**2015-2016 Goals and Objectives**

The following goals and objectives are based upon the DHCS Managed Care contract requirements for quality improvement work plans and Title 9 requirements in the following areas:

**Area 1: Service Delivery Capacity and Timeliness of Service Delivery (DHCS Site Review Protocol**

 **FY 2014-2015: 4a, b, c)**

The MHP is responsible for the monitoring of service delivery capacity and accessibility of services. The MHP will evaluate the distribution of mental health services by type of service and geography of client within its delivery system and set goals for service delivery. The MHP will set goals and monitor for timeliness of routine mental health appointments and urgent conditions, access to afterhours care, and responsiveness of the 24/7 toll-free line.

**Area 2: Beneficiary/Family Satisfaction (DHCS Site Review Protocol FY 2014-2015: 5a, b, c, d)**

The MHP is responsible for monitoring beneficiary satisfaction and ensuring that beneficiaries are informed of their rights and the problem resolution process. The MHP may use various methods for evaluating beneficiary satisfaction including: surveys, outreach, education, focus groups, and other related activities. The MHP must evaluate at least annually, beneficiary grievances, appeals, fair hearings and requests for change of providers. The MHP is also responsible for monitoring provider appeals.

**Area 3: Safety and Effectiveness of Medication and Clinical Practices (DHCS Site Review**

 **Protocol FY 2014-2015: 6; DHCS Contract 22, 23)**

The MHP is responsible for monitoring and evaluating its medication practices for safety and effectiveness. (Issues: monitoring standards and protocol, medication consents)

**Area 4: Quality Improvement Committee Infrastructure and Activities (DHCS Site Review**

 **Protocol FY 2014-2015: 1a, b, c, d, e; 2, 3, 7, 8)**

The Committee is required to have a membership of practitioners and providers, as well as beneficiaries who have accessed specialty mental health services through the MHP and family members. Committee members should have active participation in the planning, design, and execution of the QI Program. The Committee should be involved or oversee QI activities including: recommending policy decisions, reviewing and evaluating results of QI activities, instituting needed QI actions, and ensuring follow-up of QI processes. The QI Committee must evaluate the effectiveness of the QI program and work plan and show how QI activities have contributed to improvement in clinical care and beneficiary service. The work plan must monitor previously identified issues, including tracking issues over time and provide evidence of appropriate follow-up activities.

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| **Area 1: Service Delivery Capacity – Goal 1** |
| **Goal 1** | **The MHP will maintain adequate capacity for delivery of medically necessary specialty mental health services based on geographic area, that are appropriate in number and type of service.**  |
| **Objective 1** | Monitor the number and type of service by geographic area and race/ethnicity, gender, and age and evaluate for appropriate level of service and penetration rates. Make adjustments to service delivery if appropriate.  |

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| This table is an unduplicated count of clients with a Redding, Shasta County, or other address types at the time the service was rendered. Therefore a client could be counted in the residential area of Redding and Non-Residential (Shasta Co.) during the same quarter if during that quarter they were homeless and then were placed in housing. Therefore the table below is an unduplicated client count by residential area and quarter.***No specific baseline or target was set. The penetration rates for Redding and Shasta County (non-Redding) were lower in Q1 and Q2 of FY2015-16 than in the corresponding quarter of FY 2014-15. The QI Committee reviews data quarterly and evaluates for possible areas of under or over representation. To date, the committee has not found any indication in the data of need for adjustment of services based on race/ethnicity, gender, or age.***  |

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| This table is an unduplicated count of clients by the residential area of the client at the time that the service was rendered. Again, if the client moved from Anderson to Shasta Lake City they would be counted in both areas for that quarter. Therefore it is an unduplicated client count by residential area and quarter.The Shasta County (non-Redding) average penetration rate on this chart may not match the Shasta County (non-Redding) penetration rate on the previous page due to clients moving from one zip code to another during the year, which will cause them to be over counted on this chart.***No specific baseline or target was set. The relative percent of unduplicated clients by zip code for Shasta County (non-Redding) for FY 2015-16 were similar to FY 2014-15.*** |

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| This table is a count of visits by the residential area of the client at the time that the service was rendered. If the client moved from Redding to Shasta Lake City they would be counted in both areas for that quarter. Therefore it is a count of visits by the client’s residential area, quarter, and service type rendered.***No specific baseline or target was set. The ratio of the number of visits for Redding and Shasta County (non-Redding) for FY 2015-16 was similar to the ratio of the number of unduplicated clients listed in table 1 of this measure.*** |

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| This table is a count of visits by the residential area of the client at the time that the service was rendered. If the client moved from Anderson to Shasta Lake City they would be counted in both areas for that quarter. Therefore it is a count of visits by the client’s residential area, quarter, and service type rendered.***No specific baseline or target was set. The ratio of the number of visits for the three cities for FY 2015-16 was similar to the ratio of the number of unduplicated clients listed in table 2 of this measure.*** |

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| This table reflects the annual penetration rates for the various demographic groups for CY2014 and CY2015.\* includes Asian, Asian Indian, Cambodian, Chinese, Filipino, Guamanian, Hawaiian, Japanese, Korean, Laotian, Pacific Islander, Samoan, and Vietnamese.\*\* includes Multiple, No Response, No Valid Data, Non-White-Other, Other, and Unknown.***No specific underserved populations were identified for Shasta County. The penetration rates for state-wide underserved Female and Hispanic populations both showed an increase (closer to parity) from CY 2014 to CY 2015.***  |

| **Area 1: Service Delivery Capacity – Goal 2** |
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| **Goal 2** | **The MHP will maintain adequate capacity for timely delivery of routine specialty mental health services.**  |
| **Objective 1** | Increase the number of Youth clients who receive first clinical assessments within 20 business days from the first request for services from 88% to 92%. |

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| The following table shows the Assessment (Org and SCMH) activity for new Youth clients by quarter that the Access episode was opened to services and the location of the Access episode.**The target was not met for Q1 or Q2 in FY2015-16.** |

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| **Objective 2** | Maintain number of Adult clients who receive first clinical assessment within 20 business days from the first request for services at 96% or above. |

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| The following table shows the Assessment activity for new Adult clients by quarter that the Access episode was opened to services. **The target was not met for Q1 or Q2 in FY2015-16.** |

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| **Objective 3** | Increase the number of Adult clients who receive first psychiatric appointment within 30 days of first request for services from 62% to 68%.  |

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| The following table shows the medical evaluation activity for new Adult clients by quarter that the Access episode was opened to services.**The target was not met for Q1 or Q2 in FY2015-16.** |

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| **Objective 4** | Increase percentage of Youth clients referred to Organizational Providers who are scheduled for an appointment within 10 business days of first request for services by 10%. |

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| The following table shows the percentage of Organizational Provider appointments made within 10 business days by Organizational Provider and by the quarter that the Access episode was opened to services.**The target was not met for Q1 or Q2 in FY2015-16.** |

| **Area 1: Service Delivery Capacity – Goal 3** |
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| **Goal 3** | **Evaluate crisis prevention and discharge planning activities for clients at risk of hospitalization or that have been hospitalized in the previous 12 months.** |
| **Objective 1** | Maintain the percentage of Shasta County adult beneficiaries who receive a follow-up psychiatric appointment within 7 days of discharge from a psychiatric inpatient facility at FY2014-15 baseline of 44.9%. (Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health.) |

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| The following table includes the count and percent of Adult Clients scheduled for a prescriber appointment within 7 days of discharge from a Psychiatric Inpatient Facility.**The target was met for Q1 and Q3, but was not met for Q2 in FY2015-16.** |

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| **Objective 2** | 95% of Shasta County youth beneficiaries will receive follow up contact within 7 days of discharge from psychiatric inpatient facility. (Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health and its contracted organizational providers.) |

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| The following table includes the count and percent of Youth Clients who received a follow-up contact within 7 days of discharge from a Psychiatric Inpatient Facility.**The target was not met for Q1, Q2, or Q3 in FY2015-16.** |

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| **Objective 3** | 95% of Shasta County youth beneficiaries who are prescribed psychotropic medications will receive a follow up appointment with a prescriber within 14 days of discharge from a psychiatric inpatient facility.Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health and its contracted organizational providers.) |

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|  The following table includes the count and percent of youth Clients scheduled for a prescriber appointment within 14 days of discharge from a Psychiatric Inpatient Facility. **The target was not met for Q1, Q2, or Q3 in FY2015-16.** |

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| **Objective 4** | Maintain psychiatric inpatient re-hospitalization within 30 days at 13% or less.  |

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| The following table includes the count of all psychiatric IP admissions of Adult Clients, and count and percent of those what had a readmit within 30 days of discharge.**The target was met for Q1 and Q2, but was not met for Q3 in FY2015-16.** |

| **Area 1: Service Delivery Capacity – Goal 4** |
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| **Goal 4** | **Ensure access to after-hours care and the effectiveness of the 24/7 toll-free number.**  |
| **Objective 1** | 95% of test calls will be answered and all necessary elements logged on IRSMHS log sheet or in IRSMHS database. |

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| **Written log of initial requests** | **Q1** | **Q2** | **Q3** |
| **Name of the beneficiary?** | **Business** | **0%** | **50%** | **25%** |
| **After Hours** | **7%** | **40%** | **22%** |
| **Date of the request?** | **Business** | **17%** | **50%** | **75%** |
| **After Hours** | **14%** | **40%** | **67%** |
| **Initial disposition of the request** | **Business** | **17%** | **50%** | **75%** |
| **After Hours** | **14%** | **40%** | **56%** |
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**The target was not met in Q1, Q2 or Q3 in FY2015-16** |

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| **Objective 2** | 95% of test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter is obtained and successfully engages with the caller.  |

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| **Language Access** |
| **FY 1516** |  | **% calls met requirements** |
| QI | **Business** | **67%** |
| **After Hours** | **25%** |
| Q2 | **Business** | **100%** |
| **After Hours** | **25%** |
| Q3 | **Business** | **100%** |
| **After Hours** | **33%** |
|  |  |  |

 **The target was met for Q2 and Q3 for calls during business hours for FY2015-16.** |

| **Area 2: Beneficiary/Family Satisfaction – Goal 1** |
| --- |
| **Goal 1** | **Conduct client satisfaction surveys (POQI) annually or bi-annually as required by DHCS.** |
| **Objective 1** | Improve client satisfaction by a 10% increase (from 2014 baseline) of Agree or Strongly Agree in the following areas:Adult1. I like the services that I received here.
2. I was able to get all the services I thought I needed.

Youth1. Overall, I am satisfied with the services I received.
2. I got as much help as I needed.

Youth Caregiver1. My family got as much help as we needed for my child.
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|  **The target was met for both Adult/Older Adult Questions and one of two Youth/Youth Family questions, but was not met for the other Youth/Youth Family question on the 5/15 POQI. The target was not met for all questions on the 11/15 POQI, but only one of the Youth/Youth Family questions showed a statistically significant difference from the baseline.** |

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| **Objective 2** | Beneficiary/family participation and response to Client Satisfaction Survey (POQI) will increase by 10% from the baseline of 2014. |

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| **The target was not met for both Adult/Older Adult and Youth/Youth Family on the 5/15 POQI. The target was met for Youth/Youth Family, but not met for Adult/Older Adult on the 11/15 POQI.** |

| **Area 2: Beneficiary/Family Satisfaction – Goal 2** |
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| **Goal 2** | **Conduct activities to assess beneficiary/family satisfaction.**  |
| **Objective 1** |  80% of adult clients will complete the Recovery Questionnaire (ARC PIP) quarterly.  |

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|  **The target was not met for Q1, Q2, or Q3 in FY2015-16.** |

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| **Objective 2** | Upon implementation of MORS, 90% of adult clients will receive a MORS assessment at least quarterly. |

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| **The target was not met for Q1, Q2, or Q3 in FY2015-16.** |

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| **Objective 3** | The Customer Satisfaction Survey Subcommittee will develop/adopt a method for assessing beneficiary/family satisfaction and set goals for assessment activity and satisfaction ratings. Activities may include (but not limited to) develop an effective survey, outreach, education, and focus groups. The committee will obtain participation from consumers, family members, organizational providers, and Shasta County direct care, supervisory, and management staff.  |

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| **This objective is ongoing. A subcommittee of the QI Committee has been formed and is working to increase forums for beneficiary and family member access and to determine the most effective method for beneficiaries to provide input and to assess satisfaction.** |

| **Area 2: Beneficiary/Family Satisfaction – Goal 3** |
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| **Goal 3** | **Evaluate beneficiary grievances, appeals, fair hearings and change of provider requests for quality of care issues.** |
| **Objective 1** | Grievance and Change of Provider Request issues and resolutions will be reported to QI Committee quarterly and QI Committee will evaluate for quality of care issues.  |

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| **GRIEVANCE; Summary FY 15/16 (as of: 4/27/16)** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Month** | **Count** | **Pending** | **Resolved** | **Under 60** | **Over 60** | **14 Day Ext Used** | **1. Access** | **2. Services Denied** | **3. Change of Provider** | **4. Quality of Care** | **5. Con-fidentiality** | **6. Other** | **Total by Type** |
| Jul-15 | 0 |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Aug-15 | 0 |   |   |   |  |   |   |  |  |  |  |  | **0** |
| Sep-15 | 0 |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Oct-15 | 0 |   |   |   |  |   |   |  |  |  |  |  | **0** |
| Nov-15 | 0 |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Dec-15 | 0 |   |   |   |  |   |   |  |  |  |  |  | **0** |
| Jan-16 | 0 |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Feb-16 | 1 |   | 1 | 1 |  |   |   |  |  | 1 |  |  | **1** |
| Mar-16 | 0 |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Apr-16 | 0 |   |   |   |  |   |   |  |  |  |  |  | **0** |
| May-16 |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Jun-16 |   |   |   |   |  |   |   |  |  |  |  |  | **0** |
| **Total** | **1** | **0** | **1** | **1** | **0** | **0** | **0** | **0** | **0** | **1** | **0** | **0** | **1** |
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| **CHANGE OF PROVIDER; Summary FY 15/16 (as of: 4/27/16)** |  |  |  |  |  |  |  |  |
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| **Month** | **Count** | **Pending** | **Resolved** | **Under 60** | **Over 60** | **14 Day Ext Used** | **1. In-teraction** | **2. Con-sisent Provider** | **3. Trmt Planning** | **4. Appt Re-schedule** | **5. Con-fidentiality** | **6. Comfort Level** | **7. Misc** | **Total by Type** |
| Jul-15 | 0 |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Aug-15 | 4 |   | 4 | 4 |  |   |   |  | 1 | 1 |  | 1 | 1 | **4** |
| Sep-15 | 0 |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Oct-15 | 1 |   | 1 | 1 |  |   |   |  |  |  |  |  | 1 | **1** |
| Nov-15 | 0 |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Dec-15 | 1 |   | 1 | 1 |  |   |   |  |  |  |  |  | 1 | **1** |
| Jan-16 | 0 |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Feb-16 | 0 |   |   |   |  |   |   |  |  |  |  |  |  | **0** |
| Mar-16 | 0 |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Apr-16 | 0 |   |   |   |  |   |   |  |  |  |  |  |  | **0** |
| May-16 |   |   |   |   |   |   |   |   |   |   |   |   |   | **0** |
| Jun-16 |   |   |   |   |  |   |   |  |  |  |  |  |  | **0** |
| **Total** | **6** | **0** | **6** | **6** | **0** | **0** | **0** | **0** | **1** | **1** | **0** | **1** | **3** | **6** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**The target was met for FY2015-16. Grievance and Change of Provider Request reports were reported to the QI Committee (Last reported in May 2016). The QI Committee did not identify any trends requiring action.**  |

| **Area 2: Beneficiary/Family Satisfaction – Goal 4** |
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| **Goal 4** | **The QI Program will monitor provider appeals.** |
| **Objective 1** | 100% of provider appeals will be resolved within the timeframes specified in Title 9. |

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| Hospital Appeals

|  |  |  |  |
| --- | --- | --- | --- |
|  | FY 13/14 | FY 14/15 | FY 15/16 |
| Number of Appeals | 15 | 17 | 25 |
| Average Turnaround time | 12.5 days | 17 days | 8 days |
| Full Appeal granted | 2 | 2 | 5 |
| Partial Appeal granted | 2 | 5 | 7 |
| # of Appeals granted due to additional documentation | ? | ? | 5 |
| Total days denied | 33 | 56 | 106 |
| Total days granted | 4 | 9 | 37 |

**The target has been met for FY2015-16. Last reported to the QI Committee in May 2016.** |

| **Area 3: Safety and Effectiveness of Medical and Clinical Practices – Goal 1** |
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| **Goal 1** | **Ensure that clinical practices are safe, effective, and support wellness and recovery.** |
| **Objective 1** | All newly hired staff, in job specifications that require it, will receive the newly developed clinical practice and documentation training within 30 days of hire. (Youth and Adult and Med Support) |

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|  Clinical documentation training was developed and provided to all clinical staff in June 2015. It is currently provided to new hire direct care staff by their programs. A Med Support specific training was developed and provided to all medical staff in the fourth quarter of 2016. The timelines for this goal were evaluated by the programs with the result that the goal for training has been adjusted in the 16/17 Work Plan. Clinical Documentation training will be provided to new staff within 90 days of hire.  |

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| **Objective 2** | Review medication practices for safety and effectiveness Bi-Annually. |

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| Medication monitoring is currently being performed on an ongoing basis. The MHP is in the process of updating its medication monitoring procedures including: 1. Hiring external reviewers for auditing, 2. Revising the P&P, and 3. Creating a database to allow accurate and timely reporting on audit findings.  |

| **Area 4: QI Program and QI Committee – Goal 1** |
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| **Goal 1** | **Improve the practices and effectiveness of the Quality Improvement Program.** |
| **Objective 1** | The QI Committee will develop a comprehensive method for identifying, addressing, tracking, and evaluating quality of care issues.  |

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|  **The objective has been addressed and is ongoing. The QI Committee has initiated a new format for agendas and minutes. The format includes action items, to ensure the items are address and not “lost”. Items not addressed remain on the agenda until they are addressed. Action items are reviewed at the end of each meeting and the minutes from the meetings are sent to the attendees within 7 days of the meeting.**  |

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| **Objective 2** | The QI Program will report on quality improvement actions taken by Programs, including performance improvement projects. |

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|  A spreadsheet was developed for reporting and is in the testing process. See example below. A Managed Care staff attends the Youth System of Care monthly all staff meeting to gather information on quality improvement activities being performed by the programs. Performance Improvement Projects are reported to the QI Committee quarterly.\\hipaa\MHUsers$\jalmh\Desktop\Capture.JPG |

| **Area 4: QI Program and QI Committee – Goal 2** |
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| **Goal 2** | **Strengthen the infrastructure and effectiveness of the QI Committee** |
| **Objective 1** | The QI Committee will increase beneficiary and family member involvement in the QI Committee activities, decisions, and oversight. |

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|  The objective has been addressed and is ongoing. The QI Committee has spent significant time brainstorming methods to increase beneficiary and family member involvement. The QI Committee has broad representation, including both a family member and consumer. Both are active as schedules allow and provide significant insight to the Committee. A separate QI Data Committee meets prior to the QI Committee meeting, and that meeting includes family member representation. Additionally, a subcommittee has been developed and will be initiating focus groups with consumers and family members to increase access of both consumers and family members into QI activities. |

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| **Objective 2** | The QI Committee will increase participation of direct care staff in the QI Committee activities.  |

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| This objective is ongoing. Direct care staff participate regularly in ongoing quality improvement activities, both formally and informally. Direct care staff participate on the Cultural Competency Committee and take significant responsibility for developing and presenting the annual Cultural Competency Training provided to all staff. The Cultural Competency Committee surveys all mental health staff for input regarding ideas for training.  |