Grace Harbour Inc.

Quality Management
Performance Improvement Analysis
2016

QUALITY

Descriptor	Effectiveness of Services
Performance Goal	80% of individuals discharged will show an improved level of functioning on the CANS/ANSA tool.
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director & UM Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was achieved. Since the implementation of the CANS and ANSA assessment tools, approximately 88% of clients show improved level of functioning as evidenced by an improved score.
Areas Needing Performance Improvement	It is suggested that re-assessments be completed every 6 months in order to better capture interval data of the CANS and ANSA.
Action Plan to address the improvements needed to reach established or revised performance targets	Implement a policy for re-assessments to be completed every 6 months in order to better capture interval data of the CANS and ANSA.
Actions Taken or Changes made to improve performance	The clinical director has implemented a policy for re-assessments to be completed every 6 months in order to better capture interval data of the CANS and ANSA.

Descriptor	Efficiency of Services
Performance Goal	95% of all clients will have an initial assessment including an interpretative summary and a preliminary treatment plan completed within 7 works days of admission.
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director and UM & QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was achieved. 100% of all applicable clients had an initial assessment including an interpretative summary and an initial treatment plan completed within 7 works days of admission.
Areas Needing Performance Improvement	None needed
Action Plan to address the improvements needed to reach established or revised	No action needed. The success in this area is linked with Catalyst programming changes that prompt clinicians to complete work areas left undone.

performance targets	
Actions Taken or Changes made to improve performance	Catalyst programming changes were implemented that prompt clinicians to complete work areas left undone.

Descriptor	Service Access
Performance Goal	Responsiveness to Initial Request for Services (CORE Services) From Intake to Scheduled Appointment: 0 to 2 Business Days From Intake to Scheduled Appointment for Treatment: 0 to 5 Business Days From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days Percentage of Appointments Cancelled by Clinicians: not exceed 10% No Show Rate for Initial Intake Behavioral Health Assessment: not exceed 25% No Show Rate for Treatment Outpatient Services: not exceed 25% No Show Rate for Initial Psychiatric Evaluations: not exceed 25%
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director, UM & QA Manager, Clinicians
Target Goal Attainment Date	December 2016
Final Disposition	From Intake to Scheduled Appointment: 0 to 2 Business Days – 2 Days (MET) From Intake to Scheduled Appointment for Treatment: 0 to 5 Business Days – 5 days (MET) From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days – 14 Days (MET) Percentage of Appointments Cancelled by Clinicians: not exceed 10% - 5% (MET) No Show Rate for Initial Intake Behavioral Health Assessment: not exceed 25% - 8% (MET) No Show Rate for Treatment Outpatient Services: not exceed 25% - 21% (MET) No Show Rate for Initial Psychiatric Evaluations: not exceed 25% - 24% (MET)
Areas Needing Performance Improvement	All target goals were met. It is noted however that some clients did not prefer scheduled appointment times within the stated guidelines due to school/work schedules, etc.
Action Plan to address the improvements needed to reach established or revised performance targets	Telemedicine has been implemented to improve the "From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days" area.
Actions Taken or Changes made to improve performance	Telemedicine services have been contracted to allow for increased psychiatric treatment and enhanced access to the first scheduled appointment.

Grace Harbour Inc.

Quality Management
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Descriptor	Satisfaction and Other Feedback from Persons Served
Performance Goal	Individual Satisfaction Surveys will maintain an 90% client satisfaction rate
Measurement Method(s)/Source for Data Collection	Client Satisfaction Survey Results Indicator to be applied to: All Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director, UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was obtained. 92% of clients reported being satisfied with services provided.
Areas Needing Performance Improvement	The number (n) of client responses to the satisfaction surveys should ideally continue to be greater. MST and FFT programs have their own respective client surveys.
Action Plan to address the improvements needed to reach established or revised performance targets	Increase client satisfaction survey responses by emailing clients served directly with the online survey link. Implement data collection procedures and data analysis to capture MST and FFT program specific survey data to be utilized for performance improvement and quality assurance during 2017.
Actions Taken or Changes made to improve performance	During 2016, clients were asked to sign a consent form that would allow electronic communications for such purposes. Catalyst system changes were also made to require email addresses to be captured by front office staff. This will enable HIPAA complaint email solicitation of the survey link.

Descriptor	Satisfaction and Other Feedback from Stakeholders
Performance Goal	Stakeholder Satisfaction Surveys will maintain an 90% client satisfaction rate
Measurement Method(s)/Source for Data Collection	Client Satisfaction Survey Results Indicator to be applied to: All Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director, UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was obtained. 96% of stakeholders reported being satisfied with services provided.
Areas Needing Performance Improvement	The number (n) of stakeholder responses to the satisfaction surveys should ideally be greater to yield a more representative response.
Action Plan to address the improvements needed to reach established or revised performance targets	Facilitate additional stakeholder meetings in person and administer program specific stakeholder surveys that are representative of the Stakeholders interest (i.e., MST, FFT, Core, etc). Grace Harbour will continue to solicit completion of the stakeholder survey directly by placing a link and message about the survey at the bottom of the email signature of the referral coordinator. This will allow greater visibility of the survey to

	referral sources.
Actions Taken or Changes made to improve performance	Facilitate additional stakeholder meetings in person and administer program specific stakeholder surveys that are representative of the Stakeholders interest (i.e., MST, FFT, Core, etc).

BUSINESS PRACTICES/FUNCTIONS

Descriptor	Effectiveness of Services
Performance Goal	Employee attrition rate shall be no more than 15% annually
Measurement Method(s)/Source for Data Collection	Human Resource Records Indicator to be applied to: All Grace Harbour Employees
Person(s) Responsible for Collecting Data	Human Resource Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was not met. The 2016 employee attrition rate was 18%.
Areas Needing Performance Improvement	The attrition rate was largely due to the rapid expansion of evidence based programming and the high quality assurance efforts placed on staff along with a transition during 2016 to hold even greater enforcement towards the progressive discipline policy for employees in violation.
Action Plan to address the improvements needed to reach established or revised performance targets	Attrition rates will need to be monitored closely.
Actions Taken or Changes made to improve performance	Advances have already been made in the area of implementing additional interview techniques in compliance with the evidence based models that are design to better screen potential applicants for each model.

Descriptor	Efficiency of Services
Performance Goal	85% of all submitted third-party payer claims shall be paid within 60 days
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Outpatient Services
Person(s) Responsible for Collecting Data	Chief Financial Officer and Billing Analyst
Target Goal Attainment Date	December 2016
Final Disposition	This goal was not met. Approximately 78% of claims are paid within 60 days. The remaining 22% of claims unpaid. This is due to a variety of reasons and continues to reflect a large number of clients with a primary and secondary insurance type (requiring longer claim processing times as the secondary payer must receive the EOB

	from primary insurances), claim processing issues within Catalyst (EHR), and denied claim management issues associated with Change Healthcare.
Areas Needing Performance Improvement	Insurance eligibility information listed on Availity website continues to not be consistently accurate, leading to claim denials and delays; clients with primary insurances do not always disclose a primary private insurance (requiring a copay to be collected) and disclose secondary Medicaid as the only payer source. This leads to claim denials and delays. Denied claims are not always worked timely in Emdeon's (Change Healthcare's) system. Catalyst fails to electronically submit claims in their entirety (all required fields on the form) at times leading to claim denials and delays.
Action Plan to address the improvements needed to reach established or revised performance targets	Implement a denial management team which meets at least 2x times a month to problem solve denied claims in collaboration with the contracted billing company.
Actions Taken or Changes made to improve performance	The denial management team has been formulated and will start meeting in January 2017.

Descriptor	Efficiency of Services
Performance Goal	Agency budget shall be balanced at the end of each quarter
Measurement Method(s)/Source for Data Collection	Quickbooks Indicator to be applied to: All Services
Person(s) Responsible for Collecting Data	Chief Financial Officer
Target Goal Attainment Date	End of Each Quarter
Final Disposition	This goal was obtained. The budget was balanced at the end of each quarter.
Areas Needing Performance Improvement	None noted.
Action Plan to address the improvements needed to reach established or revised performance targets	No action plan warranted.
Actions Taken or Changes made to improve performance	No actions warranted pertaining to this goal. Quickbooks will transition from a desktop version to an online version in 2017 to allow for increase collaboration with external accounting firms.

Descriptor	Service Access
Performance Goal	Evidence based programming shall be expanded
Measurement Method(s)/Source for Data Collection	Number of evidence based programs available to clients. Indicator to be applied to: All Evidence Based Programs
Person(s) Responsible for	CEO and Clinical Director

Collecting Data	
Target Goal Attainment Date	December 2016
Final Disposition	This goal was obtained. Multisystemic Therapy was expanded to Chatham and Troup Counties.
Areas Needing Performance Improvement	No areas need improvement in this area.
Action Plan to address the improvements needed to reach established or revised performance targets	No action plans are warranted.
Actions Taken or Changes made to improve performance	No actions warranted.

OUTPATIENT AOD/MH- Adults

Descriptor	Effectiveness of Services
Performance Goal	At least 75% of clients will have an average length of stay of 6 months or less and at least 85% of individuals discharged will show an improved level of functioning on the ANSA tool in at least one area accessed.
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director & UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was met. 78% of adults had an average length of stay of less than 6 months. 89% of adults discharged showed an improvement on at least one area in functioning on the ANSA.
Areas Needing Performance Improvement	The 22% of clients continuing after 6 months appear upon visual inspection of the data to continue to step down to medication management.
Action Plan to address the improvements needed to reach established or revised performance targets	Consider revising goal for 2017 to indicate a percentage of adults who will step down to medication maintenance services only.
Actions Taken or Changes made to improve performance	The 2017 Quality Management & Performance Analysis Plan will revise/clarify this goal so adults receiving medication maintenance services only will not count against this goal, such as, " At least 75% of clients will be discharged or step down to medication maintenance services only within 6 months of admission per treatment episode."

Descriptor	Efficiency of Services

Performance Goal	75% of all outpatient authorization request will be authorized within 10 days of submission
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was not met. Approximately 50% of all outpatient treatment request (OTR) submitted to Medicaid CMO's takes an average of 14 days to be returned as approved, denied, or approved with modifications back from insurance companies.
Areas Needing Performance Improvement	While the OTR response time it takes from insurance companies cannot be directly controlled, it does appear that a correlation continues to exist between the clinical information provided and the approval time of OTR's. For example, Authorization request (OTR) sent in with an updated treatment plan along and relevant clinical notes/documentation appear to generate a faster response that those OTR's sent in with just the requested necessary information. Also, additional clinical information is routinely requested by the insurance company and the assigned clinician can often take up to an additional week providing that information to the requestor.
Action Plan to address the improvements needed to reach established or revised performance targets	Work with the UM to ensure treatment plans are sent in along with OTR requests in an effort to fast track approval of authorizations.
Actions Taken or Changes made to improve performance	DCH has released a statement that effective March 1, 2017, a centralized authorization system for all Medicaid CMO's will be implemented. CMO's will continue to have 14 days to turn around authorization up until July 1, 2017, when the required turnaround time will become 3 days maximum.

Descriptor	Service Access
Performance Goal	Responsiveness to Initial Request for Services From Intake to Scheduled Appointment: 0 to 2 Business Days From Intake to Scheduled Appointment for Treatment: 0 to 5 Business Days From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days Percentage of Appointments Cancelled by Clinicians: not exceed 10% No Show Rate for Initial Intake Behavioral Health Assessment: not exceed 25% No Show Rate for Treatment Outpatient Services: not exceed 25% No Show Rate for Initial Psychiatric Evaluations: not exceed 25%
Measurement Method(s)/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director & UM and QA Manager

Target Goal Attainment Date	December 2016
Final Disposition	From Intake to Scheduled Appointment: 0 to 2 Business Days – 2 Days (MET) From Intake to Scheduled Appointment for Treatment: 0 to 5 Business Days – 5 days (MET) From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days – 14 Days (MET) Percentage of Appointments Cancelled by Clinicians: not exceed 10% - 5% (MET) No Show Rate for Initial Intake Behavioral Health Assessment: not exceed 25% - 8% (MET) No Show Rate for Treatment Outpatient Services: not exceed 25% - 21% (MET) No Show Rate for Initial Psychiatric Evaluations: not exceed 25% - 24% (MET)
Areas Needing Performance Improvement	All target goals were met. It is noted however that some clients did not prefer scheduled appointment times within the stated guidelines due to school/work schedules, etc.
Action Plan to address the improvements needed to reach established or revised performance targets	Telemedicine has been implemented to improve the "From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days" area.
Actions Taken or Changes made to improve performance	Telemedicine services have been contracted to allow for increased psychiatric treatment and enhanced access to the first scheduled appointment.

OUTPATIENT AOD/MH- C&A

Descriptor	Effectiveness of Services
Performance Goal	At least 75% of clients will have an average length of stay of 6 months or less and At least 85% of individuals discharged will show an improved level of functioning on the CANS tool.
Measurement Method(s)/Source for Data Collection/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director & UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was partially met. Not met: 64% of child and adolescents had an average length of stay of less than 6 months. Met: 84% of child and adolescents discharged showed an improved level of functioning on the CANS in at least one area assessed.
Areas Needing Performance Improvement	The average length of stay continues to be greater than 6 months for 36% of the child and adolescent population served. It is noteworthy to note that some of the youth did continue beyond 6 months for medication management only services.

Action Plan to address the improvements needed to reach established or revised performance targets	Consider revising goal for 2017 to indicate a percentage of youth who will step down to medication maintenance services only.
Actions Taken or Changes made to improve performance	The 2017 Quality Management & Performance Analysis Plan will revise/clarify this goal so youth receiving medication maintenance services only will not count against this goal, such as, " At least 75% of clients will be discharged or step down to medication maintenance services only within 6 months of admission per treatment episode."

Descriptor	Effectiveness of Services- FFT
Performance Goal/ Performance Target Based Benchmark	

FFT Performance Criteria	**Performance Target**
Average Caseload	10
Caseload Utilization	95%
Completed Cases %	80%
Case Failure %	<20%
% of Clients Receiving at least 8 sessions	80%
Treatment Pacing: Referral to 1st contact	<2 days
Treatment Pacing: Referral to 1st session	<7 days
Treatment Pacing: Referral to 2nd session	<7 days
Treatment Pacing: Referral to 3rd session	<7 days
Total days in FFT	60-140 days
Consultation Attendance	14
# of Fidelity Ratings (Team Goal)	42
Fidelity Average	3+
Dissemination Adherence Ratings (Team Goal)	42
Dissemination Adherence Average	4+
Assessment Completion: OQ *Pre-Treatment*	100%
Assessment Completion: YOQ *Pre-Treatment*	100%
Assessment Completion: YOQ-SR *Pre-Treatment*	100%
Assessment Completion: OQ *Post-Treatment*	100%
Assessment Completion: YOQ *Post-Treatment*	100%
Assessment Completion: YOQ-SR *Post-Treatment*	100%
Assessment Completion: COM-P	100%
Assessment Completion: COM-A	100%
Assessment Completion: TOM	100%
Attendance at Group and Individual Supervision Sessions	95%
FSR's completed 1st and 2nd session of each phase	2 per phase (total of 6 FSR's per case)
TSR completed	1 per phase (total of 3 per case)

Measurement Method(s)/Source for Data Collection/Source for Data Collection	FFT CSS Database Indicator to be applied to: FFT Services

Person(s) Responsible for Collecting Data	Clinical Director, UM and QA Manager & FFT Program Manager
Target Goal Attainment Date	December 2016
Final Disposition	See attached TYPE Reports for final disposition in each of the assessed areas.
Areas Needing Performance Improvement	See attached Quality Assurance Report for each area indicated as needing improvement.
Action Plan to address the improvements needed to reach established or revised performance targets	See attached Quality Assurance Report for the action plan to address areas indicated as needing improvement.
Actions Taken or Changes made to improve performance	Quality assurance was addressed with the respective FFT model fidelity expert and addressed in weekly consultation calls with the teams.

Descriptor	Effectiveness of Services
Performance Goal/ Performance Target Based Benchmark	No more than 20% of participants successfully completing FFT will recidivate within 3 years post program discharge. Recidivism is defined as the participant obtaining a new delinquent charge that is adjudicated.
Measurement Method(s)/Source for Data Collection/Source for Data Collection	Evidence Based Associates (EBA) Database Data will be collected quarterly Indicator to be applied to: FFT Services
Person(s) Responsible for Collecting Data	Clinical Director & FFT Program Manager
Target Goal Attainment Date	December 2016
Final Disposition	See attached recidivism report broken down by each county.
Areas Needing Performance Improvement	See attached recidivism report broken down by each county for areas needing improvement.
Action Plan to address the improvements needed to reach established or revised performance targets	Implement case autopsies and post discharge case reviews identify strategies for model/service delivery improvement to implement in future cases.
Actions Taken or Changes made to improve performance	Case review autopsies have been implemented to review successful and unsuccessful case closures and identify strategies to implement in future cases.

Descriptor	Effectiveness of Services- MST	
Performance Goal/ Performance Target Based Benchmark	**Performance Criteria**	**Target**
	Total FTE for active therapists*	2-4

	Average number of cases per therapist	4-6
	Percent TAM-R due that were completed	70%
	Percent of youth with at least one TAM-R interview	100%
	Overall Average Adherence Score	.61
	Percent of youth with average therapist adherence score above threshold	80%
	Percent of cases completing treatment	85%
	Percent of cases discharged due to lack of engagement	< 5%
	Percent of youth placed	< 10%
	Avg length of stay in days for youth with opportunity to have full course of treatment	120
	Percent of youth living at home	90%
	Percent of youth in school/working	90%
	Percent of youth with no new arrests	90%
	Percent with parenting skills necessary to handle future problems	85%
	Percent with improved family relations	85%
	Percent with improved network of supports	85%
	Percent with success in educational/vocational setting	85%
	Percent of youth involved with prosocial peers/activities	85%
	Percent of cases where changes have been sustained	85%
Measurement Method(s)/Source for Data Collection/Source for Data Collection	MST-I Database Indicator to be applied to: MST Services	
Person(s) Responsible for Collecting Data	Clinical Director, UM and QA Manager, and MST Program Manager	
Target Goal Attainment Date	December 2017	
Final Disposition	See attached Program Implementation Review (PIR) Reports for final disposition in each of the assessed areas.	
Areas Needing Performance Improvement	See attached Program Implementation Review (PIR) Reports for each area indicated as needing improvement.	
Action Plan to address the improvements needed to reach established or revised performance targets	See attached Program Implementation Review (PIR) Report Recommendations for the specific action plan to address the improvements needed to attain goal targets.	
Actions Taken or Changes made to improve performance	Quality assurance items and action plan items was addressed with the MST model fidelity expert and addressed in weekly consultation calls with the teams to make needed improvements.	

Descriptor	Effectiveness of Services
Performance Goal/	No more than 20% of participants successfully completing MST will recidivate within 3

Performance Target Based Benchmark	years post program discharge. Recidivism is defined as the participant obtaining a new delinquent charge that is adjudicated.
Measurement Method(s)/Source for Data Collection/Source for Data Collection	Evidence Based Associates (EBA) Database Data will be collected quarterly Indicator to be applied to: MST Services
Person(s) Responsible for Collecting Data	Clinical Director & FFT Program Manager
Target Goal Attainment Date	December 2016
Final Disposition	See attached recidivism report broken down by each county.
Areas Needing Performance Improvement	See attached recidivism report broken down by each county for areas needing improvement.
Action Plan to address the improvements needed to reach established or revised performance targets	Implement case autopsies and post discharge case reviews identify strategies for model/service delivery improvement to implement in future cases.
Actions Taken or Changes made to improve performance	Case review autopsies have been implemented to review successful and unsuccessful case closures and identify strategies to implement in future cases.

Descriptor	Efficiency of Services
Performance Goal	75% of all outpatient authorization request will be authorized within 10 days of submission
Measurement Method(s)/Source for Data Collection/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data for Collecting Data	UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	This goal was not met. Approximately 50% of all outpatient treatment request (OTR) submitted to Medicaid CMO's takes an average of 14 days to be returned as approved, denied, or approved with modifications back from insurance companies.
Areas Needing Performance Improvement	While the OTR response time it takes from insurance companies cannot be directly controlled, it does appear that a correlation continues to exist between the clinical information provided and the approval time of OTR's. For example, Authorization request (OTR) sent in with an updated treatment plan along and relevant clinical notes/documentation appear to generate a faster response that those OTR's sent in

	with just the requested necessary information. Also, additional clinical information is routinely requested by the insurance company and the assigned clinician can often take up to an additional week providing that information to the requestor.
Action Plan to address the improvements needed to reach established or revised performance targets	Work with the UM to ensure treatment plans are sent in along with OTR requests in an effort to fast track approval of authorizations.
Actions Taken or Changes made to improve performance	DCH has released a statement that effective March 1, 2017, a centralized authorization system for all Medicaid CMO's will be implemented. CMO's will continue to have 14 days to turn around authorization up until July 1, 2017, when the required turnaround time will become 3 days maximum.

Descriptor	Service Access
Performance Goal	Responsiveness to Initial Request for Services From Intake to Scheduled Appointment: 0 to 2 Business Days From Intake to Scheduled Appointment for Treatment: 0 to 5 Business Days From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days Percentage of Appointments Cancelled by Clinicians: not exceed 10% No Show Rate for Initial Intake Behavioral Health Assessment: not exceed 25% No Show Rate for Treatment Outpatient Services: not exceed 25% No Show Rate for Initial Psychiatric Evaluations: not exceed 25%
Measurement Method(s)/Source for Data Collection/Source for Data Collection	Electronic Health Record- Catalyst Indicator to be applied to: All Core Outpatient Services
Person(s) Responsible for Collecting Data	Clinical Director & UM and QA Manager
Target Goal Attainment Date	December 2016
Final Disposition	From Intake to Scheduled Appointment: 0 to 2 Business Days – 2 Days (MET) From Intake to Scheduled Appointment for Treatment: 0 to 5 Business Days – 5 days (MET) From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days – 14 Days (MET) Percentage of Appointments Cancelled by Clinicians: not exceed 10% - 5% (MET) No Show Rate for Initial Intake Behavioral Health Assessment: not exceed 25% - 8% (MET) No Show Rate for Treatment Outpatient Services: not exceed 25% - 21% (MET) No Show Rate for Initial Psychiatric Evaluations: not exceed 25% - 24% (MET)
Areas Needing Performance Improvement	All target goals were met. It is noted however that some clients did not prefer scheduled appointment times within the stated guidelines due to school/work

	schedules, etc.
Action Plan to address the improvements needed to reach established or revised performance targets	Telemedicine has been implemented to improve the "From Intake to first Scheduled Physician Appointment: 0 to 14 Business Days" area.
Actions Taken or Changes made to improve performance	Telemedicine services have been contracted to allow for increased psychiatric treatment and enhanced access to the first scheduled appointment.

Extenuating or Influencing Factors: Political Climate is suspected to impact access to behavioral healthcare including potential changes to the ACA Affordable Healthcare Act. Changing DBHDD Regulations requiring significant EHR programming changes and changes in business practices continue to be an influencing factor, claim processing issues in Catalyst, ORS rules lacking clarity continue as it pertains to DATEP rules and regulations.