sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN

FISCAL YEAR 2021 – 2022

ADOPTED ON: 1/28/2022

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

PURPOSE AND INTRODUCTION

Sonoma County Department of Health, Behavioral Health Division (DHS-BHD) is committed to a culture of continuous quality improvement, in support of our goal to offer high quality behavioral healthcare services to Sonoma County beneficiaries. The Quality Assessment and Performance Improvement (QAPI) program, within DHS-BHD, serves as the unifying structure for quality improvement and quality assurance across the specialty mental health system. **The purpose of the QAPI Work Plan is to promote continuous improvement in the quality of behavioral health services provided to Specialty Mental Health Plan beneficiaries in Sonoma County**. Through the QAPI Work Plan, DHS-BHD will implement quality improvement activities that:

- Ensure service delivery is consumer-focused, clinically appropriate, cost effective, data-driven, and culturally responsive;
- Increase the capacity of DHS-BHD leadership and QAPI staff to track key indicators addressing beneficiary outcomes, program development, and system change;
- Support decision-making based on performance improvement measures; and
- Increase quality of beneficiary services across the Mental Health Plan.

MISSION, VISION, AND VALUES

The mission of the Department of Health Services, Behavioral Health Division (DHS-BHD) is to promote recovery and wellness to Sonoma County residents.

DHS-BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or a substance use disorder to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-focused system include: *

- Self-Direction
- Individualized and Person-Centered Care
- Empowerment and Shared Decision-Making
- Holistic Approach that Encompasses Mind, Body, Spirit, and Community
- Strengths-Based
- Peer Support
- Focus on Respect, Responsibility, and Hope.

DHS-BHD fosters a collaborative approach by partnering with clients, family members, and the community to provide high quality, culturally responsive services. ***Services are provided in all languages.*** DHS-BHD directly administers specialty mental health treatment services to Sonoma County residents whose mental health needs are determined to be medically necessary as defined by CCR Title 9 and W&I Code 5600.

**adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)*

LINKS TO DHS STRATEGIC PLAN

DHS-BHD QAPI Work Plan objectives and activities align with and support the Sonoma County Department of Health Services (DHS) Strategic Plan in the following ways:

DHS Strategic Plan Goal 1: All residents and community environments are healthy and safe	
DHS Objective and Strategy: Improve quality of life outcomes by advancing cross-sector partnerships, networks, collaboration, and community engagement to improve community and individual determinants of health	QAPI Work Plan Alignment: The Quality Improvement Committee is comprised of DHS-BHD Leadership, Staff, Community Providers, Clients, and Family Members of Clients; this cross-sector team collaborates to improve community and individual determinants of behavioral health
DHS Strategic Plan Goal 2: Individuals, families, and communities access high quality and coordinated services for health, recovery, well-being, and self-sufficiency	
DHS Objective and Strategy: Increase access to safety net services by strengthening coordination of services with emphasis on high-need residents	QAPI Work Plan Alignment: The Access Timeliness Performance Improvement Project improves access to safety net services by streamlining the intake process and removing delays to treatment
DHS Strategic Plan Goal 3: The Department of Health Services is a high achieving, high functioning organization	
DHS Objective and Strategy: Build a highly competent, effective, and engaged workforce by improving communication and collaboration	QI Plan Alignment: The QI Communication Plan improves communication and collaboration by informing staff performance metrics and client outcomes; regular program-level QI trainings provide a forum for technical assistance and team collaboration on best-practices

More information on the DHS Strategic Plan can be found at this link: https://healthstrategicplan.sonomacounty.ca.gov/

Cultural Responsiveness is critical to promoting equity, reducing health disparities and improving access to high-quality behavioral health services that are delivered in a manner which is respectful of and responsive to the needs of diverse clients. In support of this value, the QI Plan aligns with the Cultural Competence Plan by monitoring client satisfaction survey results pertaining to cultural responsiveness of staff, which then inform improvement goals for the service system. The QI Team analyzes and disseminates these results to Division Leadership, the Ethnic Services Manager, and Program Managers to assist in identifying disparities and developing strategies toward Cultural Responsiveness.

DHS-BHD QUALITY IMPROVEMENT PROGRAM

Quality is an organization-wide commitment in which all members of the system play a vital role. The Quality Improvement team within QAPI delineates the structure and methods used to monitor and evaluate quality improvement. A division-wide array of teams and committees exist in partnership with the QI Team, and provide overall structure for quality management as well as oversight responsibilities of DHS-BHD. The QI Team is a compilation of several organizational units and committees, including:

- Division Management Team (DMT)
- Quality Assurance & Performance Improvement Section (QAPI)
- Quality Improvement Committee (QIC)
- Quality Management Policy Committee (QMP)
- Quality Improvement Steering Committee (QIS)
- Quality Improvement Manager & QI Unit

QUALITY IMPROVEMENT PROCESS

The QI Unit utilizes a variety of QI tools and resources to assess system performance issues and plan quality interventions and projects. The over-arching process utilized is the Plan-Do-Study-Act (PSDA) Model for Quality Improvement.

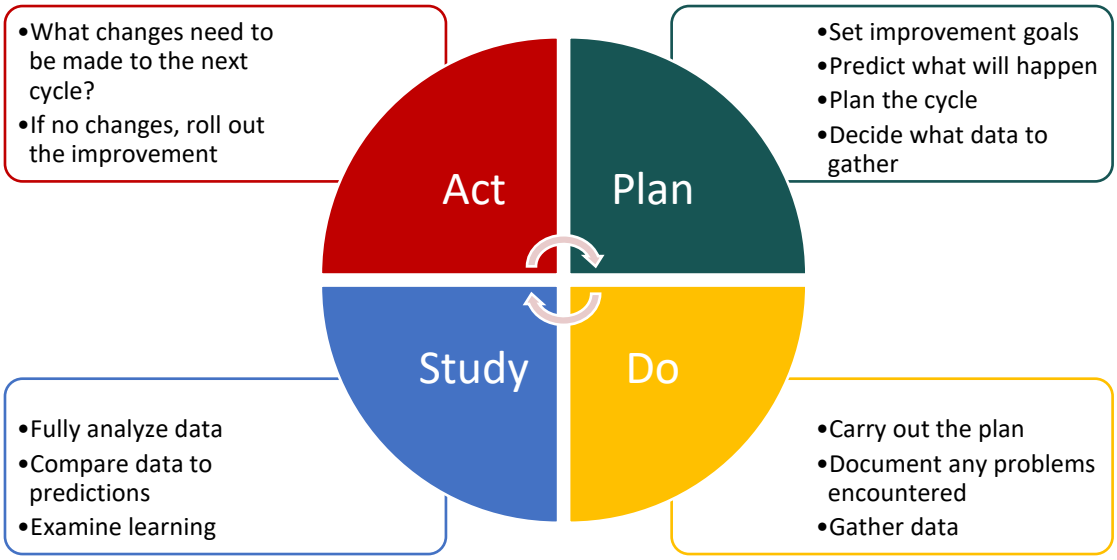
PLAN-DO-STUDY-ACT MODEL FOR QUALITY IMPROVEMENT

Plan: Investigate the current situation, fully understand the nature of any problem to be solved, and develop potential solutions to the problem.

Do: Implement the action plan on a test basis.

Study: Compare data results of the new process with those of the previous one.

Act: Decide, based upon the data, whether to adopt the new process, make slight changes to the process, or to abandon the process and start over. For decisions to adopt or adapt the improvement process, monitor the gains going forward. For decisions to abandon the process, determine a new course.



SECTION I. PERFORMANCE MONITORING ACTIVITIES

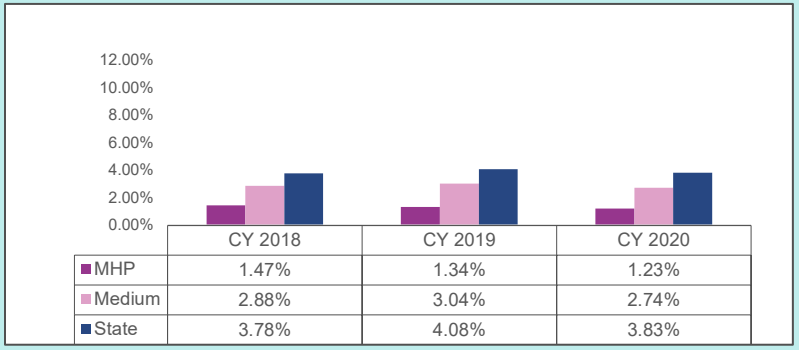
DHS-BHD Quality Improvement staff work closely with QAPI staff and other stakeholders to monitor the following activities on a regular basis to ensure meaningful improvement in clinical care and beneficiary service:

Area Monitored	Data Reviewed	Responsible Partners	FY 21-22 Objectives
Accessibility of Services	Timeliness service data, Beneficiary Access Call Database, Optum Call logs, Quarterly Test Call Reports	Quality Improvement;	DHS-BHD will regularly evaluate timeliness and accessibility of service performance across the system, and will address quality or performance issues within the QAPI workplan using actions steps for remediation.
Appeals & Expedited Appeals	Grievance & Appeals Log	Quality Assurance; Quality Improvement	DHS-BHD will continue monitoring appeals and analyzing trends.
Beneficiary Grievances	Grievance & Appeals Log	Quality Assurance; Quality Improvement	DHS-BHD will continue monitoring grievances and analyzing trends.
Clinical Records Review	Federal, State, and County Audit reports, Utilization Review (authorization findings)	Quality Assurance; Utilization Review (pre-billing audits & post training spot-checks); Auditing & Monitoring	DHS-BHD will monitor and evaluate the appropriateness and quality of services through periodic service audits and chart reviews. DHS-BHD will incorporate compliance feedback from state and federal audits.
Medication Monitoring	Medication Monitoring Peer Review Tracking Log; JV220 tracking log	Medical Director; FYT Psychiatry staff & Psychotropic Oversight Committee; Quality Improvement	DHS-BHD continue to monitor effectiveness and quality of medications, including medication practices. DHS-BHD will consoldiate SB1291 medication monitoring metrics and reports in the Avatar Electronic Health Record (objective 14)
Performance Monitoring	CANS/ANSA Outcomes, Consumer Perception Survey	Quality Improvement; System of Care Section Managers, Clinical Specialists, QAPI	DHS-BHD will consolidate CANS/ANSA data into a common electronic platform for improved outcome analysis across MHP system. DHS-BHD will conduct two annual CPS surveys in accordance with state requirements and attempt to increase CPS response rate (objective 6)
Provider Appeals	Provider Appeals Log	Quality Assurance	DHS-BHD will continue to monitor provider appeals.
Sentinel Events	Incident Report Database	Section Managers, Medical Director, Quality Improvement	DHS-BHD will continue to regularly monitor sentinel events, and continue to meet monthly for the purpose of analyzing sentinel events for quality improvement purposes.

SECTION II. QUALITY IMPROVEMENT ACTIVITIES

Quality Improvement works closely with System of Care section leaders, program managers, and other quality improvement stakeholders across the system to assess performance, monitor QI efforts for previously identified performance issues, and target areas of improvement within Sonoma County's mental health service delivery system. The following table outlines the Quality Improvement Objectives for this year based on review and analysis of MHP system performance.

DOMAIN	NO.	OBJECTIVE
ACCESS TO CARE	1	Increase Latino/Hispanic/Latinx penetration rate to 1.68% or more over a 15 month period (Non-Clinical PIP)
ACCESSIBILITY OF SERVICES	2	Improve the average length of time from initial request to first offered psychiatry appointment to 15 business days or less.
	3	95% of calls to the 24-hour toll free telephone number will be answered by a live person to provide information to beneficiaries about how to access specialty mental health services.
	4	95% of urgent initial requests originating from Access Line, will receive services within 48 hours or less.
	5	At least 50% of Adult post-hospital discharge follow-up appointments will be scheduled within 7 calendar days of inpatient discharge.
BENEFICIARY SATISFACTION	6	Increase response rate for Consumer Perception Survey to at least 15% of all beneficiaries served annually**.**
	7	For Native American Consumer Perception surveys collected in FY 21-22, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains
CALAIM/ACCESS TO CARE	8	Complete plans for Universal Behavioral Health screening & Transition of Care Tool implementation (screening workflow, P&P, training plan, report metrics) by FY21-22.
CLINICAL CARE	9	Provide Therapeutic Behavioral Services (TBS) at a minimum of a 4% utilization rate of all unique Medi-Cal beneficiaries under the age of 21.
	10	Reduce High Cost Beneficiary (HCB) count by 10% and HCB utilization of Crisis Stabilization Unit (CSU) by 20% over a 2 year period; Reduce HCB average actionable ANSA scores items by 15%. (Clinical PIP)
CULTURAL RESPONSIVENESS	11	At least 70% of DHS-BHD clinical staff will attend a cultural competence training by FY 21-22.
	12	Complete DEI policy review workflow, structure and committee development and implement review process for at least one MHP policy by FY21-22
SERVICE CAPACITY	13	Increase the peer provider FTE positions allocated throughout the service system by 15% over FY20-21 numbers.
	14	Reduce the number of Adult post-hospital follow-up "no-show" appointments by 50% from FY 20-21 base year.
PERFORMANCE MEASUREMENT	15	Consolidate all SB 1291 Medication Monitoring metrics into the Electronic Health Record

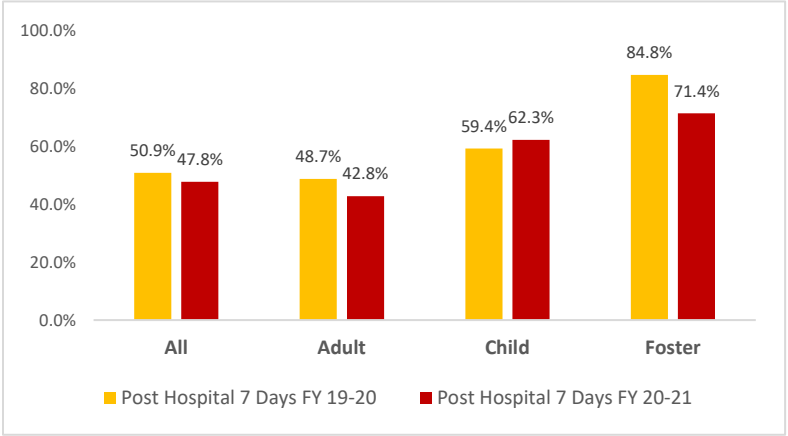
OBJECTIVE 1	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESS TO CARE Increase Latino/Hispanic/ Latinx penetration rate to 1.68% or more over a 15 month period (Non Clinical PIP)	**Latino/Hispanic/Latinx Penetration Rate** • Promotores mental health outreach • Diversity Equity & Inclusion Recruitment activities to hire and retain bilingual/bicultural clinical staff • All staff participate in cultural competence trainings annually • Staff participate in trainings and consultations to strengthen culturally appropriate clinical treatment for Latinx beneficiaries	1. Latino/Hispanic Sonoma County MHP Penetration Rates 3-year trend  CY 2018 / CY 2019 / CY 2020 MHP: 1.47% / 1.34% / 1.23% Medium: 2.88% / 3.04% / 2.74% State: 3.78% / 4.08% / 3.83% 2. % Latino/Hispanic/Latinx clients served in MHP: • 29% (FY 20-21) 3. % Latino/Hispanic/Latinx Sonoma County MediCal Eligible Pop • 41% (CY 2020)	DEI Manager MHSA Manager WET Coordinator Adult Section Mgr Youth Section Mgr Acute & Forensics Section Manager QI Manager

OBJECTIVE 2	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESSIBILITY OF SERVICES Improve the average length of time from initial request to first offered psychiatry appointment to 15 business days or less.	**Psychiatry Appointment Timeliness** • Increase psychiatry staff by 2.0 FTE • Establish expectation for target caseloads (230 adults; 130 youth per FTE), and right-size caseloads accordingly. • Adopt team-based model of psychiatry caseloads used in previous years. • Add additional 1.0 FTE scheduling staff • Adult Med Clinic scheduling staff to adopt one Avatar-based scheduling system	1. Average length of time (Mean and Median days) from initial request to first offered psychiatry appointment • Baseline Performance (FY20-21) **All** / **Adult** / **Children's** / **Foster Care** **Average length of time from first request for service to first offered psychiatry appointment (in business days)** **19.21 days (mean)** / **19.86 days (mean)** / **18.56 days (mean)** / 22.23 days (mean) **18 days (median)** / **21 days (median)** / **14 days (median)** / 20 days (median) **19.21 Std. Dev.** / **13.45 Std. Dev.** / **17.70 Std. Dev.** / 18.23 Std. Dev.	Medical Director Adult Section Mgr Youth Section Mgr Acute & Forensics Section Manager QI Manager

OBJECTIVE 3	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESSIBILITY OF SERVICES 95% of calls to the 24-hour access line will be answered by a live person to provide information to beneficiaries about how to access specialty mental health services.	**Access Line Call Abandonment** • Identify times of day with highest call volumes, as well as times that calls are most likely to be abandoned. • Explore staffing needs and call center workflow to maximize call answering capacity during highest volume times and times during which calls are abandoned during normal business hours.	1. % of All Calls to the 24-hour toll free Access line Answered by Live Person • 87.92% (FY20-21). This represented a decrease from the previous year. 2. Average # of calls to the 24-hour toll free Access line that are abandoned by caller. • 100/month (FY20-21)	Adult Section Mgr Youth Section Mgr Adult Access Manager Youth Access Manager

OBJECTIVE 4	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESSIBILITY OF SERVICES 95% of <u>urgent</u> initial requests originating from <u>Access Line</u>, will receive services within 48 hours or less.	**Access Line Urgent Requests for Service** • Conduct Adult and Youth Access staff training on criteria for urgent requests, & timely assessment service requirements for urgent requests • Examine and address any workflow barriers that delay initiation of timely assessment services from the point of an urgent initial request.	1. % of Urgent Requests to Access Line that received services within the Standard of 48 Hours or Less • Baseline Performance (FY 20-21)	Adult Section Mgr Youth Section Mgr Adult Access Manager Youth Access Manager

	All	Adult	Children's	Foster Care
# Urgent Requests	23	7	16	1
# Served in 48 hrs	3	0	3	0
% Met Standard	**13%**	**0%**	**19%**	**0%**

OBJECTIVE 5	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESSIBILITY OF SERVICES At least 50% of Adult post-hospital discharge follow-up appointments will be scheduled within 7 calendar days of inpatient discharge.	**Adult Post-Hospital Follow-Up Appointments** • Review communication loop between Hospital Liaison Team and Clinical Treatment Team, including Access. • Hire MHRS/SCSS to support tracking, and communication between Hospital Team and Clinical teams • Review caseload distribution on Clinical Team to optimize capacity for post-hospital coverage. • Review and potentially revise scheduling calendar to implement post-hospital dedicated slots for assessors and psychiatrists	1. Percent of Post-Hospital Follow-Up appointments that met the 7 day post-hospital discharge standard. • Baseline FY19-20, FY20-21 	Adult Section Manager Adult Access Team Manager QI Manager (data tracking)

OBJECTIVE 6	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
BENEFICIARY SATISFACTION Increase response rate for Consumer Perception Survey to at least 15% of all beneficiaries served annually	**Consumer Perception Survey Response Rate** • Administer the Consumer Perception Survey bi-annually (2x per year) • For electronic survey, ensure technical issues are investigated and resolved to minimize blank data submissions. • Offer paper survey administration (in addition to electronic) option to maximize participation for beneficiaries without access to electronic means of submission.	1. CPS Participation Rate (Beneficiaries Surveyed/Total Beneficiaries served MHP) • FY 20-21 CPS Participation Rate **Adults** / **Older** / **Youth** **Total Client Surveyed**: 111 / 14 / 55 **Total Served MHP**: 2,170 / 439 / 881 **% Response Rate**: 5% / 3% / 6%	QI Manager CBO & County Providers

<table>
<tr><th>OBJECTIVE 7</th><th>ACTION STEPS</th><th>PERFORMANCE INDICATOR & BASELINE</th><th>RESPONSIBLE PARTNERS</th></tr>
<tr>
<td>BENEFICIARY SATISFACTION
For Native American Consumer Perception surveys collected in FY 21-22, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains</td>
<td>Native American Consumer Perception
• Provide staff development training focused on Native American clinical interventions and best practices, particularly for youth focused staff
• Invite Native American stakeholders to participate in the QIC and Cultural Responsiveness Committee
• Increase Native American participation rate in Consumer Perception Survey</td>
<td>1. Consumer Perception Survey Domains. Minimum threshold goal: 3.5 on a Likert scale 1-5.
• FY 20-21 Native American CPS Score results
<table>
<tr><th></th><th>Adults (6)</th><th>Older (1)</th><th>Youth (2)</th></tr>
<tr><td>General Satisfaction</td><td>3.94</td><td>5.0</td><td>2.67</td></tr>
<tr><td>Access</td><td>3.97</td><td>5.0</td><td>1.00</td></tr>
<tr><td>Participation Treatment Planning</td><td>4.40</td><td>5.0</td><td>2.33</td></tr>
<tr><td>Quality & Appropriateness</td><td>3.90</td><td>5.0</td><td>1.00</td></tr>
<tr><td>Outcomes of Service</td><td>3.38</td><td>4.0</td><td>1.00</td></tr>
<tr><td>Social Connectedness</td><td>3.90</td><td>4.0</td><td>1.50</td></tr>
<tr><td>Functioning</td><td>3.56</td><td>4.0</td><td>1.00</td></tr>
</table>
2. Native American CPS Response Rate (Native Americans surveyed/total Native Americans served MHP)
• 10% 9/99 served (FY 20-21)</td>
<td>DEI Manager
Cultural Responsiveness Committee
QI Manager</td>
</tr>
</table>

OBJECTIVE 8	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CALAIM/ACCESS TO CARE Complete plans for universal Behavioral Health screening & Transition of Care Tool (screening workflow, P&P, training plan, report metrics) by FY21-22.	**CALAIM/ACCESS TO CARE** • Review and finalize BH screening and Transition of Care tool with stakeholders • Render tools in Avatar for production • Develop reporting metrics based on data collected in new tools • Develop staff training plan on new universal screening tools	1. New Objective, No baseline. The following completed deliverables will serve as performance indicators: • Universal BH Screening Tool & Transition of Care Tool • Screening Workflow for Youth and Adult Access Teams • Staff Training Plan for Youth and Access Teams • Report Metrics based on Screening and Transition of Care Tools.	Adult Section Mgr Youth Section Mgr Acute & Forensics Section Manager WET Coordinator QI Manager Interoperability Committee

OBJECTIVE 9	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CLINICAL CARE Provide Therapeutic Behavioral Services (TBS) at a minimum of a 4% utilization rate of all unique Medi-Cal beneficiaries under the age of 21.	**Therapeutic Behavioral Services (TBS)** • By examination of data determine extent this is a provider capacity issue, &/or a referral training issue. • Explore existing TBS staff capacity and staffing workforce needs at providers (vs. contract capacity) • Explore possibility of adding an additional TBS provider in FY21-22 if needed, based on analysis. • Regular data reporting on TBS utilization within BHPA	1. TBS Utilization Rate: Number of TBS services provided to beneficiaries under the age of 21 (Code 345 & M345) / Total Services for clients under 21 on service date. • In FY 20-21, DHS-BHD provided 1,664 TBS services at a 3.21% utilization rate for beneficiaries under age 21. Further decrease from FY 19-20 rate of 3.55%.	Youth Section Manager TBS Manager QI Manager

OBJECTIVE 10	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS

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

OBJECTIVE 11	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CULTURAL RESPONSIVENESS At least 70% of DHS-BHD staff will attend a cultural competence training by FY 21-22.	**Staff Cultural Competence Trainings** • Offer 2+ cultural competence training opportunities throughout FY21-22 • Track training attendance and report on goal and attendance progress at the All Staff meetings	1. 40% of DHS-BHD staff completed a cultural competence training sponsored by DHS-BHD in FY20-21. • (120/303) 40% (FY 20-21) • 303 DHS-BHD staff Workforce - Point in Time (includes extra hires)	DEI Manager WET Coordinator Cultural Responsiveness Committee

OBJECTIVE 12	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CULTURAL RESPONSIVENESS Complete DEI policy review workflow, structure and committee development and implement review process for at least one MHP policy by FY21-22	**Diversity, Equity, Inclusion in Policies** • Establish structure for DEI Review of policies and procedures, including workflow from development to review and implementation • Develop criteria for DEI review standards • Establish a committee and process for DEI review • Implement DEI review process for at least one new or existing policy	1. New Objective, No baseline. The following completed deliverable will serve as a performance indicator: • One MHP Policy & Procedure (revised or new) vetted through the new DEI policy review committee as part of its finalization.	DEI Manager Cultural Responsiveness Committee Policy and Procedure Subcommittee

OBJECTIVE 13	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
SERVICE CAPACITY Increase the peer provider FTE positions allocated throughout the service system by 15% over FY20-21 numbers.	**Expand Peer Provider Workforce** • Establish a peer-provider program (2.0 FTE) with rotations at the CSU to reduce crisis service utilization. • Hire 1.0 FTE peer housing specialist to work within Adult Services. • Participate in the SB803 peer certification program hosted by CalMHSA. • Develop peer internship and peer run housing program (West County Community Services)	1. # Peer FTE allocated at county contractors • 32.57 FTE (FY20-21) 2. # Peer county "Extra Help" FTE employees • 0.5 FTE (FY20-21)	Acute & Forensics Section Manager Adult Section Manager WET Coordinator

OBJECTIVE 14	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
SERVICE CAPACITY Reduce the number of Adult post-hospital follow-up "no-show" appointments by 50% from FY 20-21 base year.	**Adult No-Show Rate – Post Hospital Follow Up** • Develop an introductory outreach document that explains post-hospital follow-up services available • Implement outreach document with hospital partners • Review and revise post-hospital scheduling workflow and implement new coordinated client and hospital staff scheduling confirmation process • Recruit a dedicated MHRS/SCSS level staff to support Adult Med clinic, and support post-hospital aftercare connection and engagement.	1. # of Adult No-Show Post-Hospital Appointments • 128 no-show appointments (FY20-21) baseline	Adult Section Manager Adult Access Team QI Manager (data tracking)

OBJECTIVE 15	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
PERFORMANCE MEASUREMENT Consolidate all SB1291 medication monitoring metrics into the Electronic Health Record	**SB 1291 medication monitoring metrics** • Identify and map existing data systems for tracking HEDIS measures • Consolidate into single data needs summary • Validate against HEDIS standards • Render applicable reports in the Electronic Health Record.	**Avatar Electronic Health Record SB 1291 Reports:** 1. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD) • FY 20-21: in progress 2. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC) • FY 20-21: in progress 3. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP) • FY 20-21: in progress 4. Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) • FY 20-21: complete	Avatar Change Governance Committee QI Manager