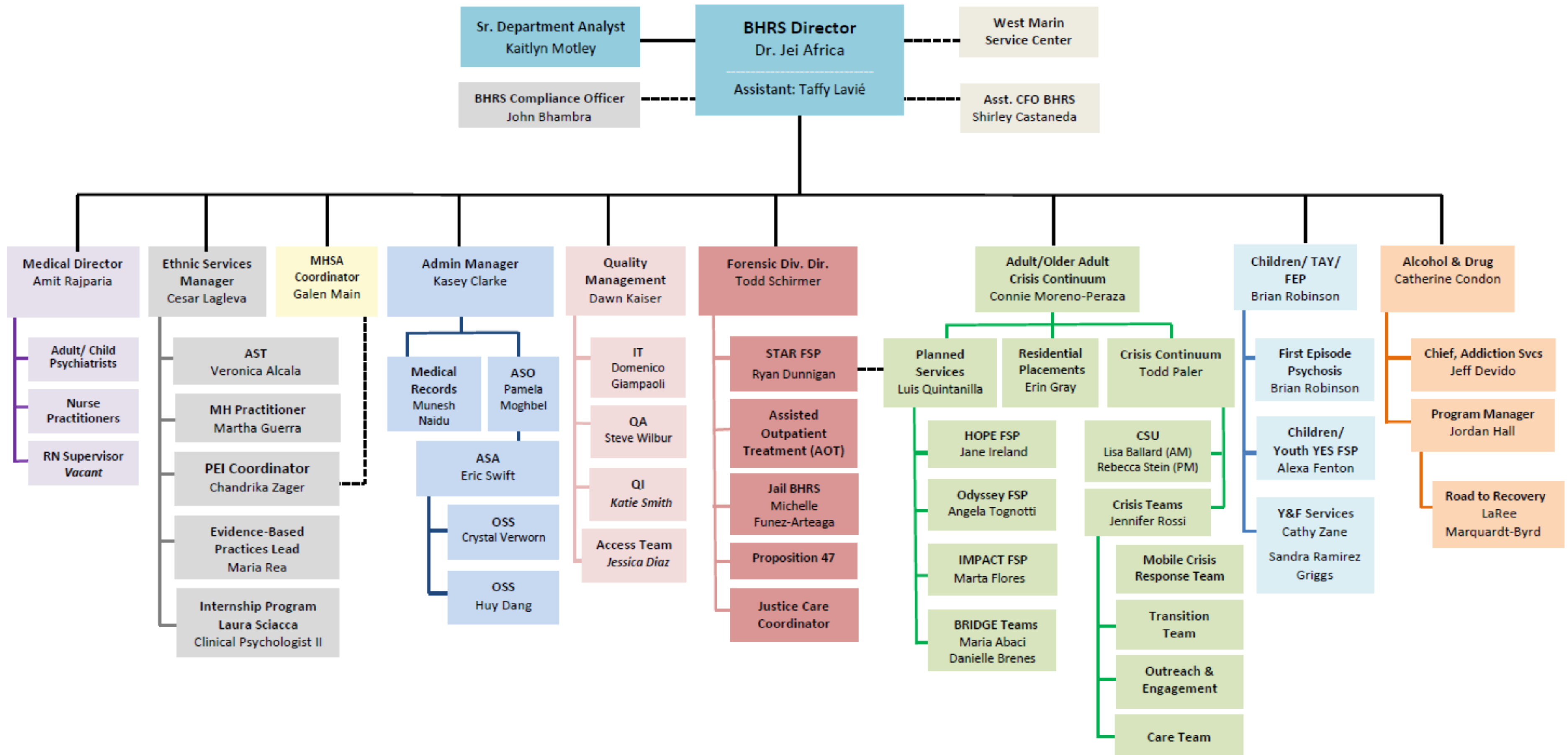
The **Quality Improvement Committee** (QIC) is a combined mental health (MH) and substance use services (SUS) committee, and is comprised of a diverse group of stakeholders, including representatives from MH and SUS administration and clinical programs, the Mental Health Board, peers/family members, 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.

Quality Assurance& Performance Improvement Work Plan FY19-20



Quality Assurance& Performance Improvement Work Plan FY19-20

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, 2019. 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 FY19-20

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. MHP 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 pilot, Drupal, a tool created by DMC-ODS which will help to automate the process and 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.	Provider network adequacy – As of September 2019 Marin County MHP has passed federal network certification requirements with no corrective action plan needed. Continue monitoring provider ratios and program siting to meet beneficiary needs. Data Source(s): NACT quarterly submission (October 2019); Provider Directory (October 2019)

Quality Assurance& Performance Improvement Work Plan FY19-20

<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. Ensure that preferred language is documented in the client's medical record and that the language in which services were provided is documented for every service.

2. 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.

3. 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><u>Provider linguistic capacity</u> – 94.5% of clients served during FY18-19had services provided in their preferred language, as documented in the EMR.

<table>
<tr><th>Encounters (n=68,167 rendered svcs)</th><th>% Encounters</th></tr>
<tr><td>Rendered in Clt's Preferred Language
(includes the use of interpreter/language line)</td><td>94.5%</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>5.5%**</td></tr>
</table>
n = 68,167 svcs ** Data quality issues contribute to this variable

<table>
<tr><th>Preferred Language</th><th>% Active Clients</th></tr>
<tr><td>English</td><td>85%</td></tr>
<tr><td>Spanish</td><td>9%</td></tr>
<tr><td>Vietnamese</td><td>2%</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 6% 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

At least 90% of Marin MHP providers will complete a minimum of four hours of cultural competency training annually.</td>
<td>1. 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.

2. 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 order to attain the 90% goal.</td>
<td><u>Provider cultural competency</u> – Out of 167 BHRS staff tracked during FY18-19, 49% 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 FY18-19.
<table>
<tr><th>Cultural Competence Training</th><th># Employees</th><th>% Completed</th></tr>
<tr><td>Completed at least 4 hours</td><td>82</td><td>49%</td></tr>
<tr><td>Did not complete 4-hour CCT</td><td>85</td><td>51%</td></tr>
<tr><td>Total</td><td>167</td><td></td></tr>
</table>
Data Source(s): BHRS Cultural Competency Training Tracking Log, SC-Provider View database</td>
</tr>
</table>

Quality Assurance& Performance Improvement Work Plan FY19-20

<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. 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.</td><td><u>Change of provider requests</u> – For FY18-19, 36 change of provider requests were received; 28 pertaining to medical staff and 8 pertaining to non-medical staff. 28 out of 36 requests were approved; 2 were denied. 14 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 18-19.

<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>28</td><td>13</td><td>13</td><td>2</td><td>0</td></tr>
<tr><td>Non-Medical Staff</td><td>8</td><td>7</td><td>1</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 90% 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 both during and after business hours in order to assess both Access team and Optum services.

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><u>24/7 Access line</u> –

An average of 16 test calls were conducted per quarter, 5.5 of which were conducted in a language other than English.

Data Source(s): Quarterly data for FY17-18 (based on 24/7 Test Call Quarterly Update Report Forms submitted to DHCS)
<table>
<tr><th>MEASURE</th><th>GOAL</th><th>FY 18/19 OUTCOME</th></tr>
<tr><td>Total test calls placed</td><td>10 calls/ quarter</td><td>16 calls/ quarter</td></tr>
<tr><td>Test call logging %</td><td>100%</td><td>81%</td></tr>
<tr><td>Test calls in a language other than English</td><td>1 call/ quarter</td><td>5.5 calls/ quarter</td></tr>
</table>
</td>
</tr>
</table>

II. Timeliness

<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 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 18-19, the timeliness standards for criteria a-d were met in every category with the exception of criteria c for children/youth to receive a psychiatric appointment within 15 business days (measured here as 21 calendar days.) Instead it took an average of 24 calendar days (approx. 18 business days). The average wait-time from BH Screening to Completed Initial Assessment has continued to improve in both adults and children (decreased by 2.5 days for adults and decreased by 4.9 days for children); both were under the requirement of 10 days.
Average wait times for FY 18-19
<table>
<tr><th></th><th>Goals</th><th>Adults (calendar days)</th><th>Children/Youth (calendar days)</th><th>Foster Youth</th></tr>
<tr><td>a) Initial request to first offered assessment appointment</td><td>10 Business days (14 calendar days)</td><td>2.5 days</td><td>2.1 days</td><td>N/A*</td></tr>
<tr><td>b) Screening to completed assessment</td><td>10 Business days (14 calendar days)</td><td>9.2 days</td><td>8.9 days</td><td>N/A*</td></tr>
<tr><td>c) Completed assessment to psychiatry appointment</td><td>15 Business days (21 calendar days)</td><td>17 days</td><td>24 days</td><td>N/A*</td></tr>
<tr><td>d) Service request for urgent appointment to actual encounter (Forster Care = 5 MCRT contacts)</td><td>48 hrs. (no prior authorization required) / 96 hours (prior authorization required)</td><td>68 minutes</td><td>59 minutes</td><td>*86 minutes</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>

<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.</td>
<td>Follow-up appointment post-psychiatric hospitalization – FY18/19
<table>
<tr><td>Adults</td><td>4.3 days</td></tr>
<tr><td>Children/Youth</td><td>3.4 days</td></tr>
<tr><td>Foster Youth (n=5) *</td><td>6.5 days</td></tr>
</table>
* There were five foster youth clients during FY18-19 with a hospitalization (n=5).

Post-psychiatric hospitalization readmission within 30 days – FY18/19
<table>
<tr><td>Adults</td><td>16%</td></tr>
<tr><td>Children/Youth</td><td>13%</td></tr>
<tr><td>Foster Youth (n=5) *</td><td>16.7% (1/6)</td></tr>
</table>
* There were six inpatient admissions for the five Foster clients, one

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 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:

<table>
<tr><td>FY 18/19</td><td>Psychiatry</td><td>Other SMHS</td></tr>
<tr><td>Adults</td><td>11.7%</td><td>2.7%</td></tr>
<tr><td>Children/Youth</td><td>11.3%</td><td>5.7%</td></tr>
<tr><td>Foster Youth</td><td>5.4%</td><td>3.9%</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 60% of programs reviewed during FY19-20</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. Implement a mechanism that will alert QM of new hires (e.g. a monthly report) and track when these new hires have been trained. Alert supervisors to new staff who have not been trained within the six-month timeframe.

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

4. 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).

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><u>UR disallowance rate</u> was < 5% for 2 out of 26, or 8% of programs reviewed during FY18-19. Despite the increase in programs with disallowance rates of greater than 5%, the overall average disallowance rate decreased from 34% in 17/18 to 28% in 18/19

<table>
<tr><th>DISALLOWANCE RATE FY 18/19</th><th>> 5%</th><th>< or equal to 5%</th></tr>
<tr><td># Programs Reviewed</td><td>24 (92%)</td><td>2 (7%)</td></tr>
</table>

Total programs reviewed during FY18/19 = 26

Data Source: UR Tracking 7/2018 to 6/2019

Currently, clinical documentation trainings are taking place every other month. During FY18/19 there were a total of 6 trainings (8/15/2018, 10/12/2018, 12/14/2018, 2/4/2019, 2/15/2019, 3/1/2019and 4/23/2019).</td>
</tr>
</table>

<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 18-19, the UR team had an average completion time of 52 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>4</td><td>67</td></tr>
<tr><td>Q2</td><td>8</td><td>71</td></tr>
<tr><td>Q3</td><td>5</td><td>31</td></tr>
<tr><td>Q4</td><td>9</td><td>40</td></tr>
</table>

Average = 52 days
Data Source: UR Tracking Log 2015 to present</td>
</tr>
</table>

<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. Medication consent forms will be updated to meet all requirements outlined in CCR, Title 9, Section 851, whether on paper or in electronic form, including evidence that prescribers have reviewed all side effects and potential risks of medication use with each patient.

3. 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>5</td></tr>
<tr><td>Q2</td><td>4</td></tr>
<tr><td>Q3</td><td>3</td></tr>
<tr><td>Q4</td><td>5</td></tr>
</table>
- During FY18/19 a total of 17 medication monitoring reviews were conducted, including at least two (2) reviews conducted quarterly. As required, the Medical Director took corrective actions to address review findings.
- A total of 45 (36%) out of 125 charts reviewed either were missing one or more medication consent(s), the prescriber did not obtain a new consent when medications were prescribed outside the dosage range indicated on the existing consent, or the chart had a consent form that was missing required elements. 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.	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.

<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. Continue 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.</td><td>During FY 18-19, an average of 41% of expected client respondents (clients served during the data collection weeks) participated in completing surveys.

FY 18-19
Client participation rate during POQI data collection week:

<table><tr><th>FY 18/19</th><th>NOV 2018 %</th><th>MAY 2019 %</th></tr><tr><td>Adult</td><td>37.4%</td><td>44.1%</td></tr><tr><td>Youth</td><td>38.7%</td><td>50.3%</td></tr><tr><td>Total</td><td>37.6%</td><td>45.3%</td></tr></table>

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

Nov-18				May-19			
Adult (N=282)	**Positive**	**Neutral**	**Negative**	**Adult (N=285)**	**Positive**	**Neutral**	**Negative**
General Satisfaction	83.5%	11.7%	4.8%	**General Satisfaction**	85.5%	8.5%	4.4%
Perception of Access	82.3%	10.9%	6.8%	**Perception of Access**	79.6%	11.7%	4.7%
Quality & Appropriateness	79.8%	13.7%	6.5%	**Quality & Appropriateness**	79.5%	11.5%	3.2%
Participation in Tx Planning	80.3%	12.7%	7.1%	**Participation in Tx Planning**	80.7%	11.1%	4.4%
Outcome of Services	72.2%	19.2%	8.6%	**Outcome of Services**	66.3%	15.8%	4.6%
Functioning	71.2%	18.9%	9.9%	**Functioning**	68.9%	15.6%	3.9%
Social Connectedness	70.9%	19.1%	10.0%	**Social Connectedness**	68.3%	14.8%	5.6%
Youth & Family (N=73)	**Positive**	**Neutral**	**Negative**	**Youth & Family (N=77)**	**Positive**	**Neutral**	**Negative**
General Satisfaction	91.4%	5.7%	2.9%	**General Satisfaction**	92.0%	5.3%	2.7%
Perception of Access	81.6%	10.2%	8.3%	**Perception of Access**	80.4%	8.4%	6.7%
Quality & Appropriateness	91.6%	4.5%	3.9%	**Quality & Appropriateness**	86.7%	4.9%	3.8%
Participation in Tx Planning	83.6%	10.6%	5.9%	**Participation in Tx Planning**	82.4%	7.7%	8.0%
Outcome of Services	65.5%	26.2%	8.3%	**Outcome of Services**	69.6%	11.7%	10.4%
Functioning	62.2%	29.6%	8.1%	**Functioning**	66.7%	20.0%	8.0%
Social Connectedness	84.2%	10.3%	5.5%	**Social Connectedness**	82.7%	9.3%	2.7%