



*Mariposa County*  
**Health & Human  
Services Agency**  
*Healthy. Safe. Thriving.*

**Mariposa County Behavioral Health and Recovery Services**

**QUALITY IMPROVEMENT WORKPLAN**

**Fiscal Year 2019 - 2020**

# 2019 – 2020 QIC Work Plan

## Quality Assurance Program

### **Required Elements for the Quality Assurance Program**

Mariposa County Behavioral Health and Recovery Services (MCBHRHS) has developed a QA work plan to meet the criteria outlined in the Department of Health Care Services Contract. The QA Program's structure and elements are outlined in this document. The QA Program assigns responsibility to appropriate individuals, adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QA Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

MCBHRHS shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in the State Department of Health Care Services contract.

The QA Program shall:

- Conduct performance-monitoring activities throughout its operations.
- Activities shall include, but not be limited to;
  - Client and system outcomes,
  - Utilization management,
  - Utilization review,
  - Provider appeals,
  - Credentialing and monitoring, and
  - Resolution of beneficiary grievances.
- Ensure continuity and coordination of care with physical health care providers.
- Coordinate with other community services agencies used by its beneficiaries.
- Assess the effectiveness of any MOU with a physical health care plan or managed care.
- Have mechanisms to detect both underutilization of services and overutilization of services, as required by Title 42, CCR, Section 438.240(b)(3).
- Implement mechanisms to assess beneficiary/family satisfaction. The Mental Health Provider (MHP) shall assess beneficiary/family satisfaction by:
  - Surveying beneficiary/family satisfaction with the MHP's services at least annually;
  - Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
  - Evaluating requests to change persons providing services at least annually.
  - Inform providers of the results of beneficiary/family satisfaction activities.
- Implement mechanisms to monitor the safety and effectiveness of medication practices.
  - The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.

## 2019 – 2020 QIC Work Plan

- Monitoring shall occur for five percent of medication charts.
- Implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.
  - Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
  - Take appropriate follow-up action when such an occurrence are identified.
  - Results of the intervention shall be evaluated by the MCBHRS annually.

### **Quality Assurance Unit (QA)**

The QA unit is charged with conducting and overseeing the elements of the QA program. The QA unit will also provide guidance and support in the implementation of the QI work plan. MCBHRS will utilize the QI Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QI Work Plan supporting evidence shall include:

- Evidence of the monitoring activities including, but not limited to,
  - Review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;
  - Evidence that QA activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
- A description of completed and in-process QA activities, including performance improvement projects. The description shall include:
  - Monitoring efforts for previously identified issues, including tracking issues over time;
  - Objectives, scope, and planned QA activities for each year; and,
  - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms MCBHRS has implemented to assess the accessibility of services within its service delivery area. This shall include:
  - Goals for responsiveness for the MCBHRS's 24-hour toll-free telephone number,
  - Timeliness for scheduling of routine appointments,
  - Timeliness of services for urgent conditions, and
  - Access to after-hours care.
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

### **Quality Improvement Committee (QIC)**

The QIC shall be accountable to the Mental Health Director as described in Title 9 CCR, Section 1810.440(a) (1). Operation of the QIC shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4).

# 2019 – 2020 QIC Work Plan

The QIC shall include active participation by practitioners and providers, as well as consumers and family members in the planning, design and execution of the QI Work Plan, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

## **QIC Activities**

The QI Committee shall monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients. The QI Program Committee shall;

- Review the quality of specialty mental health services provided to beneficiaries.
- Recommend policy decisions;
- Review and evaluate the results of QI activities, including:
  - Performance improvement projects;
  - Institute needed QI actions;
  - Ensure follow-up of QI processes; and
  - Document QI Committee meeting minutes regarding decisions and actions taken.

QI activities shall include:

- Collecting and analyzing data to measure against the goals stated in the QI annual work plan, which prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which opportunities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the QI Committee;
- Obtaining input from providers, consumers and family members in identifying barriers to delivery of clinical care and administrative services;
- Designing and implementing interventions for improving performance;
- Measuring effectiveness of the interventions;
- Incorporating successful interventions into the MCBHRS operations as appropriate;
- Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR Section 1810.440(a)(5).

QIC meeting agendas may include, but are not limited to, the following agenda items:

- Capacity and Service Delivery - Reviewing the utilization of services, assess the number of assessments monthly, identifying gaps in services in outlying areas or to underserved populations, and monitoring of penetration rates for Medi-Cal beneficiaries.
- Accessibility-Identify barriers to access of services, monitoring of afterhours access, 24/7 access components (see 24/7 Access P&P), and monitoring of threshold languages.

## 2019 – 2020 QIC Work Plan

- Satisfaction- Identify areas for improvement by reviewing beneficiary surveys, reviewing reports on client “no shows”, change of provider requests, and grievance/appeal summaries.
- Process Service Delivery- review, evaluate Policy and Procedures and compare current services with previous year’s utilization.
- Continuity of Care- Design, implement and measure effectiveness of interventions for coordination of care with Primary Care Physicians and partner agencies.
- PIP Committee- Assign projects for evaluation of improving potential. Incorporate successful interventions into MCBHRS practices. Ensure completion of annual reports.
- Cultural Responsiveness Committee- Review implementation of Cultural Competence Plan to assure culturally competent practices and trainings are occurring.

The QIC meets at minimum quarterly and consists of the following individuals:

- MCBHRS Deputy Director
- Quality Improvement/Assurance Supervisor
- All Supervisors
- MHSa Coordinator
- QA staff
- Committee Chairs
- Beneficiaries
- Mental Health Board Members
- Community Service Providers
- Contract Providers
- Other MCBHRS leadership and direct provider staff

MCBHRS Communication of QI Activities:

The Division supports QI activities through the planned coordination and communication of the results of measurement of QI Goals. There are overall efforts to continually improve the quality of care provided. The planned communication may take place through the following methods:

- Recipients participating in the QI Committee report back to recipient groups
- Emails
- Presentations to the Mental Health Board
- Posters, brochures, notices and surveys displayed in common areas
- Sharing of the Department’s annual QI Plan
- Distribution of meeting minutes

Other Division QI Activities/Committees

The Department has other standing committees where QI/UM activities occur. These include the Performance Improvement Project (PIP) committees, Compliance Committee, Cultural Competency Committee, and Primary Care Provider sub-committee (PCP). Other committees or work groups are created as necessary to resolve quality improvement issues.

# 2019 – 2020 QIC Work Plan

## **Utilization Management (UM) Program**

The Utilization Management Program shall:

- Be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Title 9, CCR, Section 1810.440(b)(1-3).
- Evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
- Implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Department's delivery system.
- Implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the MHP's 24 hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.
- Implement mechanisms to assure authorization decision standards are met. In instances when services are reduced, denied or terminated a Notice of Action (NOA) will be sent to client.

## **Evaluation**

An evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by the MHP and kept on file, along with the Quality Improvement Plan. These documents will be reviewed by the Leadership and others as appropriate.

The evaluation summarizes the following:

- The goals and objectives of the programs/service's Quality Improvement Plan;
- The quality improvement activities conducted during the past year;
- The performance indicators utilized;
- The findings of the measurement, data aggregation, assessment and analysis processes;
- The quality improvement initiatives taken in response to the findings;
- Recommendations: Based upon the evaluation, the actions deemed necessary to improve the effectiveness of the Department's/program services.

# 2019 – 2020 QIC Work Plan

## QI Goal # 1: Monitor and Ensure Service Delivery Capacity

**Objective 1.A:** Obtain on a quarterly basis reports from EHR regarding the following; location of Clients' receiving services by zip code, demographics of Clients' receiving services, types of services Clients' are receiving and Clients' diagnoses.

### **Activities:**

1. Monitor data collected on Medi-Cal beneficiaries in Mariposa County and beneficiaries in treatment with MCBHRS
2. Monitor trending of the data on quarterly basis
3. Data will be analyzed by QIC and leadership to determine areas of deficiencies
4. Review and monitor NACT

### **Person(s) Responsible:**

1. QA Staff Analyst
2. QA Supervisor
3. QIC
4. Leadership

### **Auditing Tool:**

1. Anasazi reports
  - a. Client diagnosis reports
  - b. Client assignment reports
  - c. NACT
2. GIS

### **Completion Date:**

Semi-annual, July 2019 – June 2020

### **Dates to be reported on:**

1. Report quarterly via NACT
2. Report semi-annually for diagnosis

## QI Goal # 1: Monitor and Ensure Service Delivery Capacity

**Objective 1.B:** Monitor Productivity, staff will have an overall productivity rate of 60%.

### **Activity:**

1. Staff will enter all services into Anasazi (both billable & non-billable)
2. Staff productivity will be evaluated by utilizing productivity reports based on client services reports.

### **Person(s) Responsible:**

1. QA Supervisor
2. QA Staff Analyst
3. MCBHRS Leadership
4. MCBHRS staff

### **Auditing Tool:**

1. Anasazi reports
2. Productivity reports and spreadsheets

### **Completion Date:**

Monitor total productivity monthly and once annually, July 2019 – June 2020

### **Dates to be reported on:**

Report quarterly @ QIC

# 2019 – 2020 QIC Work Plan

## QI Goal # 1: Monitor and Ensure Service Delivery Capacity

### Objective 1.C: Certify Satellite Site

**Activity:**

Locate new Coulterville site, enter into a lease for the new site, get Board of Supervisors approval, and QA will certify the new site.

**Person(s) Responsible:**

1. QA Supervisor
2. QA Staff Analyst
3. Deputy Director
4. Fiscal Analyst
5. IT Staff
6. HHS Director

**Auditing Tool:**

Certification Tool

**Completion Date:**

Completed by Dec 2019

**Dates to be reported on:**

Once, upon completion

## QI Goal # 2: Ensure Accessibility to Services

**Objective 2.A:** Monitor timeliness of routine initial mental health assessments to ensure compliance with 10-business day standard.

**Activity:**

1. Track timeliness of assessments from date of request to first offered appointments
2. The NACT

**Person(s) Responsible:**

1. QA Staff Analyst
2. QA Supervisor
3. UM Committee

**Auditing Tool:**

1. Timeline to services spreadsheet
2. Anasazi client services reports
3. The NACT

**Completion Date:**

Monthly, July 2019 – June 2020

**Dates to be reported on:**

Report quarterly



# 2019 – 2020 QIC Work Plan

## QI Goal # 2: Ensure Accessibility to Services

**Objective 2.B:** Monitor Timeliness of routine initial medication appointments from the date of request to the first offered appointment within 15 business days.

**Activity:**

1. Track timeliness of medication evaluations from date of request to first offered appointments
2. The NACT

**Person(s) Responsible:**

1. QA Staff Analyst
2. QA Supervisor
3. UM Committee

**Auditing Tool:**

1. Dr. Tracking spreadsheet
2. Anasazi client services reports
3. The NACT

**Completion Date:**

Monthly, July 2019 – June 2020

**Dates to be reported on:**

Report quarterly

## QI Goal # 2: Ensure Accessibility to Services

**Objective 2.C:** Track utilization of urgent appointments are being offered within 7 calendar days.

**Activity:**

Urgent conditions will be included in monthly timeliness report

**Person(s) Responsible:**

1. QA Staff Analyst
2. QA Supervisor
3. UM Committee

**Auditing Tool:**

Timeline to services spreadsheet

**Completion Date:**

Monitor monthly, July 2019 – June 2020

**Dates to be reported on:**

Report Quarterly

## 2019 – 2020 QIC Work Plan

### QI Goal # 2: Ensure Accessibility to Services

**Objective 2.D:** Monitor Post Hospitalization follow up appointments. Ensure they are within 7 calendar days of discharge.

**Activity:**

1. Follow up appointments will be tracked according to discharge date
2. Identify clients for increased outreach efforts
3. Supervisors and UM to monitor

**Person(s) Responsible:**

1. Hospital Liaison
2. QA Staff Analyst
3. UM Committee
4. Leadership

**Auditing Tool:**

1. Post Hospitalization follow up sheets
2. Hospitalization 19/20 spreadsheet

**Completion Date:**

July 2019 – June 2020

**Dates to be reported on:**

Report Monthly

### QI Goal # 2: Ensure Accessibility to Services

**Objective 2.E:** Monitor the 24/7 access line with an overall passing rate of 95%

**Activity:**

1. Test calls will be conducted at a rate of no less than two per month.
2. Calls will be evaluated on the following information:
  - a. How to access specialty mental health services,
  - b. Information for urgent conditions,
  - c. How to use the beneficiary problem resolution and fair hearing process.
3. 24/7 Access training (including interpreter access) will be offered to all staff bi-annually.
4. Test call reports will be submitted to DHCS quarterly.

**Person(s) Responsible:**

1. MHP Program Supervisors
2. QA Staff will monitor access log
3. Cultural Responsiveness Committee
4. QIC

**Auditing Tool:**

1. Test call worksheets
2. At least two test calls will be made every month
3. Test call logs
4. Interpreter services invoices
5. 24/7 Access report

**Completion Date:**

July 2019 – June 2020

**Dates to be reported on:**

1. Report Quarterly to QIC
2. Report Quarterly to DHCS

# 2019 – 2020 QIC Work Plan

## QI Goal # 2: Ensure Accessibility to Services

### Objective 2.F: Ensure provision of culturally and linguistically appropriate services

#### Activity:

1. Culturally relevant trainings will be planned semi-annually in accordance with the Cultural Competence Plan.
2. Linguistic access training will be offered to staff.
3. Update CRC Plan annually.
4. Update CRC Training Plan annually.
5. Annual summary to QIC.

#### Person(s) Responsible:

1. CRC Committee
2. QIC
3. QA Supervisor

#### Auditing Tool:

1. Sign in sheets
2. Training flyers
3. Pre-post tests
4. Annual summary to QIC

#### Completion Date:

Semi-annually, July 2019 – June 2020

#### Dates to be reported on:

1. Report semi-annually on updates.
2. Report annually on new CRC plan and training plan.
3. Report annually on previous years CRC plan and training plan.

## QI Goal # 2: Ensure Accessibility to Services

### Objective 2.G: Treatment authorization requests (TAR) will be reviewed for medical necessity and authorized or re-authorized as appropriate within 14 calendar days. Concurrent TARs.

#### Activity:

1. TARs will be reviewed and decisions will be documented within 14 days of receipt
2. UM Committee will monitor timeliness of TARs monthly to ensure 100% meet the 14 day timeline
3. Will explore regional contracts for concurrent TARs

#### Person(s) Responsible:

1. QA Supervisor
2. Medical Director
3. Deputy Director
4. Medical Records Staff
5. UM Committee
6. QA Team

#### Auditing Tool:

1. TAR log
2. Authorization audits

#### Completion Date:

Ongoing and active throughout July 2019 – June 2020

#### Dates to be reported on:

Report to QIC monthly

# 2019 – 2020 QIC Work Plan

## QI Goal # 3: Beneficiary Satisfaction

**Objective 3.A:** Assess Beneficiary and/or family member satisfaction with the services through MCBHRS by utilizing the POQI survey twice annually. Goal is to increase the number of completed surveys and increase overall satisfaction by 3%.

**Activity:**

1. Develop services survey and train office support in requesting surveys
2. Utilize Peer Support for client assistance
3. Survey beneficiaries and/or family member for satisfaction with MCBHRS services and service providers
4. Request pilot to utilize iPad submission

**Person(s) Responsible:**

1. FSC/ Medical Records
2. QA Supervisor
3. QIC

**Auditing Tool:**

1. QIC review
2. POQI semi-annually
3. Meeting minutes
4. Survey forms

**Completion Date:**

1. May
2. November
3. July 2019 – June 2020

**Dates to be reported on:**

After each state and MCBHRS satisfaction survey

## QI Goal # 3: Beneficiary Satisfaction

**Objective 3.B:** Communicate the results of surveys to staff, providers and stakeholders.

**Activity:**

1. QA will report results of surveys to staff, providers and stakeholders
2. Staff and providers will review the satisfaction surveys with clients as part of continuous quality improvement

**Person(s) Responsible:**

1. QA Analyst
2. Leadership

**Auditing Tool:**

Survey results

**Completion Date:**

After each state survey, July 2019 – June 2020

**Dates to be reported on:**

1. Two times annually; December 2019 and June 2020
  - a. Report to QIC
  - b. Report to BH all staff

## 2019 – 2020 QIC Work Plan

### QI Goal # 3: Beneficiary Satisfaction

**Objective 3.C:** Assess engagement and service delivery. Decrease overall no show rate. Decrease psychiatric no shows to 10%.

**Activity:**

Monitor no show and cancellation rates with a goal of 90 % of appointments being kept.

**Person(s) Responsible:**

1. QA Staff Analyst
2. PIP Committee
3. Leadership

**Auditing Tool:**

Client services reports

**Completion Date:**

Monthly, July 2019 – June 2020

**Dates to be reported on:**

Report Quarterly to QIC

### QI Goal # 4: Monitor Safety and Effectiveness of Medication Practices

**Objective 4.A:** Monitor safety and effectiveness of medication practices.

**Activity:**

1. Conduct chart audits on 5% of active charts
2. Medical director will audit charts for tele-psych clients and Nurse Practitioner
3. Run reports on the types of medications prescribed for the UM Committee
4. Find a pharmacist or psychiatrist to conduct all chart audits

**Person(s) Responsible:**

1. Medical Director
2. UM Committee
3. QA Supervisor
4. QIC

**Auditing Tool:**

Medication Chart Review Tool

**Completion Date:**

Monthly, July 2019 – June 2020

**Dates to be reported on:**

Semi-annually

# 2019 – 2020 QIC Work Plan

## QI Goal # 5: Coordination and Quality of Care

**Objective 5.A:** Coordinate services with Primary Care Providers (PCP) and other agencies utilized by MCBHRS Beneficiaries.

**Activity:**

1. Provide staff trainings on coordination with PCPs
2. Continue participation in the 'Living Free Initiative'
3. Continue quarterly meetings with managed care partners
4. Continue collaboration the MACT

**Person(s) Responsible:**

1. QA Supervisors and Staff
2. UM Committee
3. Medical Director
4. Contract Providers
5. Intense Outpatient TX
6. Case Managers
7. Living Free Initiative
8. Anthem Blue Cross
9. CA Health and Wellness

**Auditing Tool:**

1. SMI screening tool
2. Timeliness report
3. NOABD review
4. Referral form
5. Training records
6. Sign in sheets
7. Agendas
8. Minutes

**Completion Date:**

July 2019 – June 2020

**Dates to be reported on:**

## QI Goal # 5: Coordination and Quality of Care

**Objective 5.B:** Monitor Medi-cal billing and documentation compliance.

**Activity:**

1. Conduct chart audits on no less than 10 % of open clients
  - a. UM will look for trends – Identify training needs
2. Annual documentation review
3. Provide training of the documentation manual
4. Track billing errors to determine if further training is necessary
5. Review compliance log

**Person(s) Responsible:**

1. QA Supervisor
2. QA Staff Analyst
3. Super User Team
4. Compliance Officer
5. MCBHRS Leadership
6. Fiscal

**Auditing Tool:**

1. Compliance log
2. Chart audit tool
3. Chart audit log
4. Super user log
5. CSI, suspense and other errors report

**Completion Date:**

Monthly, July 2019 – June 2020

**Dates to be reported on:**

Report quarterly to QIC and report annually in UM

## 2019 – 2020 QIC Work Plan

### QI Goal # 5: Coordination and Quality of Care

**Objective 5.C:** Monitor Drug Medi-cal billing and documentation compliance with title 22 regulations.

**Activity:**

1. Utilize SUD chart audit tool with title 22 compliance
2. Conduct chart audits at a rate of 10% per year

**Person(s) Responsible:**

1. QA Supervisor
2. QA Staff Analyst
3. SUD Supervisor
4. SUD Staff
5. Compliance Officer

**Auditing Tool:**

1. SUD chart audit tool
2. Chart audit log

**Completion Date:**

Monthly, July 2019 – June 2020

**Dates to be reported on:**

1. Report Quarterly to QIC
2. Report Annually in UM

### QI Goal # 5: Coordination and Quality of Care

**Objective 5.D:** Monitor Beneficiary grievances, change of providers, and appeals. Grievances will be resolved within 90 days. Standard appeals will be resolved according to the 30-calendar day standard. Expedited appeals will be processed within 72 hours.

**Activity:**

1. Monitor change of provider requests, including the reason given by consumers
2. Provide NOABD's when needed
3. Monitor grievance/appeal log

**Person(s) Responsible:**

1. UM Committee
2. QA Supervisor
3. QI Staff
4. QA Analyst
5. Compliance Officer
6. Leadership

**Auditing Tool:**

1. Grievance submissions
2. Grievance reports
3. NOABD log
4. Change of provider requests
5. Change of provider reports

**Completion Date:**

Ongoing, July 2019 – June 2020

**Dates to be reported on:**

1. Report to QIC Quarterly
2. Report to DHCS Annually

# 2019 – 2020 QIC Work Plan

## QI Goal # 5: Coordination and Quality of Care

### Objective 5.E: Enhance Contract Provider Relations

#### Activity:

1. Provider meetings will continue to occur quarterly to assist in open communications
2. STRTP meetings will transition to provider meetings as contracts are entered into
3. Provider trainings will be held or invitations will be made for in house trainings
4. Provider appeal process will be monitored

#### Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. Compliance Officer

#### Auditing Tool:

1. Provider meeting sign in sheets
2. Provider meeting minutes
3. Training sign in sheets
4. Provider appeals

#### Completion Date:

July 2019 – June 2020

#### Dates to be reported on:

Report to QIC Quarterly

## QI Goal # 5: Coordination and Quality of Care

### Objective 5.F: Performance Improvement Projects

Clinical PIP = Decrease rate of current client hospitalizations.

Non-Clinical PIP = Increase identification of clients with co-occurring diagnosis.

#### Activity:

1. Implement PHQ-9 and Crisis Rating Scale
2. Continue to utilize the post hospitalization follow up form and provide case management services
3. Utilize DSM cross cutting tool for substance use disorder screening

#### Person(s) Responsible:

1. PIP Committee
2. Clinical Staff
3. Supervisors
4. QA Analyst
5. QIC

#### Auditing Tool:

1. PHQ-9 and Crisis Rating Scale
2. PHFU forms
3. PIP Meeting Minutes
4. PIP Submission Tool
5. Co-occurring disorder report
6. Diagnosis report

#### Completion Date:

1. Clinical PIP: PHQ-9 Implement going forward
2. Non-Clinical PIP:

#### Dates to be reported on:

1. Clinical PIP: report to QIC monthly progress
2. Non-Clinical PIP: report to QIC monthly progress