ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES


# QUALITY IMPROVEMENT PROGRAM AND WORK PLAN

## Fiscal Year 2013/2014

*(July 1, 2013 – June 30, 2014)*

***Alameda County Behavioral Health Care Services Mission Statement:***
**Our mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.**

## INTRODUCTION

Quality Improvement Programs/Work Plans are used by Executive Teams to manage (i) conformance with federal and state requirements for quality improvement and (ii) behavioral health system's priorities for quality improvement and quality management.

With this in mind, ACBHCS developed its **FY 13/14 Quality Improvement Program and Work Plan** to meet California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440; and also to support improved access to services during this first implementation year of the Affordable Care Act's Medicaid Expansion.

The contents of this *Quality Improvement Program and Work Plan* were vetted by the ACBHCS Executive Team to ensure alignment with the ACBHCS mission and values. Our mission and values were formalized in FY 2010 and reflect the experience of over two decades of leadership (including eight years of Mental Health Services Act funding). Our ACBHCS ***mission***, stated in blue, above, has anchored the behavioral health system's shift from maintenance and stabilization towards integrating wellness and recovery practices into the culture and operations of services. "Recovery, wellness and resilience" acknowledges that each beneficiary has innate strengths - and that self-efficacy and ultimately, client outcomes, will improve when services are culturally resonant and experienced as safe, collaborative and empowering.

Our ACBHCS ***values***, stated below, offer milestones that leadership uses to implement the ACBHCS mission.

- **A**ccess
- **C**onsumer & Family Empowerment
- **B**est Practices
- **H**ealth & Wellness
- **C**ulturally Responsive
- **S**ocially Inclusive

Leadership is preparing for new regulatory, organizational and political challenges. This Quality Improvement Program and Workplan is a product of this dynamic environment and includes mechanisms/activities and performance indicators that measure our progress in relationship to these values.

The purpose of this ACBHCS QI Program and Workplan is to:

- implement and evaluate quality improvement activities across ACBHCS;
- increase capacity, within the Behavioral Health Director's Office, to monitor and track key indicators addressing beneficiary outcomes, program development and system change;
- support organizational decision-making;
- develop content for communications with providers and other stakeholders; and
- increase quality improvement capability in programs operating across the continuum of care

This Quality Improvement Program and Workplan provides a vehicle for ACBHCS management to (i) meet quality improvement requirements specified in our Mental Health Plan contract with the State Department of Health Care Services (DHCS) for the expenditure of Medi-Cal (Medicaid) dollars and (ii) address and solve issues raised in the tri-annual DHCS Audits and annual EQRO Site Reviews. This Quality Improvement Program/Workplan is organized into two sections:

## Section I: Qualitative Goals: Regarding MHP Contract Requirements for " Mechanisms and Activities"

*Addresses MHP contract requirements or EQRO requirements that describe qualitatively defined goals along with mechanisms and activities used to "meet goals established in the MHP contract." (Page 4)*

**Section II: Numeric Goals: Regarding MHP Contract Requirements that include Baselines, Action Steps, Monitoring**
*Addresses MHP contract requirements or EQRO Key Indicators that describe numeric goals along with baselines, action steps and monitoring activities . (Page 19)*

- QI Goal 11: Number, Types And Geographic Distribution Of Mental Health Services Within The MHP Delivery System p.20
- QI Goal 12: Average Length Of Time From Initial Contact To First Appointment p.21
- QI Goal 13: Average Length Of Time From Initial Contact To First Psychiatry Appointment p.22
- QI Goal 14: Timeliness Of Services For Urgent Conditions p.23
- QI Goal 15: Access To After Hours Care p.23
- QI Goal 16: 24/7 Toll Free Line p.24
- QI Goal 17: Follow-Up Appointments After Hospitalization p.25
- QI Goal 18: Readmission Following Hospitalization p.25
- Previously Identified Issues p.26

*A note about the scope of this Quality Improvement Program and Workplan.*

The California Department of Health Care Services requires quality improvement efforts to focus on how Medi-Cal dollars are spent to improve mental health outcomes for beneficiaries. With this in mind, this QI Program/Workplan addresses services funded through the Mental Health Services Act or Drug Medi-Cal dollars only when they are used as 'investment capital' to improve our "core" mental health system.

**SECTION I: QUALITY IMPROVEMENT WORKPLAN / QUALITATIVE GOALS-** (*Addresses MHP requirements describing qualitatively defined goals along with mechanisms and activities used to "improve established outcomes")*

The ACBHCS Quality Improvement Program includes projects where "improvement" is based on implementation of qualitative goals and *mechanisms and/or activities* that manage and track critical areas of quality management, quality improvement, or utilization management that are required in the county MHP contract. Processes that address "one issue at a time" are trended before being analyzed as part of the Quality Improvement program.

The FY 13/14 ACBHCS Quality Improvement Program has eight components. Each component includes: a goal; baseline; description of Quality Improvement mechanisms or activities that will improve outcomes; and responsibility for monitoring. If more than one project is listed to track a component, then each project is presented with its own goal/baseline, mechanism/activity and responsibility for monitoring.

## QI Goal #1: Quality Improvement Unit

***Goal:*** To increase the Quality Improvement Unit's capacity to actively manage the Quality Improvement Program and Workplan

***Baseline:*** During FY 12/13, the ACBHCS Quality Improvement Director was promoted to the position of ACBHCS Deputy Director and continues to manage quality efforts while in both roles. QI Unit staffing consisted of 1 FTE Senior Manager (Project Management, Research and Analytical tasks), 1 FTE Ethnic Services Manager, 1 FTE Administrative Coordination position and 1 FTE Executive Administrative Support position.

***QI mechanisms and/or activities that will improve outcomes:*** During FY13/14 BHCS will formalize and strengthen the QI Unit and its role in staffing the QI decision making process in the following ways:

1. Hire a new Quality Improvement Director
2. Add 1 FTE to the Quality Improvement analytical team
3. Formalize linkage between the Quality Improvement Unit and three BHCS departments/functions that are integral to the Quality Improvement Program: Decision Support, Quality Assurance and Utilization Management. .

    - The Quality Improvement Unit and designated BHCS staff from Quality Assurance, Decision Support and Utilization Management will work together to manage the QI Workplan reporting cycle and track the implementation of mechanisms that monitor and assess quality improvement.

    - Results will be brought to the QIC for review and evaluation. QI Unit staff will then bring results to the Executive Team or ACBHCS Leadership (Behavioral Health Director; Deputy Director; Financial Officer; Director, Management Services Office).

***Responsibility for Monitoring***: ACBHCS Quality Improvement Director

## QI Goal #2: Quality Improvement Committee

***Goal:*** To increase the capacity of the QIC to be actively involved in the BHCS quality improvement process and strengthen its advisory role to Executive Administration.

***Baseline:*** In FY12/13, the BHCS Quality Improvement Committee (QIC) met, on average, every two months and heard oral reports from staff responsible for implementing activities designed to address FY 12/13 QI Plan goals. The QIC documented these discussions in meeting minutes. QIC membership consisted of 1 family member (representing the Mental Health Board), 1 consumer (representing the Alameda County Network of Mental Health Clients), 2 providers (representing the Alameda Council of Community Mental Health Agencies, and Alameda County Alcohol and Drug Programs) and 9 representatives from BHCS administration.

***QI mechanisms and/or activities that will improve outcomes:***

1. The composition of the QIC will be shifted to increase the ratio of beneficiaries, family members and providers to BHCS staff. New QIC applicants will be screened to include experience using data to monitor and trend client, program and/or system level outcomes. MHP providers, beneficiaries and family members who are on the QIC will be more involved in the planning and design of the QI Program and in evaluating data and stating the outcomes. Members of QI Subcommittees will be engaged to more actively participate in the implementation of the QI Program, including making recommendations to the QIC.

2. The QIC is an advisory body to the ACBHCS Executive Admin. BHCS QIC members will be more actively be involved in or oversee (MHP Contract (Exhibit A - Attachment I -Section 23):
   - *Instituting QI actions*;
   - *Ensuring follow-up of QI processes*;
   - *Reviewing and evaluating the results of QI activities, including Performance Improvement Projects (PIPs)*;
   - *Recommending policy decisions* to Executive Administration through the review of QI Workplan outcomes
   - *Document QI Committee meeting minutes regarding decisions and actions taken*.

3. Strengthen QIC's data reporting and feedback linkage with ACBHCS committees that address utilization management, and quality of care issues. In FY 13/14, the Quality Improvement Committee will *formalize data reporting relationships* with ACBHCS committees and departments that perform quality improvement across the continuum of services. Specifically, QIC staff will trend and format data from the following ACBHCS committees and departments for review during QIC meetings:
   - Quality Assurance Office including
     - Provider Credentialing & Appeals
     - Complaints, Grievances & Appeals
     - Sentinel Events

- Acute Care Management (Bed Control) (utilization management data)
- ACCESS and Authorizations Unit (utilization management data)

4. Strengthen QIC's communication with ACBHCS committees that address quality improvement and organizational change issues.
   - ACBHCS Co-Occurring Conditions Steering Committee (currently a subcommittee of the QIC)
   - ACBHCS Psychiatric Practices Committee
   - ACBHCS Cultural Responsiveness Committee and its Alameda County PRIDE Sub-Committee
   - ACBHCS CANS Steering Committee (Children's System of Care)
   - Pool of Consumer Champions Steering Committee
   - Alameda County Council of Community Mental Health Agencies
   - Alcohol and Other Drug Providers

***Responsibility for Monitoring***: ACBHCS Quality Improvement Director

**QI Goal #3: Mechanisms and Activities hat Assess Beneficiary/Family Satisfaction and Monitor Beneficiary Grievances, Appeals and Fair Hearings**

***Global Goal for Component:*** To add a beneficiary/family satisfaction survey that is administered on a regular basis across the continuum of care and will provide usable data to providers and ACBHCS administration, and will complement the annual administration of the full MHSIP satisfaction survey and to maintain compliance with beneficiary grievances, appeals and fair hearings; and requests to change providers.

## 3.A) SURVEY OF BENEFICIARY / FAMILY SATISFACTION

### 3.a.i *Administration of Annual MHSIP Survey*

*Goal:* ACBHCS will continue to administer the annual MHSIP survey as directed by the State Department of Mental Health Care Services (DHCS).

*Baseline:* Meet all MHSIP administration and timeline requirements of DHCS.

*QI mechanisms and/or activities that will improve outcomes*: ACBHCS will work with California Institute of Mental Health staff to administer the annual two- week MHSIP survey. Administrative Specialist, Office of Management Services will continue to be

assigned responsibility for survey administration and communication/technical assistance with providers to ensure compliance with requirements regarding how MHSIP is administered to beneficiaries. BHCS will share findings with providers when the data is available from DHCS.

*Responsibility for Monitoring*: Director, Office of Management Services

**3.a.ii. *Development of MHP Beneficiary/Family Satisfaction Survey Pilot***

*Goal:* During FY 13/14 ACBHCS will complete a pilot of one beneficiary/family satisfaction survey that will be designed for use across our continuum of care, and is easily translatable into the MHP's threshold languages.

*Baseline:* During FY 12/13, each ACBHCS System of Care Director identified one program, within their continuum of care, that had successfully administered a beneficiary satisfaction survey. (No family satisfaction surveys were identified)

*QI mechanisms and/or activities that will improve outcomes*: In FY 13/14 the QI Unit will work with senior operational managers and beneficiary/family leaders to develop a beneficiary and family satisfaction survey. In collaboration with the System of Care Directors, this survey will be piloted across the continuum of services. This survey will give providers immediate feedback on a small set of indicators. Providers will be expected to complete follow-up PDSA rapid cycle studies to identify practices that impact satisfaction. Results will be trended by provider and by continuum of care "sector" and reported back to the QIC. The QIC will use results and information from providers making practice changes to develop recommendations to Executive Administration regarding changes in system policy or resources that impact satisfaction with services.

Ground rules for the survey design include:

- Clients and family members will be administered separate surveys.
- The survey instrument will be short (one page), easy to understand, easy to complete, and easily translated into ACBHCS threshold languages
- This survey will be designed to motivate providers to take action on survey results. The survey will provide feedback to providers on two domains that have been clinically shown to define 'satisfaction' as it relates to quality of care: (i) did services help; (ii) beneficiaries' comfort and safety with the provider. (Lambert 1999 "Common Factors Meta-Analysis" and Fallot "Outreach, Engagement and Outcomes" 2013 SAMHSA").
- Survey questions will be based on sociometrically evaluated questions that have been translated into ACBHCS threshold languages and are set up for data input using ACBHCS teleform equipment. (i.e., California MHSIP).
- The survey and the administration procedure will be beta-tested with beneficiaries and family members from across age and ethnic cohorts who are currently receiving mental health services.
- The project will include a protocol that explains how the survey questions address domains; includes a data aggregation and data analysis plan; a provider dissemination plan and a QIC reporting plan.

*Responsibility for Monitoring*: Quality Improvement Director

## 3B) BENEFICIARY GRIEVANCES, APPEALS, AND FAIR HEARINGS

### 3.b.i. *Compliance with "BHCS Consumer Grievance and Appeal Policy"*

*Goal:* to assure that (i) each beneficiary has adequate information about the grievance and appeals processes and (ii) all beneficiary grievances, appeals, expedited appeals, fair hearings, expedited hearings, including the issuing of Notice of Appeal (NOA's) and Notice of Appeal Denials (NOADs), are addressed and in compliance with regulations.

*Baseline:* In FY 12/13, 100% of beneficiaries were offered adequate information about the grievance and appeals processes and 100% of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited hearings, including the issuing of Notice of Appeal (NOA's) and Notice of Appeal Denials (NOADs), were addressed and in compliance with regulations (963 grievances, 27 appeals and 2 state fair hearings).

*QI mechanisms and/or activities that will improve outcomes*: The Quality Assurance (QA) Unit will complete its monthly review of the Consumer and Family Grievance Report.

- QA Unit coordinates with and monitors its contractor that assists consumers and family members with the grievance/appeal process - Alameda County Mental Health Association (MHAAC) Consumer and Family Assistance Office.
  - The Consumer and Family Assistance Office continues to track and organize calls as they relate to hospitalization; access to care; quality and provision of services; legal/financial issues and information and referrals and includes them in the monthly Consumer and Family Grievance Report that is sent to the BHCS QA Unit for review.
  - The QA Associate Administrator and Director of Patient Rights, MHAAC, present the Consumer and Family Grievance Report to the QIC.
- The Authorization Services Unit continues to manage and monitor the appeals process, issue NOA's and NOAD's and assure that the appeals processes and timelines meet regulatory requirements.

*Responsibility for Monitoring*: Quality Assurance Associate Administrator, Authorization Services Manager. Semi-annual presentation on Consumer and Family Grievance Report to QIC (mid-year and "state report" – annual report to DHCS).

### 3.b.ii. *"Consumer Complaint and Grievance Process Study."*

*Goal:* Describe, understand and improve the current ACBHCS consumer complaint and grievance process.

*Baseline:* In FY 12/13 the ACBHCS Quality Assurance Unit submitted its annual state report and made its annual presentation to the QIC. QA staff made shifts that improved the accuracy of how grievances and appeals were classified into the "state" categories. This shift brought out new trends (much higher numbers) regarding grievances for denied services and change of provider requests.

Towards the end of the year, the ACBHCS Mental Health Board, in response to comments received at a public meeting, established an Ad Hoc Committee on Grievances. The purpose of this Ad Hoc Committee is to *"ensure that the perspectives of consumers, family members and the community-at-large would be represented in a project that proactively reviews and evaluates existing grievance procedures. Our action plan is to work collaboratively with ACBHCS to proactively review the grievance process existing in hospitals and clinics and make improvements" (2012/13 Alameda County Mental Health Board Annual Report to the Board of Supervisors pg.11).* This committee worked with the ACBHCS Office of Management Services to design a system-wide grievance program review project.

*QI mechanisms and/or activities that will improve outcomes*: In FY 13/14 the QI Unit, in collaboration with the Quality Assurance Unit and the Office of Management Services will complete a "Consumer Complaint and Grievance Process Review." Results will be reported to the QIC. This review has been designed as an evaluation with four objectives:

1. "To document practices and procedures constituting the implementation of the Alameda County MHP implementation of the Consumer Complaint and Grievance Process.
2. To determine whether or not BHCS is in compliance with the State of California regulations, policies, and procedures;
3. To document consumers' experience(s) with the Consumer Complaint and Grievance Process .
4. To assess the effectiveness of the Consumer Complaint and Grievance Process in addressing consumer complaints/grievances."

A consultant with qualifications as an external and objective evaluator with experience working with beneficiaries, family members and mental health providers will be identified to complete this evaluation.

*Responsibility for Monitoring*: Director, Office of Management Services

## 3C) EVALUATING REQUESTS FOR CHANGING PERSONS PROVIDING SERVICES

*Goal*: Understand reasons for the FY 12/13 increase in number of people requesting change of provider and develop interventions to decrease the rate.

*Baseline*: In FY 12/13, ACBHCS received 447 requests to change persons providing services (in FY11/12 the number of requests was 24). The number is explained by shifts, made by the QA Unit, that improved the accuracy of how grievances and appeals were classified into the "state" categories. This shift brought out new trends that increased the number of persons requesting a change of provider.

*QI mechanisms and/or activities that will improve outcomes* : In FY 13/14 the ACBHCS Quality Assurance and ACCESS units will conduct a secondary analysis of this data to identify trends that might suggest an intervention (geography, ethnic or age group,

service delivery sector, program). The ACBHCS Quality Assurance Unit will submit its annual state report and make its annual presentation to the QIC.

*Responsibility for Monitoring*: Quality Assurance Associate Administrator

### 3D) INFORMING PROVIDERS OF THE RESULTS OF BENEFICIARY/FAMILY SATISFACTION ACTIVITIES

*Goal:* To develop a mechanism that brings satisfaction data to providers in a format that is useable and in a timeframe that supports process improvement.

*Baseline*: In FY 12/13, results of beneficiary/family satisfaction activities were not consistently reported to providers.

*QI mechanisms and/or activities that will improve outcomes:* See item 3.b.ii Beneficiary/Family Satisfaction Surveys. This survey's protocol will include a dissemination plan that will inform providers of their results and also share trended results for sectors of providers with the QIC.

*Responsibility for Monitoring*: ACBHCS Quality Improvement Director

## QI Goal #4: Mechanisms And Activities To Monitor The Safety And Effectiveness Of Medication Practices

***Goal:*** To improve monitoring of the safety and effectiveness of Medication Practices

***Baseline:*** By FY 12/13, the ACBHCS Office of the Medical Director, Pharmacy Unit completed three multiyear Quality Improvement efforts that focused on Adult "Level I" clients assigned to service teams:

- *Polypharmacy Monitoring PIP*. Completed data based review to identify all clients whose prescription claims data indicated polypharmacy (defined as more than 2 antipsychotic medications prescribed concomitantly). Worked with prescribing psychiatrists to change medication protocol. 100% chart review ended FY 11/12.
- *High Dosage Tracking:* Reviewed prescription claims data for mental health clients with prescribed dosages of antipsychotic drugs that exceeded FDA maximums. 100% chart review ended FY 11/12.

- *Increasing Access to Primary Care for Clients Using Psychotropics:* Used claims data to identify clients taking psychotropics who were not engaged in primary care. Worked with prescribers and case managers to suggest linkage with primary care sites. 100% chart review ended FY 12/13.

***QI mechanisms and/or activities that will improve outcomes:*** In FY 13/14 the Pharmacy Unit will focus on a project that addresses safety and effectiveness of medication practices for adults and children within the mental health system. This quality improvement effort is called the *Medication Monitoring Project.* Table I, below, lists the adult and children's providers that are included in this project. The protocol is to review 15% of each psychiatrist's charts during the course of a year. This review is completed in quarterly increments. Guidelines for psychotropic medication practices are applied to psychiatrist's documentation and prescribing practices.

Feedback is given to individual psychiatrists in two stages:

- Verbal or written feedback concurrent with the quarterly review of their records (feedback is immediate).
- At the end of the year, each psychiatrist receives a personalized "Summary Report "that profiles their record of meeting or not meeting the prescription guidelines and compares their record to the average for the universe of records.

Trended feedback that summarizes all charts reviewed over the course of the year is given to the ACBHCS Medical Director in the form of a "Super Summary Report." Results of the system-wide report are currently shared with Executive Administration. In FY 13/14, results will be also shared with the QIC.

**Table I: Medication Monitoring Project: Which Programs are Included?**
**(by System of Care and Type of Provider)**

| | |
|---|---|
| **Adult System of Care** | • Level I Service Teams<br>• Santa Rita Jail<br>• Full Service Partnerships serving adults<br>• Wellness Centers |
| **Children's/TAY System of Care** | • Level I Adult Service Team providers who also provide services to children<br>• Child Guidance Clinic<br>• Full Service Partnerships serving children<br>• County Providers serving children |

***Responsibility for Monitoring***: ACBHCS Clinical Psychiatric Pharmacist, ACBHCS Medical Director.

## QI Goal #5: Interventions Implemented When Quality Of Care Concerns Are Identified

***Global Goal for Component:*** To increase the number and efficacy of systemic interventions that address Quality of Care Concerns.

**5.a. *Sentinel Events and Formalized Case Reviews*.**

- *Goal:* To implement a system that tracks and trends issues leading to sentinel events and case reviews

- *Baseline:* The QA Associate Administrator responds to 100% of sentinel events and critical incidents, and is responsible for conducting Formalized Case Reviews and completing follow-up activities: including grievances, sentinel events, critical incidents and formalized case reviews. Monitoring includes follow-up in the form of interventions, Plans of Correction, and debriefings. Formalized Case Reviews include BHCS Leadership, the QI Director, identified providers and other staff as required

- *QI mechanisms and/or activities that will improve outcomes:* . The QA Associate Administrator will partner with the QI Unit to (i) track and trend sentinel events and formalized case reviews. (ii) analyze results and (iii) develop proposals for systemic interventions. Propsoals may involve operational and administrative units.

- *Responsibility for Monitoring*: Quality Assurance Associate Administrator. Proposals will be brought to the QIC for review.

***5.b Performance Improvement Projects (PIPs)***

*Goal:* to add to PIPs that address performance improvement issues that will systemically address issues of wellness recovery and resiliency for beneficiaries and family members receiving services within our systems of care

*Baseline:*

- The MHP learned on November 25 2013 that CAEQRO identified the current Clinical PIP as completed.
- A topic is being considered to replace the current clinical PIP. This PIP topic addresses the impact of clinical practices associated with Trauma Informed Care on mental health outcomes, functional status and/or beneficiary satisfaction.
- Two non-clinical PIPs are being considered. The first will address practices that support resiliency and transitions through the continuum of care for Transition Age Youth. The second will address practices that improve timelines to first psychiatric visits for adults and children.
- The MHP will identify one clinical and one non-clinical PIP for FY 13/14.

*QI mechanisms and/or activities that will improve outcomes:*

| PIP Title and Subject | PIP Type / Implementation Phase |
|---|---|
| Transition Age Youth: Impact of Engagement Practices on Transitions Through Systems of Care with Correlates for Mental Health Outcomes and Resiliency | Non-Clinical PIP. In planning stage. |
| Improve Timeliness to First Psychiatric Visit | Non-Clinical PIP. Recommended by EQRO Recommendation #7, pg.43 |
| Improving the Mental Health and Health Outcomes of Beneficiaries Receiving Services in Primary Care and Behavioral Health Programs Using Trauma Specific Interventions Implemented in Trauma Informed Environments | Clinical PIP. In planning stage.<br><br>This PIP will build on the baseline established in (i) the ACBHCS Trauma Informed Care Capacity Building project that ended in early 2013; (ii) the current experience with our FQHC's use of *Seeking Safety* in integrated behavioral health/primary care settings and (iii) with the requirement for contracted network providers to implement one Trauma Informed Practice from the Welcoming Toolkit.<br><br>The TIC Capacity Building Project started in 2010 by the Pool of Consumer Champions and was developed from the premise that (i) 90% of public mental health beneficiaries have been exposed to complex trauma (Mueser et.al 2004); (ii) adaptive behaviors to trauma (that are normative for trauma survivors) are easily misdiagnosed as severe or moderate mental health issues; and (iii) mental health clients who are seen in the jail, in the hospital, in social services and in other environments where policies and procedures are known to retrigger traumatic experience. This exploratory project established a system-wide inventory of trauma informed practices used by providers, beneficiaries and family members within and outside of our mental health system; local thought and practice leaders in trauma informed care, and the demand for approaches to address vicarious trauma experienced by providers.) A planning group will meet to review study results and develop a PIP protocol that addresses the impact of a sample of TIC practices on beneficiary health status in primary care and mental health settings<br><br>The FQHC interest in TIC practices is based on the Adverse Child Experience (ACE) study (Felitti, Anda 1998) that showed the correlation between trauma experiences have a negative impact on health outcomes. |

*Responsibility for Monitoring*: ACBHCS Quality Improvement Director

## QI Goal #6: Mechanisms and Activities Regarding "No-Show Rates" for Psychiatrists and Non-Psychiatrist Clinicians

***Goal:*** To establish a data collection mechanism that effectively captures "no-show" rates for psychiatrist and non-psychiatrist clinicians across the continuum of care.

***Baseline:*** The External Quality Review Organization (EQRO) requires MHPs to report "No Show Rates for Psychiatrists and Non-Psychiatrist Clinicians." Our MHP has not established a method to consistently report on this metric for our system of 150 providers. To increase conformance with this EQRO requirement, the QI Unit completed an exploratory survey of ACBHCS providers (telephone and group interviews) and MHP data collection methods (interviews with decision support and information systems) to describe our MHP's current capacity to track 'no-shows.'

- County-managed programs have access to a reporting code "308" for 'no shows' and space on the "hard copy" of progress notes to document them. The ACBHCS Information Systems department confirmed the minimal use of that code, and discussions with clinical managers identified reasons why the code was underutilized.
- A small number of contractors keep track of "no-shows" as a means to address access issues within their programs.
- The Children's System of Care Outpatient Services (county managed) implemented a robust system to track "no-shows" that included completing conversations with staff to reflect on the metric and then design/implement interventions that address the cause of the "no-show." Results were tracked quarterly and success rates documented.
- Adult System of Care (county managed) Community Support Centers reported uneven use of 'no-show' code.

The barriers to collecting this data included:

- Providers experience current documentation requirements as overly burdensome and a distraction from client care (Feedback from providers is that 40% of the workday is spent on documentation).
- Lack of a common electronic or paper data system that can be used to record "no-shows" across county and contract sites.
- Low motivation for this change - lack of understanding about the impact of "no-show" rates on access to care and minimal understanding of PDSA "rapid cycle" techniques required to set up practice changes that impact scheduling of appointments.
- Need for skills-based training to make the practice changes required to capture and use 'no-show' rates ( i.e., process improvement techniques).

***QI mechanisms and/or activities that will improve outcomes:*** In FY 13/14, the QI Unit will establish a workgroup complete a study that identifies 'best practices' used by MHP to study providers that currently use "no-show" statistics to make practice changes that increase access to services for beneficiaries. Concurrently, the QI Unit will work with our Information Systems Department, Provider Relations/training and Decision Support to build a prototype system that can be used to capture and report this data. The system will be tested in a small sample of contract and county programs in FY 14/15.

***Responsibility for Monitoring***: ACBHCS QI Unit.

## QI Goal #7: Mechanisms And Activities To Monitor Provider Appeals As Per Title 9 Regulations

***Global Goal for Component:*** All provider appeals related to the authorization of services and processing/payment of claims will be in conformance to Title 9 regulations.

**7a. Provider appeals related to the authorization of services**

*Goal:* All Provider appeals related to the authorization of services and processing or payment of claims are in compliance with the resolution process and timelines. If a provider appeal is not in compliance with the resolution process, documentation exists that provides an explanation.

*Baseline*: 100% of provider appeals related to the authorization of services are in compliance with Title 9 requirements for the resolution process, including timelines.

*QI mechanisms and/or activities that will improve outcomes:* Providers may appeal denied requests for authorization directly to the Authorization Unit Administrator, who is responsible for provider authorization appeals and monitors appeals to ensure compliance with the resolution process and timelines. Provider needs to submit a written appeal within 90 days of the date of receipt of non-approval of payment. The Authorization Unit will respond within 60 days from the date of receipt of the appeal to inform provider, in writing, of the decision, with rationale.

*Responsibility for Monitoring*: Authorization Unit Administrator. Annual Report presented to QIC

**7.b. Provider appeals related to the processing or payment of claims.**

*Goal:* All provider appeals related to the processing or payment of claims are in compliance with the resolution process and timelines. If a provider appeal is not in compliance with the resolutions process, there is documentation that provides an explanation.

*Baseline*: 100% of provider appeals related to the processing or payment of claims are in compliance with Title 9 requirements for the resolution process, including timelines.

*QI mechanisms and/or activities that will improve outcomes:* Providers that receive payment from BHCS may submit appeals about the processing or payment of claims within 90 days from the disposition of the original claim to the Provider Relations Unit (which is responsible for claiming and payment appeals and monitors appeals to ensure compliance with the resolution process and timelines). Provider Relations will reply to the appeal within 60 days of receipt of the appeal.

If the appeal is not to the satisfaction of the provider, they may file a request for a second level appeal with the Director of Fiscal Operations.

*Monitoring Responsibility*: Provider Relations Director.

## QI Goal #8: Mechanisms And Activities To Improve Clinical Record Documentation

***Goal:*** Maintain compliance with state and federal regulations by ensuring competency of clinical staff to comply with documentation requirements.

***Baseline:***

1) Quarterly trainings on Documentation Standards offered to 100% of provider network and county programs.

*QA Documentation Manual. Section 8-1. Policy: Provider Audits - Policy and Procedure:*

2) Audits are conducted by the Quality Assurance Office. Time frame is 3 months within any 18 month period. Charts are sampled according to the following guidelines
   - 1-2 charts per clinician are audited annually.
   - Adult County Clinics achieving an aggregate 90% compliance rate are exempt from the next year's audit.
   - Children's County Clinics achieving an aggregate 95% compliance rate (EPSDT standard) are exempt from the next year's audit

***QI mechanisms and/or activities that will improve outcomes:***

*1) Documentation Training*

- QA Unit will provide quarterly provider trainings on Documentation Standards to county operated and community-based contract agencies.
- QA Clinical Review Specialists will provide ongoing CQRT on authorization and quality review of day treatment programs to all new day treatment programs.
- QA Unit will conduct a HealthPAC CQRT process for Level 2 services with Adult and TAY System of Care provider representatives. HealthPAC CQRT will follow the Clinical and Quality Reviews described in the CQRT Manual 2011.

*Assuming QA staffing levels are adequate; the following QI mechanisms and activities will be implemented to support improvement in outcomes for this goal:*

*2) Chart audits for CBOs will be sampled in accordance with the following guidelines:*

- 10% of CBOs will be audited annually
- 1-2 charts per clinician audited annually.
- Adult Programs achieving an aggregate 90% compliance rate are exempt from the next year's audit.
- Children's Programs achieving an aggregate 95% compliance rate (EPSDT standard) are exempt from the next year's audit

*3) Chart audits for Fee-For-Service Providers will be sampled in accordance with the following guidelines:*

- Approximately 10% of providers who are active on the provider network will be audited annually
- A minimum of 2 charts or 10%, whichever is greater, will be audited annually.
- The standard is 90% compliance rate.

***Responsibility for Monitoring***: Quality Assurance Associate Administrator

**QI Goal #9: Mechanisms and Activities To Evaluate and Improve 5150 Guidelines (EQRO Recommendation)**

***Goal:*** Improve the design of the current "5150 system" for 72 hour evaluation and treatment.

***Baseline:*** CAEQRO (FY 13/14 Draft Report) was concerned about the role of community police in the current involuntary detention (5150) for 72-hour evaluation and treatment. Although the BHCS Crisis Response Program works closely with local police, the majority of 5150 police calls do not involve clinical support. When 5150 procedures place clinical decision making in the hands of non-clinicians, the results may include multiple iatrogenic effects, including long wait times for police response, counter-therapeutic interactions during crisis situations, disruption of community settings, and diversion of police officers from other needed duties. Providers report delays in police response to 5150 calls which impact beneficiary outcomes.

***QI mechanisms and/or activities that will improve outcomes:***
Convene a BHCS workgroup to design a descriptive analysis of 5150 current system, focusing on entry into involuntary treatment. Workgroup members will include people with experience as providers, beneficiaries and family members who have 'lived experience' with the 5150 process.

- Examine the system impact of current 5150 policies on the MHP and its consumers; compare with 5150 practices of similar large urban counties.
- Consider methods to improve MHP policies regarding entry to involuntary acute treatment, including offering involuntary detention training and privileges to an expanded cohort of licensed mental health professionals.
- Review current Policies& Procedures and current communication of P&Ps to providers and other stakeholders involved in the 5150 process.
- Review current efforts to improve 5150 process through education and training.

Research will be completed by the QI Unit in collaboration with BHCS operations staff. Results will be used to recommend improvements in current 5150 system to BHCS Executive Team.

***Responsibility for Monitoring***: Quality Improvement Director

**QI Goal #10: Mechanisms and Activities to Improve Tracking of Beneficiary Treatment Demand and Service Capacity (by Language and Geographic Location)**

***Goal:*** Increase MHP capacity to match, in real time, beneficiary treatment demand with service capacity by language and geographic location.
***Baseline:*** The MHP Access Unit manually tracks 'intake demand' and 'capacity by language' for a large and complex system. (CAEQRO Draft FY 13/14 Report). The MHP Access Unit uses an electronic provider database, that is not 'realtime' and includes filters showing geographic location of providers, languages spoken, and availability.
***QI mechanisms and/or activities that will improve outcomes:*** Convene a BHCS Workgroup that will develop electronic tracking mechanism that enables 'real time' tracking with accurate representation of demand for treatment and service availability as well as wait times by language and location
***Responsibility for Monitoring***: Quality Improvement Director

## SECTION II: QUALITY IMPROVEMENT WORKPLAN *(Addresses MHP requirements describing numeric goals along with action steps and monitoring activities)*

The ACBHCS Quality Improvement Workplan includes projects where "improvement" is based on a pre-set numeric goal that is tracked over the course of a year as action steps are completed to "turn the curve." At the end of the year, outcomes are measured against the initial baseline and compared to the original goal. The impact of the interventions is gauged by a quantified measure of improvement. This Quality Improvement Workplan includes the following eight goals that address service delivery capacity and access to services, and also includes the requirement that the MHP track "previously identified issues:

- QI Goal 11: Number, Types And Geographic Distribution Of Mental Health Services Within The MHP Delivery System
- QI Goal 12: Average Length Of Time From Initial Contact To First Appointment
- QI Goal 13: Average Length Of Time From Initial Contact To First Psychiatry Appointment
- QI Goal 14: Timeliness Of Services For Urgent Conditions
- QI Goal 15: Access To After Hours Care
- QI Goal 16: 24/7 Toll Free Line
- QI Goal 17: Follow-Up Appointments After Hospitalization
- QI Goal 18: Readmission Following Hospitalization
- Previously Identified Issues.

| QUALITY IMPROVEMENT GOALS FOR FY 2013-14 | BASELINE | ACTION STEPS | MONITORING MECHANISMS (Timelines/ Responsible Staff) |
|---|---|---|---|
| **GOAL #11:** Number, types and geographic distribution of mental health services within the MHP delivery system. | | | |
| **ACBHCS goals addressing the number, types and distribution of mental health services within the MHP's four regions are formulated:**<br>• ***On a contract-by contract basis through the procurement process that is administered by the ACBHCS Network Office;*** **and**<br>• ***During the provider network recruitment process.***<br><br>*MHP Contract Element*: monitor and set goals for the current number, types and geographic distribution of mental health services within the delivery system. | **In FY 12/13, baselines that identified the number, types and geographic distribution of mental health services within the MHP delivery system were used to develop the design of the following Request- for-Proposals in the Children's and Adult's systems of care. Two examples:**<br>– **Children's System of Care (RFP #13-07) EPSDT Expansion IIB "Culturally And Linguistically Responsive Services To Asian And Southeast Asian Children Living In Central County"**<br>– **Adults and TAY (RFI 14-01 "Specifications, Terms And Conditions For Level II Services: Adults And Transition Age Youth With Mental Health And Substance Use Conditions."**<br><br>*Background on Baselines*<br>ACBHCS divides the County into four regions: North (Alameda, Albany, Berkeley, Emeryville, Oakland and Piedmont); Central (unincorporated areas of Ashland, Castro Valley, Cherryland and cities of Hayward, San Leandro and San Lorenzo); South (Fremont, Newark and Union City); and East (Dublin, Livermore, Pleasanton, Sunol and unincorporated areas).<br><br>The *ACCESS Provider Data Base* gives users the option to filter information requests by City, and then by provider type, number of providers currently available and languages spoken.<br><br>ACBHCS currently contracts with 96 organizational providers and over 400 individual providers that bill to | *When a request to develop an Request for Proposal for services, or contract augmentation comes to the Network Office*, the number and types of providers and the need for services within geographic regions is assessed and compared to service penetration data.<br><br>A request is made to BHCS' Decision Support , who produces data that is used to develop the contract augmentation or RFP -analyze where services are needed; plan where services will be located; and identify which ethnic and/or linguistic populations might be prioritized.<br><br>*Provider Network* | Data is ACBHCS Network Office monitors for this goal - the 'Network Office' completes a contract review process each quarter to ensure that goals for each system of care are being reached through procurement process.<br><br>Trended results reported annually to QIC. Recommendations are made to Executive Admin |

<table>
<tr><th>QUALITY IMPROVEMENT GOALS FOR FY 2013-14</th><th>BASELINE</th><th>ACTION STEPS</th><th>MONITORING MECHANISMS (Timelines/ Responsible Staff)</th></tr>
<tr><td></td><td>Medi-Cal and who provide an array of services. 83 contractors provide 304 outpatient programs in 278 locations across the county. There are 23 providers that offer partial or full day services in the following billing categories: Crisis Stabilization, Day Treatment Intensive, and Day Treatment Rehabilitation services. These 23 providers sponsor 63 programs in 61 locations throughout the county.</td><td><u>composition:</u><br>ACBHCS Network office, in collaboration with the BHCS credentialing committee, sets provider network recruitment targets and offers admission to providers who serve targeted populations - based on culture, ethnicity, language capacity and/or geography. These provider applications are ‘fast tracked’ for approval.</td><td></td></tr>
<tr><td>GOAL #12: Average length of time from initial contact to first appointment (first request for service to first clinical assessment)</td><td></td><td></td><td></td></tr>
<tr><td>
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Children</th></tr>
<tr><td>Goal</td><td>See ‘baseline’ footnote (1)</td><td>14 days</td><td>14 Days</td></tr>
</table>
Goal ‘rolled over’ from FY 12.13<br><br><u>MHP Contract Element</u>: Goals Are Set And Mechanisms Established To Monitor Timeliness Of
</td><td>
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Children</th></tr>
<tr><td>FY 12.13 actual</td><td>- Days (1)</td><td>14 days(2)</td><td>14 Days(3)</td></tr>
</table>
(1) Left blank because Adults and Childrens services use definitions that can not be validly combined.<br>
(2) <u>First contact (1-800 ACCESS) to BHCS Crisis Response Team</u> for Level I clients only. In previous years, the experience of Level III clients was reported here. The data definition was changed this year because Level I clients experience more serious
</td><td>ACBHCS System of Care Directors identifies interventions to improve outcomes if “actual” falls below goal.</td><td>ACBHCS System of Care Directors receive quarterly reports.<br><br>Annual “Timeliness” report presented to QIC.</td></tr>
</table>

<table>
<tr><th>QUALITY IMPROVEMENT GOALS FOR FY 2013-14</th><th>BASELINE</th><th>ACTION STEPS</th><th>MONITORING MECHANISMS (Timelines/ Responsible Staff)</th></tr>
<tr><td>Routine Mental Health Appointments</td><td>mental health conditions than Level III clients. Level I data provides a metric that is more useful to improve services for clients with the most need.<br><br>(3) <u>First contact (1-800 ACCESS) to Children's Outpatient Services</u> (Level III)</td><td></td><td></td></tr>
<tr><td>GOAL #13: Average length of time from initial contact (first request for service) to first psychiatry appointment</td><td></td><td></td><td></td></tr>
<tr><td><table><tr><th></th><th>All</th><th>Adult</th><th>Children</th></tr><tr><td>Goal</td><td>21 days</td><td>21days</td><td>21days</td></tr></table><br>Goal 'rolled over ' from FY 12.13<br><u>MHP Contract Element</u>: Goals Are Set And Mechanisms Established To Monitor Timeliness Of Routine Mental Health Appointments</td><td><table><tr><th></th><th>All</th><th>Adult</th><th>Children</th></tr><tr><td>FY 12.13 actual</td><td>36 days</td><td>31 days</td><td>39 days</td></tr></table></td><td>Interventions will be identified by the ACBHCS System of Care Directors. Operations leads in Management Services Office and Network Office work with identified providers to implement practice change or design contract augmentations to produce desired change.</td><td>ACBHCS System of Care Directors receive quarterly reports.<br><br>Annual "Timeliness" report presented to QIC.</td></tr>
</table>

<table>
<tr><th>QUALITY IMPROVEMENT GOALS FOR FY 2013-14</th><th>BASELINE</th><th>ACTION STEPS</th><th>MONITORING MECHANISMS (Timelines/ Responsible Staff)</th></tr>
<tr><td>GOAL #14: Timeliness of services for Urgent Conditions</td><td></td><td></td><td></td></tr>
<tr><td>
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Children</th></tr>
<tr><td>Goal</td><td>Clinical Assessment within 24 hrs</td><td>24 hrs</td><td>23 hrs</td></tr>
<tr><td></td><td>Face to face clinical evaluation within 3 days based on initial CRP assessment</td><td>3 days based on Initial assessment at Crisis Response Program</td><td>3 days based on initial assessment</td></tr>
</table>
<u>MHP Contract Element:</u> Goals Are Set And Mechanisms Established To Monitor Timeliness Of Services For Urgent Conditions
</td><td>A numeric baseline for FY 12/13 will be established retrospectively for the urgent care portals established by the MHP:<br>• The ACBHCS ACCESS ‘Contact Tracking Database’ will be used to track clients calling who are referred for urgent care services.</td><td>QI Staff will work with staff from Adults and Children’s Urgent Care portals listed in the “baseline” to: design a report; and complete the analysis.</td><td>Results will be brought to the BHCS OPS meeting. OPS members will make a report to the BHCS quality improvement committee.<br><br>Annual “Timeliness” report presented to QIC.</td></tr>
<tr><td>GOAL #15: Access to After Hours Care</td><td></td><td></td><td></td></tr>
<tr><td>Goal not established across programs.<br><br><u>MHP Contract Element</u>: Goals Are Set And Mechanisms Established To Monitor Access To After-Hours Care</td><td>Programs that offer after hours care include:<br>Older Adults and Adults<br>▪ John George Pavilion/Psych Emergency Services (24/7)<br>▪ Sausal Creek<br>▪ FSP clinician “on-call”.<br><br>TAY, Children and Youth<br>• Willow Rock<br>• Mobile Response (Seneca Center)<br>• FSP clinician “on-call”<br><br>Crisis stabilization (Seneca Center)</td><td>Convene a work group, accountable to the BHCS OPS Committee, that will establish data sources and trend the experience of adult and child cohorts in accessing after hours care.<br><br>This information will be used by the OPS Committee to establish mechanisms that monitor access to after hours care and to set goals.</td><td>ACCESS Director Presents annual “Timeliness” report presented to QIC.</td></tr>
</table>

| QUALITY IMPROVEMENT GOALS FOR FY 2013-14 | BASELINE | ACTION STEPS | MONITORING MECHANISMS (Timelines/ Responsible Staff) |
|---|---|---|---|
| **GOAL #16: 24/7 Toll Free Number** | . | | |
| **Goal: The 24/7 toll free line is responsive in all 5 threshold languages 100% of the time.**<br><br>*<u>MHP Contract Element</u>: Goals Are Set And Mechanisms Established To Monitor Responsiveness Of The 24/7 Toll Free Number* | **Baseline: In FY 12/13, the MHP 24/7 toll free line was responsive in all 5 threshold language 100% of the time**<br><br>*<u>Background</u>*<br>*Language capacity <u>during office hours</u> is covered from 8:00 am to 5:00 pm by the following sources:*<br>• *ACCESS staff working in the Oakland offices or at the 1-800 lines managed by La Clinica, La Familia or Asian Community Mental Health or Deaf Community Counseling Services.)*<br>• *ACCESS/Oakland staff are fluent in Spanish – only urgent calls from monolingual Spanish speakers are transferred to the 1-800 line that is managed by La Clinica and La Familia.*<br>• *All other language needs are referred to . Lionbridge Services for translation support..*<br><br>*All <u>after hours</u> calls coming to the 1-800 access line are rolled over to a contract provider (Crisis Services of Alameda) which offers 102 languages. A record of all after-hours calls is given to the ACCESS Manager each morning to ensure follow-up.* | Monitor 24/7 toll free line for responsiveness and threshold language capability through random test calls completed by Quality Assurance staff.<br><br>Director of ACCESS addresses and resolves responsiveness issues that may arise with the 24/7 toll free line.<br><br>Continue to provide language and interpretation services to ACCESS and CRP clients as needed through BHCS and HCSA interpreters, the Language Line and/or the California Relay Service (CRS) for the hearing impaired. | ACCESS Director<br><br>Quality Assurance Associate Administrator<br><br>Annual "Timeliness" report presented to QIC. |

<table>
<tr><th>QUALITY IMPROVEMENT GOALS FOR FY 2013-14</th><th>BASELINE</th><th>ACTION STEPS</th><th>MONITORING MECHANISMS (Timelines/ Responsible Staff)</th></tr>
<tr><td>GOAL #17: Average length of time for follow-up appointments after hospitalization</td><td></td><td></td><td></td></tr>
<tr><td>
<table>
<tr><td></td><td>All</td><td>Adult</td><td>Children</td></tr>
<tr><td>Goal</td><td>7 Days</td><td>7 Days</td><td>7 days</td></tr>
</table>
(HEDIS measure is 7 days post-hospitalization)
</td><td>
<table>
<tr><td></td><td>All</td><td>Adult</td><td>Children</td></tr>
<tr><td>FY 12.13 actual</td><td>5.57 days</td><td>5.65 days</td><td>5.34 days</td></tr>
</table>
</td><td>System of Care Directors monthly review of trended data on Emanio Dashboards.</td><td>Annual “Timeliness” report presented to QIC.</td></tr>
<tr><td>GOAL #18: Readmission 30 days following Hospitalization</td><td></td><td></td><td></td></tr>
<tr><td>GOAL: Reduce 30 day readmission rate by 5%:
<table>
<tr><td></td><td>All</td><td>Adult</td><td>Children</td></tr>
<tr><td>Goal</td><td>17.65%</td><td>17.9%</td><td>16.6%</td></tr>
</table>
</td><td>
<table>
<tr><td></td><td>All</td><td>Adult</td><td>Children</td></tr>
<tr><td>FY 12.13 actual</td><td>18.58 %</td><td>18.85 %</td><td>17.48 %</td></tr>
</table>
</td><td>System of Care Directors monthly review of trended data on Emanio Dashboards.</td><td>Quality Improvement Director<br><br>Adult and Children’s System of Care Directors<br><br>John George Psychiatric Pavilion Administrator<br><br>Children’s Hospital Administrator<br>Annual “Timeliness” report presented to QIC.</td></tr>
</table>

<table>
<tr><th>PREVIOUSLY IDENTIFIED QI ISSUES</th><th>RESPONSIBILITY / ACTIONS</th></tr>
<tr><td>

***1) From FY 12/13 EQRO Recommendations:***

"(Develop a) consistent, system-wide set of service-related expectations and outcome goals (that) would impact 23,000 consumers of behavioral health services. Application of these principles will improve timeliness outcomes, No-show rates, wait times for interpretative services, and re-hospitalization rates for county-operated and provider-operated programs, and would countywide standards for delivery of services."

**2) Set goals and monitor the current number, types and geographic distribution of mental health services within the MHP delivery system.** *Goal was not defined in FY 11/12 or FY 12/13.*

**3) Access to after-hours care** *Goal was not defined in FY 11/12 or FY 12/13.*

**4) Average length of time from initial contact to first psychiatry appointment**

| Goal | All | Adult | Children | Met? |
|---|---|---|---|---|
| **11/12** | 21 | 21 | 21 | no |
| **12/13** | 21 | 21 | 21 | no |

**5) Timeliness of services for urgent conditions**

| Goal | All | Adult | Children | Met? |
|---|---|---|---|---|
| **11/12** | - | - | - | No goal defined |
| **12/13** | - | - | - | No goal defined |

.

**6) Readmission following Hospitalization**

| Goal | All | Adult | Children | Met? |
|---|---|---|---|---|
| **11/12** | % | % | % | No goal defined. |
| **12/13** | % | % | % | No goal defined. |

</td><td>

**FY 13/14 EQRO Report identified this QI issue was fully met.**

**QI UNIT / Goal is in FY 13/14 QI Workplan.**

**QI UNIT / Addressed in FY 13/14 QI Workplan.**

**QI UNIT / Goal is in FY 13/14 QI Workplan.**

**QI UNIT / Goal is in FY 13/14 QI Workplan.**

**QI UNIT / Goal is in FY 13/14 QI Workplan.**

</td></tr>
</table>