

Mendocino County

Behavioral Health & Recovery Services

Quality Assurance & Performance Improvement Annual Work Plan

Fiscal Year 2022/2023

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Quality Assurance and Performance Improvement Program

The Mendocino County Behavioral Health and Recovery Services (MCBHRS) Quality Assurance and Performance Improvement (QAPI) Program is responsible for providing support services to the Mental Health Plan (MHP), Substance Use Disorder Treatment (SUDT) program, beneficiaries, and family members. The QAPI Program is accountable to the Behavioral Health Director, Behavioral Health Advisory Board, and Board of Supervisors.

The goal of the QAPI Program is to improve access to and delivery of mental health and substance abuse treatment services, while assuring that services are community based, client focused, age appropriate, culturally competent, and process and outcome focused. The QAPI Program monitors, evaluates, and works to improve client access to services and the quality of services. The program coordinates with performance monitoring activities throughout the MHP and SUDT, including, but not limited to, beneficiary and system outcomes, utilization management, clinical records review, monitoring of beneficiary and provider satisfaction, and resolution of beneficiary and provider grievances/appeals.

The Quality Assurance and Performance Improvement Program supports the strategic initiatives and the Goals and Objections of MCBHRS. The goals and objectives are analyzed and evaluated to identify the effectiveness of programs and areas for improvement. The MCBHRS leadership, MHP Providers, and quality improvement committee formulate these Goals and Objectives and evaluate their effectiveness.

The Quality Improvement Work Plan ensures the opportunity for input and active involvement of beneficiaries, family members, MHP providers, Substance Use Disorder staff, and other interested stakeholders in the Quality Improvement (QAPI) Program.

The Administrative Service Organization (ASO) assist the MHP in providing contractual oversight for the provision of specialty mental health services. RQMC works with the providers that provide specialty mental health services to beneficiaries to ensure quality of care, timeliness, and compliance with County, State and Federal regulations. MCBHRS provides substance use disorder treatment, oversight of Mental Health Services Act programs and contracts, LPS conservatorship placement and oversight, AB109, Assisted Outpatient Treatment, Mobile Outreach and Prevention, Mobile Crisis Dual Response, Jail Discharge Planning, and CalWORKS services.

Quality Improvement Committees/Groups

The QAPI Program’s principle workgroup is the Quality Improvement Committee (QIC). The QIC is comprised of MHP staff, providers, beneficiaries, family members, and other community stakeholders concerned about the quality of the behavioral health service delivery system. The committee has several subcommittees carrying out quality improvement and evaluation activities. These subcommittees include Quality Management/Quality Improvement, Utilization Management, a Clinical Performance Improvement Project, and a Non-Clinical Performance Improvement Project.

Additional quality management committees and workgroups include the Cultural Diversity Committee, Administrative Service Organization Care Coordination, Behavioral Health Executive Team, and the Compliance Committee. These entities inform and provide feedback to the QIC.

A. Quality Improvement Committee

The Quality Improvement Committee (QIC) recommends policy decisions, reviews and evaluates the results of QI activities, institutes needed QI actions, and ensures follow-up of QI processes. QIC also coordinates performance monitoring activities by reviewing reports from committees such as: Utilization Management, Quality Improvement/Quality Management, Cultural Diversity, and Compliance.

Standing members of the QIC are:

- MCBHRS Director,
- MCBHRS Deputy Director,
- MCBHRS Compliance Officer,
- QAPI Manager/Supervisor,
- MCBHRS Manager/Supervisor,
- Ethnic Services Representative,
- MCBHRS Fiscal Representative,
- Administrative Service Organization staff
- ASO Compliance Officer,
- Clinical staff,
- Beneficiaries,
- Family members,
- Patient Rights Advocate, and
- Community service providers.
    - Ad Hoc Member: Medical Director.

The QIC meetings are held bi-monthly at different locations throughout the county allowing the public and beneficiaries to attend, ask questions, report on their experience receiving Specialty Mental Health Services and Substance Use Disorders Treatment, and provide recommendations for improvement. In order to entice stakeholder involvement by attending meetings, the QIC and MHSA meetings have been combined. Meetings are held both in person and virtual to allow more individuals to attend and accommodate those that prefer the virtual format.

All departmental personnel, MHP providers, and committee members may contribute to the agenda items. QIC meeting agendas may include, but are not limited to, the following agenda items:

- Grievances, appeals, expedited appeals, and state fair hearings
- Requests for change of provider
- Request for second opinions
- Notice of Adverse Benefit Determinations (NOABD)
- Consumer Satisfaction Questionnaire Survey results
- Accessibility of Services
- Timeliness to Access Reports
- Provider Appeals
- In-patient Hospitalizations Reports
- Utilization of Specialty Mental Health
- Access Line Test Calls Report
- Service delivery capacity, trends, quality, and outcomes
- Cultural competency and linguistic services

- Policies and Procedures
- Performance Improvement Projects (PIP)
- Verification of Services

Data collected is reviewed, monthly, bi-monthly, semi-annually, and annually to determine the overall effectiveness of the QI program.

B. Cultural Diversity Committee

The Cultural Diversity Committee (CDC) provides oversight of cultural competency and linguistic services provided by the MHP providers and SUDT providers. They monitor, review, evaluate, and make policy recommendations to develop strategies to address disparities. The CDC notifies MHP providers, SUDT providers, and community partners of available trainings, workshops, and cultural events to increase knowledge and raise awareness about cultural diversity issues. Local tribal representatives and Latino providers are invited to attend CDC to report on cultural services and provide recommendations for improvement.

Members of the Cultural Diversity Committee include:

- MCBHRS Director,
- MCBHRS Deputy Director,
- MCBHRS Quality Assurance/Quality Improvement Manager/Supervisor,
- MCBHRS Manager/Supervisor,
- Ethnic Services Representative,
- Administrative Service Organization staff,
- Clinical staff,
- Beneficiaries,
- Family members,
- Patient Rights Advocate, and
- Community service providers, and
- Mental Health Advisory Board Liaison.
    - Ad Hoc Member: Medical Director and BHRS Fiscal staff.

C. Quality Improvement/Quality Management Work Group

The Quality Improvement /Quality Management Work Group (QI/QM Work Group) is a collaboration of MCBHRS and the Administrative Service Organization (ASO) staff. QI/QM provides quality improvement and collaboration across the MHP. The QI/QM Work Group includes, but is not limited to, client satisfaction, grievance, appeals, and state fair hearings, outreach efforts, chart audits results including medical necessity, appropriateness and efficiency of services, reviewing reports, policies and procedures review and recommendations, and survey outcomes.

Members of the QI/QM Work Group include:

- MCBHRS Deputy Director,
- MCBHRS Manager/Supervisor,
- MCBHRS Quality Assurance and Performance Improvement staff,
- MCBHRS MHSA Program Manager,
- MCBHRS fiscal staff,
- Patient's Right Advocate, and

- As applicable the equivalent Administrative Service Organization staff.
    - Ad Hoc Member: MCBHRS Director and Medical Director.

E. Administrative Service Organization Care Coordination

The Administrative Service Organization Care Coordination (ASO) brings MCBHRS and ASO management together to strategize, plan, and collaborate on specialty mental health services being provided to Mendocino County beneficiaries.

Members of the Care Coordination meeting include:

- MCBHRS Director,
- MCBHRS Deputy Director,
- MCBHRS Manager,
- MCBHRS Fiscal Manager,
- MCBHRS Quality Assurance and Performance Improvement Manager/Supervisor,
- MCBHRS Compliance Officer, and
- Administrative Service Organization (ASO) administrative staff.

F. Compliance Committee

The Compliance Committee is responsible for analyzing and understanding the regulatory environment and legal requirements, monitoring internal and external audits and investigations, and identifying risk areas. The committee develops, in conjunction with the Quality Improvement Committee, standards of conduct and policies and procedures that promote adherence to the Compliance Program. The committee also reviews and updates the Compliance Work Plan annually.

Members of the Compliance Committee include:

- MCBHRS Director
- MCBHRS Compliance Officer,
- MCBHRS Deputy Director,
- MCBHRS Manager
- MCBHRS Fiscal Manager, and
- MCBHRS Quality Assurance and Performance Improvement Manager/Supervisor.
    - Ad Hoc Member: Medical Director, County Counsel, Administrative Service Organization Compliance Officer.

G. Utilization Management Committee

The Utilization Management Committee (UM) assures that beneficiaries have timely access to services, populations served, accessibility of services, ongoing capacity of service delivery, access line test calls, underutilization and overutilization, treatment authorization, and MHP system data trends.

Members of the Utilization Management Committee include:

- MCBHRS Deputy Director,
- MCBHRS Quality Assurance and Performance Improvement Manager/Supervisor,
- MCBHRS Manager,

- MCBHRS Fiscal staff,
- MCBHRS MHSA Program Manager, and
- As applicable the equivalent Administrative Service Organization staff.
    - Ad Hoc Member: MCBHRS Director and Medical Director.

Service Capacity

Goal 1: Monitor service delivery measurements			
Objective 1.1 Ensure network adequacy for service delivery			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
1.1.1 Provider ratios for psychiatry meet network adequacy standards. **1.1.2** Provider ratios for outpatient SMHS meet network adequacy standards. **1.1.3** Report network adequacy metrics to DCHS.	Data from NACT database/tool	QAPI Unit Annually reports NACT Submission	Monitored July 2022 – June 2023 Monthly Updates to 274 Database Report completed July 2023
Objective 1.2 Monitor and increase penetration rates for underserved populations			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
1.2.1 Monitor the current number of clients served, types and geographic distribution of mental health services within the MHP delivery system in comparison to previous years. **1.2.2** Monitor the number of services, type of services, population types, and geographical locations to ensure accessibility for all. Compare against previous year. **1.2.3** Increase penetration rates for underserved populations from previous years. **1.2.4** Examine penetration rates subdivided to the race/ethnicity, age, and region level to further understand the distribution of underserved populations. **Regions**: Coast, South Coast, Inland, and North County	Client Population Reports Reports provided by MCBHRS and ASO, and County Medi-Cal data Data Analysis by UM work group and recommendations	Bi-monthly Reports to QIC provided by MCBHRS and ASO Monthly Reports reviewed in UM meeting	July 2022 – June 2023
Objective 1.3 Monitor service capacity			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
1.3.1 Staff productivity will be evaluated via productivity reports generated by the MHP Providers. Clinical Staff will bill an average of 60% per month.	Provider productivity reports	Annual Report to QIC provided by MCBHRS and ASO (Due in July)	July 2022 – June 2023

Accessibility of Services

Goal 2: Beneficiaries will have timely access to the services they need			
Objective 2.1 The length of time from initial request to first offered appointment			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.1.1 At least 90% of first appointments are offered to clients within 10 business days.	Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 2.2 The length of time from initial request to first kept appointment			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.2.1 At least 90% of first appointments are offered to clients within 10 business days.	Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 2.3 The length of time from initial request to first offered psychiatry appointment:			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.3.1 At least 90% of first appointments are offered to clients within 15 business days.	Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 2.4 The length of time from initial request to first kept psychiatry appointment:			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.4.1 At least 90% of first appointments are offered to clients within 15 business days.	Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023

Objective 2.5 The length of time from service request for urgent appointment to actual encounter			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.5.1 At least 95% of crisis conditions are no more than one (1) elapsed hour from the request for service and face-to-face evaluation during regular clinic hours. **2.5.2** At least 95% of crisis conditions are no more than two (2) elapsed hours from the request for service and face-to-face evaluation after regular clinic hours. **2.5.3** At least 95% of urgent or emergent conditions are no more than 72 elapsed hour from the request for service and face-to-face evaluation during regular clinic hours.	Review of Crisis Logs. Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 2.6 Clients discharged from hospitals are provided a follow-up appointment within 7 calendar days.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.6.1 Clients receive an outpatient appointment within an average of 7 calendar days from hospital discharge.	Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 2.7 Psychiatric inpatient readmission rates within 30 days			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.7.1 No more than 10% of clients discharged from psychiatric inpatient will be readmitted within 30 days **2.7.2** Trends and comparisons to previous year will be monitored.	Timeliness of Access report Total number with readmission within 30 days	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 2.8 Monitor timeliness to authorization			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
2.8.1 Treatment Authorization Requests (TAR) will be reviewed for medical necessity and authorized or reauthorized as appropriate within 14 calendar days, a minimum of 100% will meet the timeline. RQMC POA and MC POA will authorize expedited TARs as needed.	Treatment Authorization Timeliness report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023

2.8.2 Trends and comparisons to previous year will be monitored.			

Goal 3: Reduce missed appointment rates			
Objective 3.1 Psychiatrist and Clinician No Show rates:			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
3.1.1 Monitor that no show rates are no higher than 10%: standard or goal for Psychiatrists **3.1.2**. Monitor that no show rates are no higher than 10%: standard or goal for Clinicians other Psychiatrists **3.1.3** Identify disparities in no shows. **3.1.4** Include contractor data in timeliness reports and demonstrate use of aggregate reporting for capacity management.	Timeliness of Access report	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Goal 4: Improve the Behavioral Health Access Line triaging and referral processes into the behavioral health system of care			
Objective 4.1 The MHP will provide beneficiaries with accurate information on how to access services.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
4.1.1 On quarterly basis, conduct 10 test calls, split during business hours after hours. [to be reported to DHCS] **4.1.2** Provide callers with information at initial contact on how to access Specialty Mental Health Services (SMHS), including SMHS required to assess whether medical necessity criteria are met. **4.1.3** At least three (3) test calls will be made each month in English **4.1.4** At a minimum 5% of calls will be in a language other than English.	24/7 Access Report Access log	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 4.2 Monitor responsiveness of the 24-hour, toll-free telephone number.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***

4.2.1 95% of all access line calls will provide beneficiaries with the information they need regarding how to access specialty mental health services, information on urgent conditions, and information on beneficiary problem resolution and fair hearing process. 100% of all calls will be logged.	Test Calls	Compliance Unit will schedule and ensure test calls and follow up training and corrections occur. County & ASO to conduct tests	July 2022 – June 2023

Beneficiary Satisfaction

Goal 5: Monitor client/family satisfaction			
Objective 5.1 Conduct the Mental Health Statistics Improvement Program (MHSIP) State Consumer Perception Survey.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
5.1.1 Conduct the MHSIP CPS biannually to obtain level of client satisfaction with services. Work with State partners to ensure results are provided to County, and if we are not able to obtain results, conduct our own surveys to collect feedback on Consumer and family member satisfaction. **5.1.2** Implement changes based on survey data.	Bi-Annual Completion of the DHCS Consumer Perception Survey	This information is distributed on a semiannual basis in QIC. QAPI unit to work with State entities on obtaining results and conduct County survey if unable.	July 2022 – June 2023
Objective 5.2 Informing providers of the results of the beneficiary and/or family satisfaction Activities			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
5.2.1 The results of client and family satisfaction surveys are shared with providers, stakeholders and the public.	Survey results will be shared with staff, providers, local Behavioral Health Board and QIC.	This information is distributed on an annual basis in QIC.	July 2022 – June 2023

Cultural and Linguistic Competence

Goal 6: Provide all clients with culturally- and linguistically appropriate client-centered care			
Objective 6.1 All services are delivered in a culturally responsive manner.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
6.1.1 All forms, services, communications, and contact to be provided to clients are to be in threshold or preferred languages. **6.1.2** Progress notes in audited charts will indicate the language services were provided in (if applicable - who provided the interpretation). To determine if a successful and appropriate response was provided which adequately addressed the beneficiary's cultural and linguistic needs.	Audits of the Access Log, Crisis Log and/or chart audits, as well as the results of test calls.	Annual audits of the Access Log, Crisis Log and/or chart audits, as well as the results of test calls.	July 2022 – June 2023

Objective 6.2 The MHP has a racially diverse staff with the language capacity to provide access to services in threshold languages.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
6.2.1 Administer a staff diversity survey to obtain data about their ability to provide services in specific languages, comfort/experience working with ethnic populations, and workforce needs.	Staff diversity survey results	Reported annually in the NACT for direct services providers. Ethnic Services Manager and CDC Coordinator to work with QAPI unit on conducting annual survey for those not reported in the NACT.	July 2022 – June 2023

Client Safety and Medication Practices

Goal 7: Promote safe and effective medication practices.			
Objective 7.1 Mental Health charts Medication Clinic charts reviewed Quarterly.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
7.1.1 Medication monitoring will be accomplished during quarterly independent chart reviews, where a total of 5% of clients charted will be audited per year. The charts selected at random will be clients who have received services during the period involving prescribed medications. These reviews will be conducted by a person licensed to prescribe or dispense medications. The charts selected will be clients who have received services during the period being audited and reviewed for the following indicators: **7.1.2** 100% of charts reviewed will have MD Medication Review. **7.1.3** 100% of charts reviewed will have DSM-V diagnosis codes written. **7.1.4** 90% of charts reviewed will have a signed release of information for the beneficiary's health care provider(s), or documentation of beneficiary's decline to release. **7.1.5** 100% of charts reviewed will have Progress notes within 14 calendar days. **7.1.6** 100% of charts reviewed will have Medication Consent Form(s) Signed.	Independent Chart Monitoring of Medication Charts Quarterly	Quarterly report to MCBHRS Provided by Contracted Pharmacist	July 2022 – June 2023

Objective 7.2 Monitor safe medication practices.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
7.2.1 Review safe medication reports quarterly, and identify client concerns to address with Medication Clinic	Independent Chart Monitoring of Medication Charts Quarterly	Quarterly report to QAPI and Medication Clinic	July 2022 – June 2023
Objective 7.3 Meet HEDIS measures for children and adolescents, including foster care children.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***

7.3.1 Monitor that clients prescribed ADHD medication are also scheduled outpatient visits. **7.3.2** Monitor that clients prescribed antipsychotic medication are also scheduled outpatient visits. **7.3.3** Monitor clients prescribed multiple concurrent antipsychotic medications for medication interactions. **7.3.4** Monitor youth on antipsychotic medication receive metabolic monitoring **7.3.5** Monitor youth on concurrent antipsychotics receive follow up visits (1+, 5+).	Data pulled from the EHR Pharmacist Review	Quarterly report to QAPI	July 2022 – June 2023

Service Delivery and Clinical Issues

Goal 8: Evaluate client grievances, unusual occurrence notifications, and change of provider appeal requests.			
Objective 8.1 Review and respond to 100% of grievances and change of provider and appeal requests to identify system improvement issues.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
8.1.1 MCBHRS will log, process and evaluate beneficiary grievances, appeals, expedited appeals, state fair hearings, and expedited state fair hearings within the State required timeframe. 100% will meet the DHCS timeline of not to exceed 90 calendar days from the day BHRS receives the grievance; 30 calendar days from the day BHRS receives the appeal; as expeditiously as the health condition requires, no linger that 72 hours; and 10 business days from the day BHRS receives the change of provider request.	Grievance and Appeal logs State Fair Hearing Log Change of Provider Requests logs Second Opinion Requests logs	Reports to QIC bi-monthly provided by County & ASO Reports to QA/QI monthly provided by County & ASO	July 2022 – June 2023
8.1.2 The nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. **8.1.3** Present finding to the QIC and in QA/QI to identify strategies to improve reporting and address issues.			

Goal 9: Monitor utilization review practices			
Objective 9.1 At least 5% of all charts reviewed through utilization review practice.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
9.1.1 5% of all charts will be reviewed throughutilization review practice **9.1.2** Results of the utilization review will be analyzed and presented to the provider, ASO,and UM	Chart Reviews	Presentation in QA/QI following the scheduled Chart Review	July 2022 – June 2023
Objective 9.2 Monitor authorized services to verify claimed/billed services were actually provided			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
9.2.1 MHP Compliance will send verification ofservices letters to a total of 10% of beneficiaries receiving services, chosen at random.	Verification of service Logs	Semiannually by Compliance	July 2022 – June 2023

Goal 10: Promote Integration of Behavioral Health Services			
Objective 10.1 Identify clients for SUD services.			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
10.1.1 During or after Assessment MHP staff to refer beneficiaries identified as having issues or concerns with alcohol, tobacco, methamphetamines, or opiate use disorder for potential referral to substance abuse services.	Increased referrals to SUDT from service providers	Reports to UM monthly provided by County & ASO	July 2022 – June 2023
Objective 10.2 Monitor SUDT clinical records and chart reviews			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
10.2.1 A total of 5% of clients charted will be audited per year. The charts selected will be clients who have received services during the period being audited.	Chart Reviews	Presentation in QA/QI following the scheduled Chart review	July 2022 – June 2023

Objective 10.3 Monitor timeliness of SUDT service delivery			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
10.3.1 Timeliness of Stay Reviews (Goal: every 6 months), with a minimum of 100% will meet the timeline.	SUDT Reports from EHR and results of Chart Reviews	Reports to QA/QI monthly provided by County & ASO	July 2022 – June 2023
10.3.2 Timeliness of Completion of progress notes (Goal: 5 days), with a minimum of 90% will meet the timeline.			

Performance Improvement

Goal 11: Conduct Performance Improvement Projects			
Objective 11.1 Review of Clinical and Non-Clinical Performance Improvement Projects			
Activities/Strategies	***As Evidenced By***	***Reporting Timelines Staff Responsible***	***Anticipated Completion Dates***
11.1.1 Conduct one clinical performance improvement project **11.1.2** Conduct one non-clinical performance improvement project	Quarterly Reporting to UM meeting	Reports to QIC bi-monthly provided by County & ASO Reports to UM monthly provided by County & ASO	July 2022 – June 2023