

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES QUALITY IMPROVEMENT  
PROGRAM AND WORK PLAN



# Quality Improvement Program and Work Plan

2018 - 2019

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## **INTRODUCTION**

In accordance with the California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440, the County of San Diego Behavioral Health Services (BHS) has a Quality Improvement (QI) Unit and an Annual Quality Improvement Work Plan (QIWP).

The goals of the BHS QI Unit are based on the healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: "*Crossing the Quality Chasm.*" The targeted quality improvement aims for all health care services are to be *safe, client centered, effective, timely, efficient, and equitable*. These IOM aims are interwoven throughout the QI Unit and QIWP. In addition, both are guided by BHS' mission statement and guiding principles.

SDCBHS Guiding Principles:

- To foster continuous improvement to maximize efficiency and effectiveness of services.
- To support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems.
- To maintain fiscal integrity.
- To ensure services are:
  - Outcome driven
  - Culturally competent
  - Recovery and client/family centered
  - Innovative and creative
  - Trauma-informed
- To assist County employees to reach their full potential.

### **County of San Diego Behavioral Health Services**

#### Mission Statement:

To help ensure safe, mentally healthy, addiction-free communities.  
In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

## **Quality Improvement Unit, FY 2018-19**

### **Quality Improvement Unit Purpose**

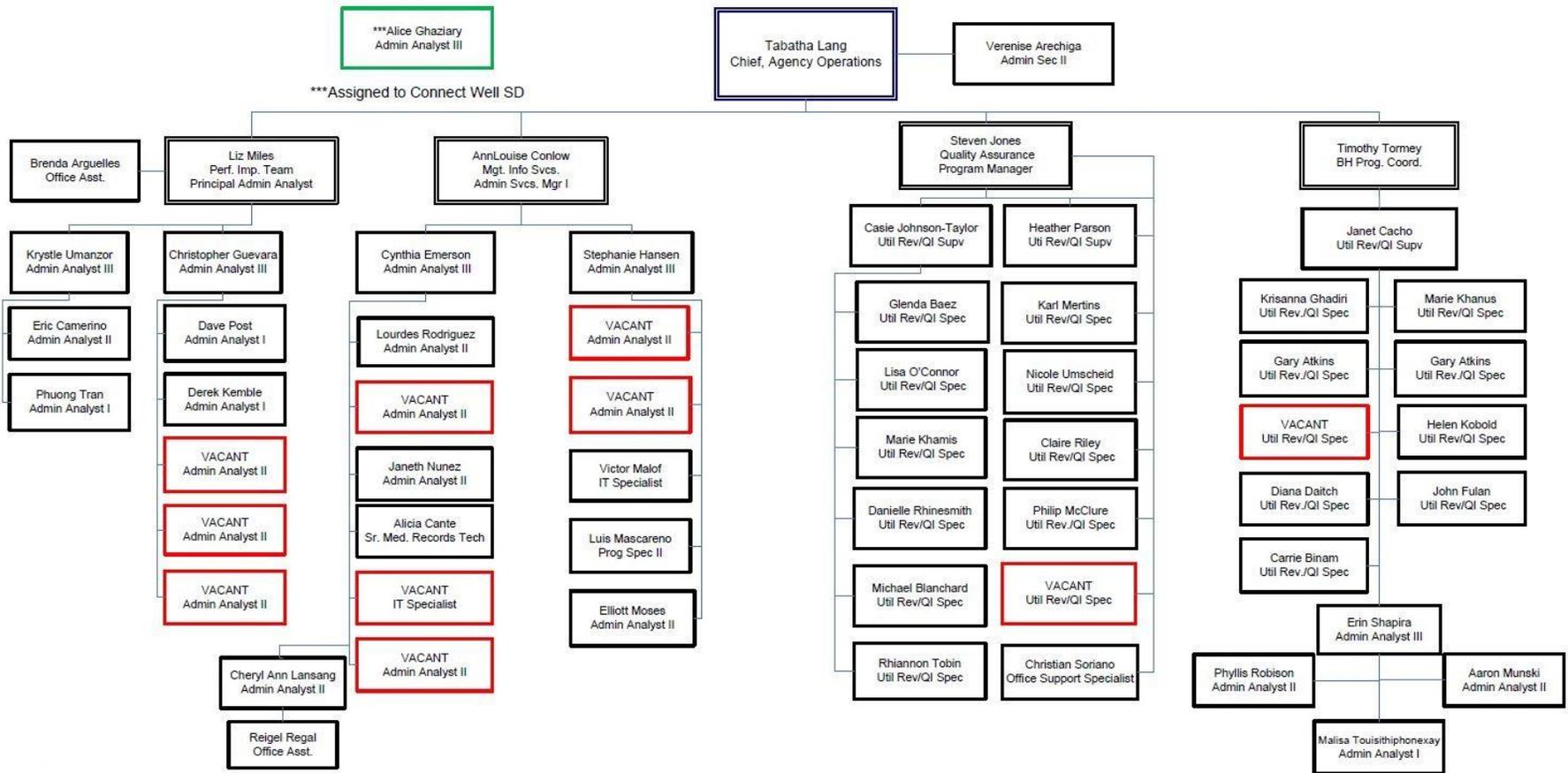
The purpose of the BHS QI Unit is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Unit delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance abuse services provided. The QI Unit encompasses the efforts of clients, family members, clinicians, mental health advocates, substance abuse treatment programs, quality improvement personnel, and other stakeholders.

The QI Unit and QIWP are based on the following values:

- Development of QI Unit and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Unit and QIWP objectives.
- QI Unit and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

# Quality Improvement Unit Organizational Chart



## Quality Improvement Unit Structure

The following are components of the QI Unit structure:

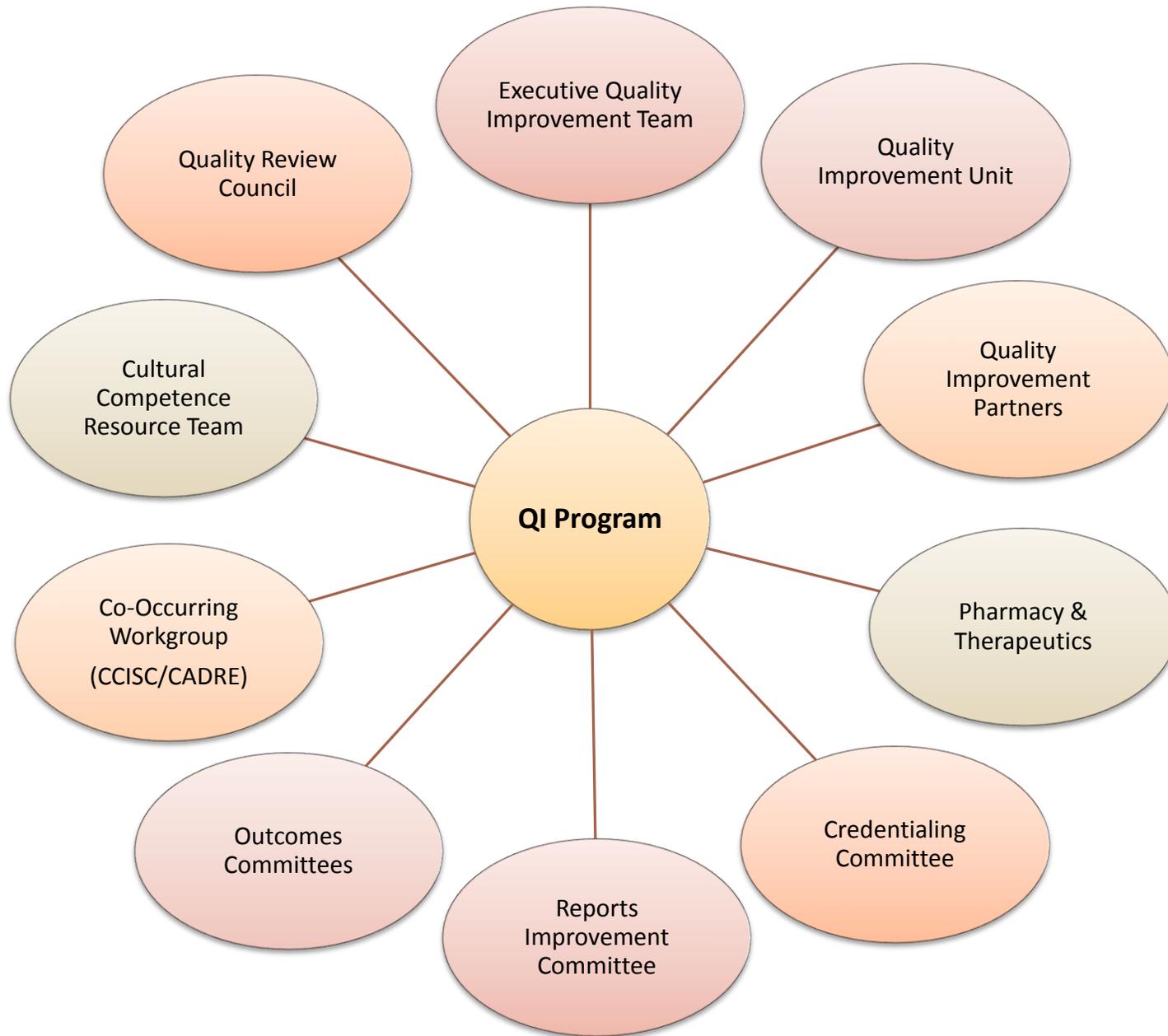
- **Executive Quality Improvement Team (EQIT)**  
The EQIT is responsible for implementing the QI Unit, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities. The EQIT consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Chief. The EQIT reviews Serious Incidents and Grievances routinely.
- **Quality Improvement Performance Improvement Team (QI PIT)**  
The QI Unit includes the BHS QI PIT, which monitors targeted aspects of care on an ongoing basis and produces reports monthly, quarterly, or annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are periodically brought to the EQIT and QRC for input.
- **Quality Management (QM) Team**  
The QM team is another component of the QI Unit and is comprised of Quality Improvement Specialists—licensed therapists and clinicians—who conduct a variety of reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs.
- **Management Information Services (MIS) Team**  
The MIS Unit provides support services to BHS programs through internal security management of user accounts, development of electronic forms, troubleshooting system issues, implementation of new functionality within CCBH, user acceptance testing of releases for CCBH and SanWITS, and the coordination of IT support for BHS Administration. Staff serve in a variety of advisory capacities including committees on interoperability and other system functionality. Staff also collaborate with other BHS departments, the County's outsourced IT Vendor, and Cerner, the software vendor for CCBH to design, test, and implement new functionality and hardware.
- **Quality Review Council (QRC)**  
The QI Unit includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and the QIWP. The QRC meets at least quarterly, and the members are clients or family members, as well as stakeholders, from the behavioral health communities across all regions. The QRC provides advice and guidance to SDCBHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review, interpretation, and evaluation of quality improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.

- Quality Improvement Committees (QICs)
  - The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:
    - o QRC Membership Committee
    - o Serious Incidents (ad hoc committee)

The QI Unit's recent accomplishments have included, but weren't limited to:

- Revising and testing multiple forms in Cerner Community Behavioral Health (CCBH) Client Management System
- Collaborating with other teams and stakeholders on the Project One for All (POFA) Agency Initiative
- Implementing Prevention and Early Intervention (PEI) program regulations
- Completing inter-rater reliability procedures and standards to improve consistency of Medical Record Reviews
- Completing and submitting the 2018 Cultural Competence and 3-Year Strategic Plan to DHCS
- Updating the 2018 Mental Health Implementation Plan
- Developing a new Pathways to Well-being Dashboard
- Collaborating on Hepatitis A reporting to assist with efforts to increase vaccinations within BHS programs
- Implementing client attachments and progress note template updates in CCBH
- Developing and updating an electronic database for tracking AB 109 clients
- Developing a paperless procedure for processing and filing Access Request Forms

The following diagram depicts the committees and workgroups that make up the structure of the QI Program:



## Quality Improvement Process

BHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key systems, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built, measured consistently, interpreted, and articulated into the performance of the BHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of BHS. It is applied when examining the care and services delivered by the BHS network of providers, programs, facilities, and the Administrative Service Organization.

## Client and Family Involvement in Quality Improvement

Consistent with our goals of involving clients and family members in the quality improvement process, many of the QI activities are based on input from clients and family members.

Clients, family members, providers and stakeholders are involved in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Behavioral Health Advisory Board, community coalitions, planning councils, community engagement forums, client and family focus groups, client- and family-contracted liaisons, youth and Transition Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input from the County Behavioral Health website.

## Goals of Quality Improvement

The goals of the quality improvement process are to:

- 1) Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards
- 2) Monitor these functions accurately
- 3) Draw meaningful conclusions from the data collected using valid and reliable methods
- 4) Implement useful changes to improve quality
- 5) Evaluate the effectiveness of changes
- 6) Communicate findings to the appropriate people
- 7) Document the outcomes

## Quality Review Council Focus

QRC has identified the following potential focus topics for FY 2018-19:

- *Client-centered services*: client grievances, client interaction with the Support Specialists, customer service, and monitoring of requests for Appeals and State Fair Hearings.
- *Safety*: reducing serious incidents, medication monitoring standards, and Psychiatric Emergency Response Team (PERT) expansion.
- *Effective services*: continuity of care, Project One for All (POFA) housing efforts, reducing readmissions, and continued collaboration with stakeholders and hospital partners.
- *Efficient and accessible services*: focus on the AB 109 client population and expanding crisis stabilization services.
- *Equitable services*: client and family access to information in their preferred language, and continuity of care and connection to services for the jail population.
- *Timely services*: timely access to crisis and non-crisis Access and Crisis Line options, access time for mental health assessments, and access time between assessment and initial treatment.

## Performance Improvement Projects

To be responsive and transformative, the QI Unit will continue its work on four Performance Improvement Projects (PIPs) focused on:

### 1) Family Engagement (Mental Health Clinical)

While research has found that high caregiver engagement in a child's therapy results is associated with better client outcomes (Dowell & Oggles, 2010), data from the CYF System of Care indicates that family therapy is not being provided to clients as often as it is in other service systems. While there is no standard amount of family therapy that has been recommended by professional mental health organizations, practice guidelines from the American Academy of Child and Adolescent Psychiatry state that caregivers should be active participants in their child's treatment. Particularly, in the case of behavior disorders, the most promising interventions focus on the caregivers.

This clinical PIP will focus on providing training on caregiver engagement and whether this intervention will increase the number of family therapy sessions, and the quality of caregiver participation in these sessions.

In Q1 of FY 2018-19, BHS completed the following activities:

- Hosted a presentation by two psychologists (Dr. Brent Crandal and Dr. Rachel Haine-Schlagel) on two different engagement interventions (MEET and PACT) that may be implemented for the PIP;
- Examined options for training in the engagement interventions with intervention developers, workgroup, and San Diego CYF BHS representatives;
- Discussed recruitment for training in engagement interventions with intervention developers, workgroup, and San Diego CYF BHS representatives;
- Discussed sources of data and data collection with workgroup and San Diego CYF BHS representatives; and
- Processed and analyzed data on caregiver participation in treatment from Youth Services Survey.

Subsequently, the findings from the Youth Services Survey will be presented to the PIP Advisory Committee, and the training schedule for MEET and PACT interventions will be finalized for implementation.

## 2) Discharge Summary Reasons: Client-Reported Reasons for Discontinuing Services (Mental Health Non-Clinical)

Initial efforts focused on identifying why some programs within the OP LOC had unexpectedly high or low proportions for some discharge reasons. For example, only 7% of clients were discharged from the OP level of care for the reason “satisfactorily achieved goals.” Upon further examination of the data extracted from the CIBH MIS, it became evident that some of the problems were likely due to the nature of the discharge question in the system. A detailed analysis of the data was conducted, and issues were found that are likely impacting the effectiveness of the information and the interpretation of the data. A summary of these issues includes:

- The current Discharge Summary Form (DSF), mixes the “where” and “why” questions to be addressed during discharge. Only one choice is allowed, so often the choice has to be made between two equally applicable choices (e.g., “SAG” and “TLLOC” for a Crisis Residential program).
- There are redundant choices in different part of the DSF that often are in conflict in the data.
- Even given a well-designed DSF, the information cannot be interpreted at the systemwide level. For example, OP and Crisis Residential would choose differently with regard to the use of certain answer choices to reflect the same disposition.

Through consultation with other BHS stakeholders, it was revealed that other groups were simultaneously aware of and discussing possible solutions to the problem. The PIP then forged ahead into consolidating these efforts and

organized stakeholder and interested party meetings. The first such meeting resulted in a draft plan of action consisting of design ideas for a new discharge form with improved content and layout.

Information was also gathered from clients during the Spring 2018 Client Satisfaction Survey. The questions were designed to gain insight to the client's perspective of the circumstances under which they are discharged from services. The analysis of these survey questions took place during FY 2018-19 Q1.

Following these efforts, a plan is to be formulated to implement the new DSF in CCBH and test its effectiveness and impact on the clients. Results of the supplemental questions will then be evaluated against existing summary choices.

### 3) Relapse Prevention Evidence-Based Practice (DMC Clinical)

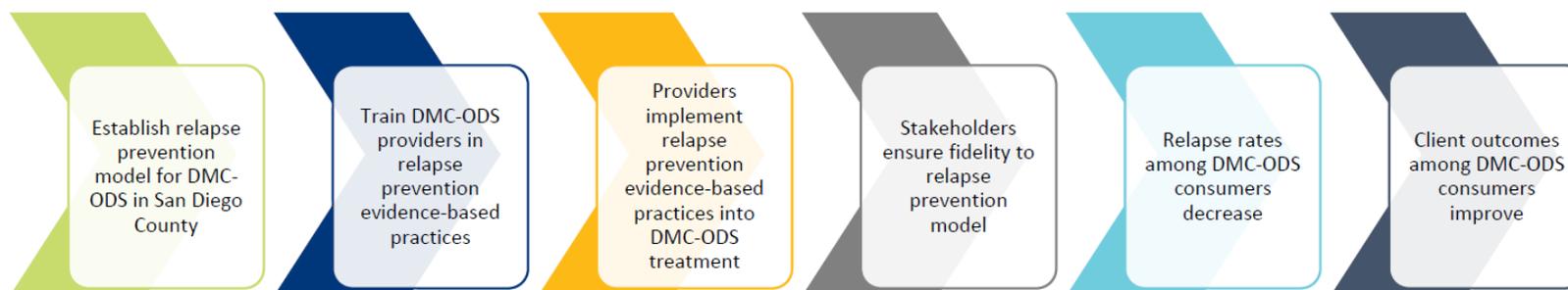
This clinical PIP focused on evaluating fidelity to relapse prevention evidence-based practices (EBPs) and whether these improve client outcomes among clients of the DMC-ODS in San Diego County.

During the end of 2018, stakeholders observed utilization and fidelity to the relapse prevention EBP at DMC-ODS programs in the County. Stakeholders will then train treatment providers at DMC-ODS SUD programs in relapse prevention evidence-based practices in the beginning of 2019, then continue to observe utilization and fidelity.

It is expected that training the County's DMC-ODS providers in relapse prevention evidence-based practices will:

- Increase fidelity to the relapse prevention evidence-based practices;
- Decrease relapse rates among consumers of the DMC-ODS; and
- Improve outcomes among consumers (see Figure 1).

Figure 1. Relapse Prevention Evidence-Based Practice Logic Model



4) Grievances and Appeals Awareness (DMC Non-Clinical)

This PIP seeks to improve the utilization of processes and identification of problems within DMC-ODS and other BHS programs by increasing client awareness of the grievances and appeals processes.

In October 2018, clients receiving SUD treatment services from DMC-ODS were surveyed on their familiarity and comfort level with the grievances and appeals processes, including their perception of existing materials on these processes. Following the survey, a team of subject matter experts from BHS, JFS, CCHEA, and HSRC will be assembled to develop new training materials which will be vetted with clients through interview and focus groups. Recommendations from the vetting process will then be considered before representatives from JFS and CCHEA begin training DMS-ODS SUD program treatment providers in providing new materials and explaining the grievances and appeals process to clients. From this intervention, clients will be surveyed on their familiarity and comfort with the processes, and then the number of grievances filed after the intervention will be compared with prior numbers.

It is expected that increasing awareness of the grievances and appeals processes among consumers of the DMC-ODS will increase the number of grievances that are filed, helping to identify programmatic and system-wide issues that can be addressed, ultimately improving the system as a whole and increasing satisfaction with the DMC-ODS in the future (see Figure 2).

Figure 2. Grievances and Appeals Processes Logic Model



## Targeted Aspects of Care Monitored by QI Unit

### Appropriateness of Services

- Assessment
- Level of Care
- Treatment Plans
- Discharge Planning
- Education Outcomes
- Employment Outcomes
- Utilization Management
- Crisis Stabilization Services

### Access to Routine, Urgent and Emergency Services

- Crisis Stabilization Services
- Access Times for Assessments
- Access to Inpatient Hospital Beds
- Access to Crisis Residential Services
- Access to Residential Treatment Services
- Call Volume for the Access and Crisis Line (ACL)

### Utilization of Services

- Retention Rate
- Completion Rate
- Readmission Rate
- Patterns of Utilization
- Average Length of Stay (ALOS) for Hospitals

### Client Satisfaction

- Grievances
- Satisfaction Surveys
- Provider Transfer Requests

### Cultural Competence

- Trauma-Informed
- Staff Cultural Competence
- Analysis of Gaps in Services
- Provider Language Capacity
- Penetration Rate of Populations
- Training Provided and Evaluated for Feedback

### Client Rights

- LPS Facility Reviews
- Patient Advocate Findings
- Quarterly Client Rights Reports
- Conservatorship Trend Reports

### Effectiveness of Managed Care Practices

- Provider Satisfaction
- Provider Denials and Appeals
- Credentialing Committee Actions
- Client Appeals and State Fair Hearings

### Coordination with Physical Health and Other Community Services

- MOAs with Healthy San Diego
- Integration with Physical Health Providers
- Outcomes Resulting from Improved Integration

### Safety of Services

- Serious Incidents
- Medication Monitoring
- On-Site Review of Safety

## **Quality Improvement Work Plan, FY 2018-19**

### **Developing the Quality Improvement Work Plan**

The purpose of the SDCBHS QIWP is to establish the framework for evaluating how the QI Unit contributed to meaningful improvement in trauma-informed care and administrative services. The QIWP defines the specific areas of quality of services, both clinical and administrative, that SDCBHS will evaluate for FY 2018-19.

The QIWP defines the 1) objectives, 2) goals, 3) indicators and/or measures, 4) planned interventions, 5) data collection and interpretation, and 6) planned reports. The QIWP includes plans for monitoring previously identified issues, sustaining improvement from previous years, and tracking of issues over time.

The QIWP will be monitored and revised throughout the year, as needed. The QIWP is reviewed by the QRC and approved by the EQIT. A formal evaluation will be completed annually.

### **Annual Evaluation of the Quality Improvement Work Plan**

SDCBHS shall evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for any process revisions and modifications.

### **Target Objectives for the Quality Improvement Work Plan**

The targeted objectives of the QIWP are based on the IOM aims and address QRC recommendations. It ensures high-quality trauma-informed systems and services are being engaged by clients and family members in San Diego County.

### **Quality Improvement Work Plan Goals**

The QIWP Goals define targeted measures by which Behavioral Health Services can objectively evaluate the quality of services, both clinical and administrative, provided to clients and families. Some of the goals are process goals while others are measurable objectives. The target areas for improvement have been identified in the following ways:

- 1) Client and family feedback about areas that need improvement
- 2) Systemwide enhancement identified through data and analysis

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
<b>QIWP Target Area: Services Are Client Centered</b>					
1	State Requirement Ongoing	Maintain the number of Quality of Care related grievances.	Number of grievances related to quality of care.	Quarterly Grievances and Appeals report.  Annual Medi-Cal Beneficiary Grievance and Appeal Report (ABGAR).	Advocacy contractors to report on trends of incomplete grievances. Note that last year there was an increase, thus the goal is to maintain.
2	State Requirement Ongoing	Implement a new data collection system for 100% of Clubhouses to enhance tracking of attendance and employment and social engagement outcomes.	Implementation of the new ClubHOMS	Confirm that the new system is operational with UCSD, the system's developer.	Work with UCSD, the Adult/Older Adult System of Care team, and Clubhouse directors to develop a system that enhances outcomes tracking.
3	State Requirement 1 <sup>st</sup> Year	Establish baseline data from the new outcome tool Child and Adolescent Needs and Strengths (CANS), recently implemented in the CYF System of Care.	Successfully implemented tools per the State requirements.  Analyze reports to determine baseline data for measures.	Gather data from initial implementation of new tools.  Examine data on a quarterly basis to identify trends.	Collaborate with University of California, San Diego on how to measure the data being entered.  Establish a baseline after analysis of data for each quarter in FY 2018-19.  Collaborate with Behavioral Health Education and Training Academy (BHETA) and the Praed Foundation on the training for the tools.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
<b>QIWP Target Area: Services Are Safe</b>					
4	Systemwide Enhancement Ongoing	Decrease the number of completed suicides in the Behavioral Health System of Care by 5% from Fiscal Year 2017-18.	Number of suicides.	Suicide report based on data from the Medical Examiner's Office.	Identify risk factors and work with the Systems of Care to ensure appropriate assessment and intervention for high risk clients.
5	Systemwide Enhancement 3 <sup>rd</sup> Year	Ensure that 65% of Full Service Partnership (FSP) Project One for All (POFA) clients are in permanent housing at the latest compared intake.	At least 65% of FSP POFA clients are in permanent housing at the latest assessment compared to intake.	POFA specific indicators and data. FSP Quarterly Reports.	Continue to meet the 1,250 new treatment slots as part of the POFA outreach effort.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
<b>QIWP Target Area: Services Are Effective</b>					
6	Systemwide Enhancement Ongoing	Increase the number of individuals discharged from a psychiatric hospital that connect to services within 7, and within 30 days after discharge by 5% from last Fiscal Year to provide effective continuity of care.	Connection to services within 7 and within 30 days after psychiatric inpatient discharge.	BHS Electronic Health Record  ASO report and dashboard on client services 7 and 30 days following psychiatric hospital discharge.	Enhance case management and care coordination efforts to increase connection to services after discharge.
7	Systemwide Enhancement Ongoing	Ensure 80% of active job seekers in a supported employment specific program will be placed in employment within 90 days. The 90-day period begins upon jobseeker's determination of employment readiness.	80% of job seekers are placed in employment within 90 days	AOA data tracking for programs with specific supported employment goals (ISP). Data will be submitted by the programs to AOA.	Collaborate with AOA to identify specific programs with supported employment goals to track outcomes on a quarterly basis.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
<b>QIWP Target Area: Services Are Efficient and Accessible</b>					
8	State Requirement Ongoing	Provide specialty mental health services to 2% of county uninsured or Medi-Cal under 200% Federal Poverty Level (FPL) eligible population.*	Number of Specialty Mental Health Services clients in ratio to number San Diego County residents who are uninsured or Medi-Cal under 200% FPL.  Percent of uninsured or Medi-Cal under 200% FPL.	Quarterly reports and Databook.  Penetration rates.  Triennial Disparities Report.	Continue outreach efforts to unserved and underserved communities.
9	State Requirement Ongoing	Ensure 100% of clients will have access to adult and children/youth outpatient specialty mental health services within 15 miles or 30 minutes from their place of residence.	Optum Geographic Access Maps; Results from Network Adequacy Certification Process	Network Adequacy Certification Tool (NACT)	Collaborate with programs to ensure network adequacy standards are met.  Collaborate with programs to ensure accuracy of NACT data collection.

\*The new methodology is based on the population eligible for county Specialty Mental Health Services vs the total San Diego County population.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
<b>QIWP Target Area: Services Are Equitable</b>					
10	State Requirement  Ongoing	Ensure 100% of clients and families indicate in the State-required Consumer Perception Surveys that they had access to written information in their primary language and/or received services in the language they prefer.	Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey (YSS) responses to items focused on the availability of materials and services in the clients' preferred language.	Annual client satisfaction survey, including threshold languages from MHSIP and YSS.	Administer the YSS and MHSIP surveys.  Continue to provide all beneficiary packet materials in all threshold languages.  Continue to regularly evaluate and update translated documents.
11	Systemwide Enhancement	Ensure a minimum of 80% of interpreter services are provided by BHS contractors' bilingual staff to ensure treatment is immediately accessible to all clients.	80% of interpreter services will be conducted by program staff instead of utilizing an outside/contracted interpreter.	Cerner fields indicated who provided the interpretation during a service provided.	Ensure diverse workforce recruitment.  Enhance outreach efforts.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed Intervention or Previous Next Steps:
<b>QIWP Target Area: Services Are Timely</b>					
12	State Requirement Ongoing	<ul style="list-style-type: none"> <li>o Ensure 95% of calls answered by the Access and Crisis Line (ACL) crisis queue are within 45 seconds.</li> <li>o Ensure average speed to answer all other (non-crisis) calls is within 60 seconds.</li> </ul>	<p>Number of crisis and non-crisis ACL calls received.</p> <p>Response rates for crisis and non-crisis ACL calls.</p>	<p>Report on ACL access times and types of calls received.</p> <p>Quarterly ACL Performance Standards Report.</p>	<p>Continue to track trends to ensure goals are met.</p>
13	State Requirement Ongoing	<ul style="list-style-type: none"> <li>o Ensure 100% of CYF programs meet the mental health assessment timeliness standard (10 business days).</li> <li>o Ensure 100% of A/OA programs meet the mental health assessment timeliness standard (10 business days).</li> <li>o Ensure 100% of CYF and A/OA programs meet the timeliness standard for mental health assessment requests deemed as urgent (48 hours).</li> </ul>	<p>Percent of CYF and A/OA providers who provide face-to-face clinical contact within timeliness standards.</p>	<p>Data from Request for Services Logs on routine and urgent mental health services requests.</p>	<p>Implement Cerner system capabilities to develop a report that is able to document access times from assessment to initial treatment service.</p>