2019-2021 Goals and Objectives

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

Service Delivery-Capacity and Timeliness

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.

Beneficiary/Family Satisfaction

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.

Safety and Effectiveness of Medication and Clinical Practices

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

QIC Infrastructure and Activities

The QIC 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 Workplan 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.

Service Delivery – Capacity and Timeliness	
Goal 1	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.a	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. Adjust service delivery when appropriate.

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.

Residential Areas	Fiscal Year 2019-2020													Avg Monthly Population FY2019-2020	Penetration Rate
	Q1	Pop	Pen Rate	Q2	Pop	Pen Rate	Q3	Pop	Pen Rate	Q4	Pop	Pen Rate	Undup Total		
Redding	1,380	30,081	4.6%	1,377	29,980	4.6%	1,456	29,960	4.9%	1,334	30,598	4.4%	**2,614**	30,155	8.7%
Shasta County (non-Redding)	690	21,016	3.3%	656	20,893	3.1%	633	20,824	3.0%	549	21,168	2.6%	**1,243**	20,975	5.9%
Non-Residential (Shasta Co.)	251	N/A	N/A	247	N/A	N/A	251	N/A	N/A	226	N/A	N/A	**647**	N/A	N/A
Homeless	*219*			*215*			*218*			*194*			***583***		
PO Box	*22*			*25*			*28*			*27*			***65***		
Other	*11*			*11*			*9*			*8*			***13***		
Out of County/ Unknown	99		N/A	96		N/A	69			65			262	N/A	N/A
Grand Total (undup.)	**2,326**	**55,244**	**4.2%**	**2,288**	**55,097**	**4.2%**	**2,326**	**54,637**	**4.3%**	**2,102**	**55,438**	**3.8%**	**4,406**	**55,104**	**8.0%**
Residential Areas	**Fiscal Year 2020-2021**													**Avg Monthly Population FY2020-2021**	**Penetration Rate**
	Q1	**Pop**	**Pen Rate**	**Q2**	**Pop**	**Pen Rate**	**Q3**	**Pop**	**Pen Rate**	**Q4**	**Pop**	**Pen Rate**	**Undup Total**		
Redding	1,321	31,358	4.2%	1,208	32,403	3.7%	1,270	33,891	3.7%	1,258	34,933	3.6%	**2,449**	33,146	7.4%
Shasta County (non-Redding)	573	21,619	2.7%	512	22,242	2.3%	556	23,136	2.4%	523	23,766	2.2%	**1,068**	22,691	4.7%
Non-Residential (Shasta Co.)	214	N/A	N/A	182	N/A	N/A	210	N/A	N/A	194	N/A	N/A	**501**	N/A	N/A
Homeless	*160*			*134*			*173*			*157*			***413***		
PO Box	*33*			*26*			*22*			*26*			***69***		
Other	*23*			*22*			*17*			*12*			***25***		
Out of County/ Unknown	88		N/A	71		N/A	75			93			239	N/A	N/A
Grand Total (undup.)	**2,123**	**56,645**	**3.7%**	**1,950**	**58,233**	**3.3%**	**2,062**	**60,563**	**3.4%**	**2,025**	**62,196**	**3.3%**	**4,031**	**59,409**	**6.8%**

Evaluation: No specific baseline or target were set. The QI Committee reviews data annually and evaluates for possible areas of under or over representation. To date, the committee has not found any indication of need for adjustment of services in the data based on race/ethnicity, gender, or age.

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.

City - Zip	Fiscal Year 2019-2020						FY2019-2020 Monthly Avg. Population	Penetration Rate**	Fiscal Year 2020-2021						FY2020-2021 Monthly Avg. Population	Penetration Rate**
	Qrtr 1	Qrtr 2	Qrtr 3	Qrtr 4	Undup. Total*	Percent			Qrtr 1	Qrtr 2	Qrtr 3	Qrtr 4	Undup. Total*	Percent		
ANDERSON - 96007	321	294	281	249	547	43.6%	8,529	6.4%	226	243	272	242	494	46.0%	9,313	5.3%
SHASTA LAKE CITY - 96019	151	145	142	115	274	21.8%	3,626	7.6%	122	115	109	117	217	20.2%	3,889	5.6%
COTTONWOOD - 96022	96	108	97	81	182	14.5%	2,334	7.8%	90	67	70	57	139	13.0%	2,501	5.6%
North East	32	23	29	32	96	7.6%	3,424	2.8%	18	21	24	33	85	7.9%	3,663	2.3%
East	61	53	46	42	110	8.8%	2,060	5.3%	47	37	52	35	92	8.6%	2,248	4.1%
West	16	16	14	12	32	2.5%	619	5.2%	11	13	12	11	26	2.4%	655	4.0%
North	7	8	12	9	15	1.2%	384	3.9%	8	7	8	11	20	1.9%	423	4.7%

North East includes: Bella Vista, 96008; Big Bend, 96011; Burney, 96013; Cassel, 96016; Fall River Mills, 96028; McArthur, 96056; Montgomery Creek, 96065; Oak Run, 96069; and Round Mountain, 96084

East includes: Hat Creek, 96040; Millville, 96062; Old Station, 96071; Palo Cedro, 96073; Shingletown, 96088; and Whitmore, 96096

West includes: French Gulch, 96033; Igo/Ono, 96047; Old Shasta, 96087; Platina, 96076; and Whiskeytown, 96095

North includes: Castella, 96017 and Lakehead, 96051 & 96070

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.

Evaluation: No specific baseline or target was set. The relative percent of unduplicated clients by zip code for Shasta County (non-Redding) for FY 2019-20 and FY2020-21 were similar to FY 2018-19.

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.

REDDING															
	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY19-20 Q1	976	29	3,786	623	251	270	308	1,707	457	163	1,701	601	1,340	70	40	12,322
FY19-20 Q2	897	30	4,242	660	333	309	181	1,783	511	160	1,895	574	1,118	122	23	12,838
FY19-20 Q3	1,036	35	4,996	839	348	316	158	1,989	486	195	1,811	593	952	85	44	13,883
FY19-20 Q4	815	28	4,775	837	336	239	58	2,016	482	116	2,112	582	455	33	27	12,911
FY19-20 Total	**3,724**	**122**	**17,799**	**2,959**	**1,268**	**1,134**	**705**	**7,495**	**1,936**	**634**	**7,519**	**2,350**	**3,865**	**310**	**134**	**51,954**
FY20-21 Q1	902	35	4,380	853	316	260	190	1,895	516	115	1,958	592	759	96	34	12,901
FY20-21 Q2	800	32	4,024	609	271	230	45	1,705	431	75	2,335	508	528	16	31	11,640
FY20-21 Q3	838	22	4,342	632	327	291	44	1,999	504	168	2,442	549	767	23	66	13,014
FY20-21 Q4	752	34	3,663	255	328	67	49	1,212	438	130	2,187	323	760		41	10,239
FY20-21 Total	**3,292**	**123**	**16,409**	**2,349**	**1,242**	**848**	**328**	**6,811**	**1,889**	**488**	**8,922**	**1,972**	**2,814**	**135**	**172**	**47,794**

SHASTA COUNTY (non-Redding)															
	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY19-20 Q1	429	14	1,870	371	188	155	58	818	51	17	774	288	324	26	15	5,398
FY19-20 Q2	341	8	1,812	443	155	179	50	830	49	9	833	243	305	58	2	5,317
FY19-20 Q3	355	16	2,052	510	183	218	56	937	61	12	853	242	342	88	1	5,926
FY19-20 Q4	282	10	1,982	422	131	142	9	904	13	11	986	246	196	13	6	5,353
FY19-20 Total	**2,593**	**101**	**13,020**	**1,746**	**1,273**	**552**	**350**	**4,814**	**300**	**103**	**5,577**	**1,724**	**2,465**	**273**	**64**	**35,918**
FY20-21 Q1	326	12	2,044	406	175	156	13	842	38	26	1,055	254	224	59	10	5,640
FY20-21 Q2	284	14	1,888	313	150	164	22	838	71	27	1,132	238	180	30	16	5,367
FY20-21 Q3	336	12	1,765	323	116	181	12	961	146	35	1,037	235	274	99	5	5,537
FY20-21 Q4	270	19	1,694	85	129	49	8	560	102	9	955	155	286	14	19	4,354
FY20-21 Total	**1,216**	**57**	**7,391**	**1,127**	**570**	**550**	**55**	**3,201**	**357**	**97**	**4,179**	**882**	**964**	**202**	**50**	**20,898**

Evaluation: No specific baseline or target was set. The ratio of the number of visits for Redding and Shasta County (non-Redding) for FY2019-20 and FY2020-21 were similar to the ratio of the number of unduplicated clients listed in table 1 of this measure.

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.

ANDERSON	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY19-20 Q1	183	6	865	169	75	57	24	395	32	13	351	151	187	16	8	2,532
FY19-20 Q2	145		818	204	53	90	24	382	17		380	126	220	37	1	2,497
FY19-20 Q3	133	10	959	249	80	92	25	440	9		376	128	200	23		2,724
FY19-20 Q4	104	3	951	187	54	52	4	407	4		446	111	108			2,431
FY19-20 Total	**565**	**19**	**3,593**	**809**	**262**	**291**	**77**	**1,624**	**62**	**13**	**1,553**	**516**	**715**	**76**	**9**	**10,184**
FY20-21 Q1	150	4	888	193	68	67	13	381	19		407	137	96	2		2,425
FY20-21 Q2	132	6	865	205	63	76	22	400	42	1	533	118	83	22	5	2,573
FY20-21 Q3	165	3	829	185	56	87	7	449	96	3	536	105	120	29		2,670
FY20-21 Q4	122	8	717	25	52	19	5	272	52		447	65	120	3		1,907
FY20-21 Total	**569**	**21**	**3,299**	**608**	**239**	**249**	**47**	**1,502**	**209**	**4**	**1,923**	**425**	**419**	**56**	**5**	**9,575**

SHASTA LAKE CITY	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY19-20 Q1	87	6	517	89	60	37	27	186	15	3	203	57	66	10	5	1,368
FY19-20 Q2	90	3	425	91	39	34	23	229	8	4	182	40	46	15		1,229
FY19-20 Q3	95	3	578	101	44	63	30	236	6	6	220	52	91	17	1	1,543
FY19-20 Q4	95	3	529	107	35	37	5	242	6	8	283	60	54			1,464
FY19-20 Total	**367**	**15**	**2,049**	**388**	**178**	**171**	**85**	**893**	**35**	**21**	**888**	**209**	**257**	**42**	**6**	**5,604**
FY20-21 Q1	77	3	596	85	40	49		203	14	17	332	41	74	31	3	1,565
FY20-21 Q2	76	5	471	33	27	40		212	12	17	240	48	51	4	3	1,239
FY20-21 Q3	67	4	435	38	20	58	1	236	9	10	228	45	71	17	5	1,244
FY20-21 Q4	63	1	406	16	15	23	3	165	10	9	194	43	100		19	1,067
FY20-21 Total	**283**	**13**	**1,908**	**172**	**102**	**170**	**4**	**816**	**45**	**53**	**994**	**177**	**296**	**52**	**30**	**5,115**

COTTONWOOD	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY19-20 Q1	74		259	85	14	34	2	126	2	1	110	54	69		2	832
FY19-20 Q2	46		293	95	25	28	3	126	11	5	128	45	28		1	834
FY19-20 Q3	63		249	76	21	36		141	8	3	120	36	20			773
FY19-20 Q4	24	1	210	71	14	26		126		3	107	32	20			634
FY19-20 Total	**207**	**1**	**1,011**	**327**	**74**	**124**	**5**	**519**	**21**	**12**	**465**	**167**	**137**	**-**	**3**	**3,073**
FY20-21 Q1	52	2	264	57	26	12		127		9	194	48	16	1		808
FY20-21 Q2	34		177	38	14	17		125	5	9	131	53	9		1	613
FY20-21 Q3	39	1	186	54	8	11		143	8	22	108	39	31	13		663
FY20-21 Q4	28	3	198	12	16	1		72	20		104	18	18	11		501
FY20-21 Total	**153**	**6**	**825**	**161**	**64**	**41**	**-**	**467**	**33**	**40**	**537**	**158**	**74**	**25**	**1**	**2,585**

Evaluation: No specific baseline or target was set. The ratio of the number of visits for the three cities for FY 2019-20 and FY2020-21 were similar to the ratio of the number of unduplicated clients listed in table 2 of this measure.

This table reflects the annual penetration rates for the various demographic groups for CY2019 and CY2020.

	2019								2020		
	EQRO					MMEF			MMEF		
	Average Number of Eligibles per month	Number of Beneficiaries Served per Year	Penetration Rate	Small Counties	California	Average Number of Eligibles per month	Number of Beneficiaries Served per Year	Penetration Rate	Average Number of Eligibles per month	Number of Beneficiaries Served per Year	Penetration Rate
Total	62,974	3,099	4.92%	5.15%	4.86%	55,527	4,761	8.57%	56,195	4,761	8.47%
0-5	7,592	151	1.99%	1.61%	2.23%	6,490	200	3.08%	6,457	200	3.10%
6-17	14,245	1,077	7.56%	6.93%	6.88%	11,185	1,313	11.74%	11,600	1,313	11.32%
18-59	32,273	1,646	5.10%	5.65%	5.06%	30,027	2,854	9.50%	30,209	2,854	9.45%
60+	8,864	225	2.54%	3.23%	2.90%	7,824	394	5.04%	8,352	394	4.72%
Female	33,080	1,582	4.78%	4.95%	4.48%	29,219	2,232	7.64%	29,819	2,232	7.49%
Male	29,894	1,517	5.07%	5.38%	5.31%	26,308	2,526	9.60%	26,799	2,526	9.43%
Ratio of Female versus male PR			**0.94**	**0.92**	**0.84**			**0.80**			**0.79**
White	43,396	2,236	5.15%	6.07%	6.73%	38,431	3,778	9.83%	38,616	3,778	9.78%
Hispanic	6,371	260	4.08%	4.47%	4.08%	5,555	415	7.47%	5,803	415	7.15%
Ratio of Hispanic versus White PR			**1.68**	**0.74**	**0.61**			**1.32**			**1.37**
Black	1,067	91	8.53%	8.17%	8.49%	880	135	15.34%	859	135	15.72%
Asian or Pacific Islander *	2,362	62	2.62%	1.83%	2.26%	2,210	82	3.71%	2,250	82	3.65%
Alaskan Native or American Indian	1,775	72	4.06%	5.57%	7.50%	1,557	139	8.93%	1,524	139	9.12%
Other **	8,005	378	4.72%	2.16%	5.01%	6,938	627	9.04%	7,566	627	8.29%
Foster Care	576	315	54.69%	44.00%	51.91%	605	296	48.91%	587	296	50.43%
TAY (Age 16-25)	8,501	517	6.08%	6.17%	5.31%	7,264	813	11.19%	7,166	813	11.35%

* 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.

Evaluation: No specific underserved populations were identified for Shasta County.

Service Delivery-Capacity and Timeliness	
Goal 2	Maintain adequate capacity for timely delivery of routine and urgent specialty mental health services.
Objective 2.a	Track and monitor External Quality Review Organization (EQRO) timeliness measurements. The MHP will meet or exceed 28 out of the 32 identified goals.
	Action Steps: 1. Gather and evaluate data on when clients receive their first clinical assessment based on EHR assessment billing data (or scheduler if applicable). 2. Share data analysis results with Program. 3. If goal is not met, Program will plan and implement actions to achieve the goal.
Monitoring Method	1. Where available, data will be gathered from the EHR 2. Additional data may be gathered from the Contacts Log database 3. The list of Foster Care Youth is provided by Children's Services
Reporting Frequency	Quarterly
Responsible Partners	• QI Committee • OPE • Program Directors and Managers
Reference	• DHCS Annual Review Protocol • DHCS Contract
Evaluation	See Attachment 1 for the EQRO Timeliness Measures

Service Delivery – Capacity and Timeliness	
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 3.a	Maintain percentage of **Adult** beneficiaries who receive a follow-up mental health practitioner appointment face to face within 7 days of discharge from a psychiatric inpatient facility at the FY 2018-2019 baseline of 53.0% (Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health). ***Healthcare Effectiveness Data and Information Set (HEDIS) Measure Follow Up after Hospitalization (FUH)*

The following table includes the count and percent of Adult Clients scheduled for or receiving a mental health practitioner appointment within 7 days of discharge from a Psychiatric Inpatient Facility.

Adult received a scheduled mental health practitioner appointment or service within 7 days after discharge from a psychiatric inpatient facility

Discharge Quarter/Year	Count of Discharges*	Appt. Made Within 7 Days		Clients Seen Within 7 Days		Count Seen within 30 days	Count not Seen within 30 days	Average Number of Days	Count Seen on Day of Discharge	% Seen in 7 Days With Day DC
		Count	Percent	Count	Percent					
FY16-17 Total	**69**	**59**	**85.5%**	**53**	**76.8%**	**66**	**3**	**5.4**	**NA**	**NA**
FY17-18 Total	**61**	**41**	**67.2%**	**40**	**65.6%**	**50**	**11**	**5.8**	**NA**	**NA**
FY18-19 Q1	18	14	77.8%	14	77.8%	16	2	4.3	4	100.0%
FY18-19 Q2	24	15	62.5%	13	54.2%	23	1	7.7	3	66.7%
FY18-19 Q3	19	4	21.1%	2	10.5%	11	8	9.0	3	26.3%
FY18-19 Q4	16	8	50.0%	6	37.5%	11	5	9.9	3	56.3%
FY18-19 Total	**77**	**41**	**53.2%**	**35**	**45.5%**	**61**	**16**	**7.4**	**13**	**62.3%**
FY19-20 Q1	10	7	70.0%	4	40.0%	9	1	7.3	2	60.0%
FY19-20 Q2	25	18	72.0%	15	60.0%	22	3	6.1	10	100.0%
FY19-20 Q3	17	14	82.4%	12	70.6%	18	-1	7.2	4	94.1%
FY19-20 Q4	30	22	73.3%	21	70.0%	25	5	5.2	9	100.0%
FY19-20 Total	**82**	**61**	**74.4%**	**52**	**63.4%**	**74**	**8**	**6.2**	**25**	**93.9%**
FY20-21 Q1	27	16	59.3%	14	51.9%	25	2	8.2	8	81.5%
FY20-21 Q2	29	14	48.3%	13	44.8%	24	5	8.2	8	72.4%
FY20-21 Q3	22	4	18.2%	2	9.1%	12	10	12.8	2	18.2%
FY20-21 Q4	40	19	47.5%	0	0.0%	0	40	Pending	0	0.0%
FY20-21 YTD	**118**	**53**	**44.9%**	**29**	**24.6%**	**61**	**57**	**8.9**	**18**	**39.8%**

YTD Avg may differ from single quarter Avg due to admits in the quarter whose discharge occurs in the following quarter.

	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.b	Maintain percentage of **Youth** beneficiaries who receive a follow-up mental health practitioner appointment face to face within 7 days of discharge from a psychiatric inpatient facility at the FY 2018-2019 baseline of 70.8% (Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health). ***HEDIS Measure FUH*

The following table includes the count and percent of Youth Clients who received a follow-up mental health practitioner appointment face to face within 7 days of discharge from a Psychiatric Inpatient Facility.

Youth received a scheduled mental health practitioner appointment or service within 7 days after discharge from a psychiatric inpatient facility

Discharge Quarter/Year	Count of Discharges*	Appt. Made Within 7 Days		Clients Seen Within 7 Days		Count Seen within 30 days	Count not Seen within 30 days	Average Number of Days	Count Seen on Day of Discharge	% Seen in 7 Days With Day DC
		Count	Percent	Count	Percent					
FY16-17 Total	**36**	**25**	**69.4%**	**24**	**66.7%**	**30**	**6**	**4.0**	**NA**	**NA**
FY17-18 Total	**39**	**32**	**82.1%**	**31**	**79.5%**	**37**	**2**	**4.7**	**NA**	**NA**
FY18-19 Q1	3	3	100.0%	3	100.0%	3	0	2.0	0	100.0%
FY18-19 Q2	11	7	63.6%	7	63.6%	9	2	5.4	3	90.9%
FY18-19 Q3	5	3	60.0%	3	60.0%	5	0	5.7	1	80.0%
FY18-19 Q4	15	13	86.7%	13	86.7%	15	0	3.1	2	100.0%
FY18-19 Total	**34**	**26**	**76.5%**	**26**	**76.5%**	**32**	**2**	**4.3**	**6**	**94.1%**
FY19-20 Q1	10	8	80.0%	8	80.0%	9	1	3.8	2	100.0%
FY19-20 Q2	7	4	57.1%	4	57.1%	6	1	5.5	2	85.7%
FY19-20 Q3	12	12	100.0%	9	75.0%	11	1	3.3	3	100.0%
FY19-20 Q4	8	6	75.0%	6	75.0%	8	0	6.5	2	100.0%
FY19-20 Total	**37**	**30**	**81.1%**	**27**	**73.0%**	**34**	**3**	**4.7**	**9**	**97.3%**
FY20-21 Q1	13	12	92.3%	12	92.3%	13	0	3.4	1	100.0%
FY20-21 Q2	11	10	90.9%	10	90.9%	11	0	4.0	1	100.0%
FY20-21 Q3	16	14	87.5%	14	87.5%	16	0	2.3	2	100.0%
FY20-21 Q4	4	3	75.0%	0	0.0%	0	4	Pending	0	0.0%
FY20-21 YTD	**44**	**39**	**88.6%**	**36**	**81.8%**	**40**	**4**	**3.2**	**4**	**90.9%**

YTD Avg may differ from single quarter Avg due to admits in the quarter whose discharge occurs in the following quarter.

	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Programs. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.c	Maintain percentage of **Foster Care Youth** beneficiaries who receive a follow-up mental health practitioner appointment face to face within 7 days of discharge from a psychiatric inpatient facility at the FY 2018-2019 baseline of 63.0% (Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health). ***HEDIS Measure FUH*

The following table includes the count and percent of Foster Care youth Clients scheduled for a follow-up mental health practitioner appointment within 7 days of discharge from a Psychiatric Inpatient Facility.

Foster Youth received a scheduled mental health practitioner appointment or service within 7 days after discharge from a psychiatric inpatient facility

Discharge Quarter/Year	Count of Discharges*	Appt. Made Within 7 Days		Clients Seen Within 7 Days		Count Seen within 30 days	Count not Seen within 30 days	Average Number of Days	Count Seen on Day of Discharge	% Seen in 7 Days With Day DC
		Count	Percent	Count	Percent					
FY16-17 Total	**19**	**11**	**57.9%**	**11**	**57.9%**	**15**	**4**	**5.4**	**NA**	**NA**
FY17-18 Total	**32**	**24**	**75.0%**	**23**	**71.9%**	**27**	**5**	**4.1**	**NA**	**NA**
FY18-19 Q1	3	3	100.0%	3	100.0%	3	0	2.3	0	100.0%
FY18-19 Q2	5	5	100.0%	5	100.0%	5	0	2.4	0	100.0%
FY18-19 Q3	8	5	62.5%	3	37.5%	7	1	11.1	0	37.5%
FY18-19 Q4	11	7	63.6%	7	63.6%	9	2	5.3	1	72.7%
FY18-19 Total	**27**	**20**	**74.1%**	**18**	**66.7%**	**24**	**3**	**6.0**	**1**	**70.4%**
FY19-20 Q1	4	3	75.0%	3	75.0%	4	0	7.0	0	75.0%
FY19-20 Q2	3	1	33.3%	1	33.3%	2	1	9.0	0	33.3%
FY19-20 Q3	9	8	88.9%	8	88.9%	8	1	2.6	0	88.9%
FY19-20 Q4	4	2	50.0%	2	50.0%	2	2	1.0	1	75.0%
FY19-20 Total	**20**	**14**	**70.0%**	**14**	**70.0%**	**16**	**4**	**4.3**	**1**	**75.0%**
FY20-21 Q1	11	5	45.5%	5	45.5%	8	3	5.5	0	45.5%
FY20-21 Q2	6	4	66.7%	4	66.7%	5	1	5.2	1	83.3%
FY20-21 Q3	1	1	100.0%	1	100.0%	1	0	6.0	0	100.0%
FY20-21 Q4	2	1	50.0%	0	0.0%	0	2	NA	0	0.0%
FY20-21 YTD	**20**	**11**	**55.0%**	**10**	**50.0%**	**14**	**6**	**5.4**	**1**	**55.0%**

YTD Avg may differ from single quarter Avg due to admits in the quarter whose discharge occurs in the following quarter.

	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.d	Maintain psychiatric inpatient re-hospitalization within 30 days at 12.8% or less for **Adult** beneficiaries.
	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.e	Maintain psychiatric inpatient re-hospitalization within 30 days at 12.2% or less for **Youth** beneficiaries.
	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.f	Maintain psychiatric inpatient re-hospitalization within 30 days at 0.0% or less for **Foster Care Youth** beneficiaries.
	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.

The following table includes the count of all psychiatric IP discharges of Adult, Youth Clients, and Foster Care Youth and count and percent of those what had a readmit within 30 days of discharge.

Inpatient Clients with a Readmit within 30 Days of Discharge									
	Adults			Youth			Foster Care Youth		
Discharge Quarter	Total Discharges	Readmitted within 30 Days	Percent Readmitted	Total Discharges	Readmitted within 30 Days	Percent Readmitted	Total Discharges	Readmitted within 30 Days	Percent Readmitted
FY16-17 Total	**633**	**87**	**13.7%**	**166**	**17**	**10.2%**	**0**	**0**	**NA**
FY17-18 Total	**626**	**92**	**14.7%**	**175**	**17**	**9.7%**	**32**	**7**	**21.9%**
FY18-19 Q1	143	6	4.2%	39	5	12.8%	3	0	0.0%
FY18-19 Q2	159	20	12.6%	60	9	15.0%	5	0	0.0%
FY18-19 Q3	237	46	19.4%	63	6	9.5%	8	2	25.0%
FY18-19 Q4	211	24	11.4%	62	7	11.3%	10	2	20.0%
FY18-19 Total	**750**	**96**	**12.8%**	**224**	**27**	**12.1%**	**26**	**4**	**15.4%**
FY19-20 Q1	211	31	14.7%	35	2	5.7%	4	0	0.0%
FY19-20 Q2	180	37	20.6%	48	5	10.4%	3	0	0.0%
FY19-20 Q3	183	21	11.5%	59	8	13.6%	9	3	33.3%
FY19-20 Q4	166	24	14.5%	38	5	13.2%	4	0	0.0%
FY19-20 Total	**740**	**113**	**15.3%**	**180**	**20**	**11.1%**	**20**	**3**	**15.0%**
FY20-21 Q1	164	18	11.0%	44	10	22.7%	11	1	9.1%
FY20-21 Q2	158	24	15.2%	33	2	6.1%	6	1	16.7%
FY20-21 Q3	133	10	7.5%	41	9	22.0%	2	0	0.0%
FY20-21 Q4	164	18	11.0%	45	1	2.2%	0	0	NA
FY20-21 YTD	**619**	**70**	**11.3%**	**163**	**22**	**13.5%**	**19**	**2**	**10.5%**

Objective 3.g	Maintain psychiatric inpatient re-hospitalization within 90 days at 22.4% or less for **Adult** beneficiaries.
	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.h	Maintain psychiatric inpatient re-hospitalization within 90 days at 19.8% or less for **Youth** beneficiaries.
	Action Steps: 1. Gather and evaluate data from EHR Scheduler.

	2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.
Objective 3.i	Maintain psychiatric inpatient re-hospitalization within 90 days at 0.0% or less for **Foster Care Youth** beneficiaries.
	Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Share data analysis results with Program. 3. Program will engage in continuous QI process until goal is reached and ongoing to maintain the goal.

The following table includes the count of all psychiatric IP discharges of Adult, Youth Clients, and Foster Care Youth and count and percent of those what had a readmit within 90 days of discharge.

Inpatient Clients with a Readmit within 90 Days of Discharge									
	Adults			Youth			Foster Care Youth		
Discharge Quarter	Total Discharges	Readmitted within 90 Days	Percent Readmitted	Total Discharges	Readmitted within 90 Days	Percent Readmitted	Total Discharges	Readmitted within 90 Days	Percent Readmitted
FY16-17 Total	**633**	**143**	**22.6%**	**166**	**27**	**16.3%**	**0**	**0**	**NA**
FY17-18 Total	**626**	**148**	**23.6%**	**175**	**29**	**16.6%**	**32**	**11**	**34.4%**
FY18-19 Q1	143	25	17.5%	39	6	15.4%	3	0	0.0%
FY18-19 Q2	159	34	21.4%	60	14	23.3%	5	1	20.0%
FY18-19 Q3	237	65	27.4%	63	14	22.2%	8	5	62.5%
FY18-19 Q4	211	45	21.3%	62	10	16.1%	10	2	20.0%
FY18-19 Total	**750**	**169**	**22.5%**	**224**	**44**	**19.6%**	**26**	**8**	**30.8%**
FY19-20 Q1	211	45	21.3%	35	4	11.4%	4	0	0.0%
FY19-20 Q2	180	49	27.2%	48	10	20.8%	3	1	33.3%
FY19-20 Q3	183	40	21.9%	59	12	20.3%	9	3	33.3%
FY19-20 Q4	166	35	21.1%	38	6	15.8%	4	0	0.0%
FY19-20 Total	**740**	**169**	**22.8%**	**180**	**32**	**17.8%**	**20**	**4**	**20.0%**
FY20-21 Q1	164	34	20.7%	44	12	27.3%	11	2	18.2%
FY20-21 Q2	158	43	27.2%	33	4	12.1%	6	1	16.7%
FY20-21 Q3	133	15	11.3%	41	10	24.4%	2	0	0.0%
FY20-21 Q4	164	29	17.7%	45	3	6.7%	0	0	NA
FY20-21 YTD	**619**	**121**	**19.5%**	**163**	**29**	**17.8%**	**19**	**3**	**15.8%**

Monitoring Method	1. For Adult, EHR Scheduling Data for psychiatric appointments.

	2. Data from Urgent Care database for discharge date. 3. For Children's, data gathered from EHR on SAI appointment with client.
Reporting Frequency	Quarterly
Responsible Partners	• QI Committee • OPE • Program Directors and Managers • Organizational Providers
Reference	• DHCS Annual Review Protocol (look up references) • DHCS Contract, Exhibit A Attachment 1, 2. Availability and Accessibility of Services

Service Delivery – Capacity and Timeliness	
Goal 4	Ensure access to after-hours and the effectiveness of the 24/7 toll-free number.
Objective 4.a	90% of test calls will have all necessary elements logged on Initial Request for Specialty Mental Health Services (IRSMHS) log sheet or in IRSMHS database.
	Action Steps: 1. Training of staff who answer the 24/7 line on required elements and correct logging of information. 2. 4 Total test calls will be performed monthly in English testing specific knowledge elements. 3. Gather and evaluate data. 4. If goal not reached, plan and implement actions to achieve goal.

Count of Test Calls				
		Number of Calls Required to be Logged	**Number of Calls where Requirements are Met**	**% of Calls Where Requirements Met**
FY 19-20				
Q1 (July-Sept)	Business	4	1	50%
	After Hours	0	0	NA
Q2 (Oct-Dec)	Business	8	7	88%
	After Hours	2	1	50%
Q3 (Jan-Mar)	Business	7	5	71.43%
	After Hours	0	0	NA
Q4 (Apr-Jun)	Business	13	7	54%
	After Hours	4	0	0%
FY 20-21				
Q1 (July-Sept)	Business	8	3	38%
	After Hours	1	1	100%
Q2 (Oct-Dec)	Business	9	6	67.0%
	After Hours	6	3	50.00%
Q3 (Jan-Mar)	Business	12	7	58.0%
	After Hours	5	0	0.00%
Q4 (Apr-June)	Business	7	5	71.43%
	After Hours	7	1	14.29%

Evaluation:	In FY 19-20, a total of 38 test calls were conducted with 21 calls meeting requirements. 55% of test calls were logged with all necessary elements. In FY 20-21, a total of 55 test calls were conducted with 26 calls meeting requirements. 47% of test calls were logged with all necessary elements. The target has not been met for FY 2019-2021. To address this issue, the 24/7 Access Line staff (internal and contracted after-hours operators) have received follow up training regarding processes with responding to calls from the line, including the appropriate logging of all required elements. We have recently incorporated a new mechanism (Access to Services Journal) for logging/tracking calls, to simplify the logging process for responsible staff.
Objective 4.b	90% of test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter and interpreter engages with the caller.
	Action Steps: 1. Training of staff who answer the 24/7line on required elements and correct logging of information. 2. 1 Total test call will be performed quarterly in another language testing specific knowledge elements. 3. Gather and evaluate data. 4. If goal not reached, plan and implement actions to achieve goal.

Count of Non-English Test Calls				
		Number of Test Calls Made	**Number of test calls where requirements met**	**% test calls where requirements met**
FY19-20				
Q1 (July-Sept)	Business	1	1	100%
	After Hours	0	0	NA
Q2 (Oct-Dec)	Business	0	0	NA
	After Hours	0	0	NA
Q3 (Jan-Mar)	Business	1	1	100%
	After Hours	0	0	NA
Q4 (Apr-Jun)	Business	1	0	0.00%
	After Hours	0	0	NA
FY20-21				
Q1 (July-Sept)	Business	0	0	NA
	After Hours	0	0	NA
Q2 (Oct-Dec)	Business	0	0	NA
	After Hours	0	0	NA
Q3 (Jan-Mar)	Business	0	0	NA
	After Hours	0	0	NA
Q4 (Apr-June)	Business	0	0	NA
	After Hours	0	0	NA

Evaluation:	During this QI Work Plan, the MHP conducted three language only test calls, two out of three test calls (67%) were successful in obtaining a correct language interpreter. This goal was not met for FY19-21. We were recently able to successfully recruit two interpreters, one Mien and one Spanish speaking. Once they are onboarded, we will have staff who can proficiently perform test calls that require interpreter
Objective 4.c	100% of test calls to the 24/7 Access line will be answered by a live person.

The following table includes the count of all 24/7 Access line calls, the count and percent of total calls that were answered by a live person, the count and percent of calls that were not answered by a live person but left a voicemail message, and the count and percent of calls that were not answered by a live person and did not leave a voicemail message, by quarter.

FY/Qtr	Total Calls	Answered Calls		Calls Not Answered			
		Count	Percent	Count of Calls with Message Left	Percent of Calls with Message Left	Count of Calls without Message Left	Percent of Calls without Message Left
FY19-20 Q1	850	848	99.76%	2	0.24%	0	0.00%
FY19-20 Q2	756	754	99.74%	2	0.26%	0	0.00%
FY19-20 Q3	911	908	99.67%	3	0.33%	0	0.00%
FY19-20 Q4	853	853	100.00%	0	0.00%	0	0.00%
FY 19-20 YTD	**3,370**	**3,363**	**99.79%**	**7**	**0.21%**	**0**	**0.00%**
FY20-21 Q1	719	715	99.44%	4	0.56%	0	0.00%
FY20-21 Q2	269	268	99.63%	1	0.37%	0	0.00%
FY20-21 Q3	639	630	98.59%	9	1.41%	0	0.00%
FY20-21 Q4	285	285	100.00%	0	0.00%	0	0.00%
FY 20-21 YTD	**1,912**	**1,898**	**99.27%**	**14**	**0.73%**	**0**	**0.00%**

Action Steps:

1. Answer log will be kept by access line staff.
2. Rate of calls answered will be monitored and reported by staff supervisor and reported to QIC.
3. Supervisor and staff will implement strategies to meet goal.
4. After-hours contract staff will keep log of calls answered.

<table>
<tr><td></td><td>5. Rate of calls answered will be monitored and reported by contract monitor and reported to QIC.</td></tr>
<tr><td>Objective 4.d</td><td>100% of calls, beneficiaries will have access to care, including after hours.</td></tr>
<tr><td colspan="2">The following table includes the count of all after hours' calls, and the count and percent of calls that were answered by a live person, by quarter.
<table>
<tr><th>FY/Qtr</th><th>Total Calls</th><th>Calls Answered</th><th>Percent Answered</th></tr>
<tr><td>FY19-20 Q1</td><td>258</td><td>258</td><td>100.0%</td></tr>
<tr><td>FY19-20 Q2</td><td>213</td><td>213</td><td>100.0%</td></tr>
<tr><td>FY19-20 Q3</td><td>270</td><td>270</td><td>100.0%</td></tr>
<tr><td>FY19-20 Q4</td><td>203</td><td>203</td><td>100.0%</td></tr>
<tr><td>FY19-20 YTD</td><td>944</td><td>944</td><td>100.0%</td></tr>
<tr><td>FY20-21 Q1</td><td>275</td><td>275</td><td>100.0%</td></tr>
<tr><td>FY20-21 Q2</td><td>168</td><td>168</td><td>100.0%</td></tr>
<tr><td>FY20-21 Q3</td><td>113</td><td>113</td><td>100.0%</td></tr>
<tr><td>FY20-21 Q4</td><td>126</td><td>126</td><td>100.0%</td></tr>
<tr><td>FY 20-21 YTD</td><td>682</td><td>682</td><td>100.0%</td></tr>
</table></td></tr>
<tr><td></td><td>Action Steps:
1. After-hours contract staff will keep log of calls answered.
2. Rate of calls answered will be monitored and reported by contract monitor and reported to QIC.
3. If goal is not met, contract monitor, and contract employees will implement strategies to meet goal.
4. MHP will monitor urgent condition/crisis calls received after hours that are transferred to ensure that all urgent condition/crisis calls are successfully transferred to a live mental health worker.
5. If goal is not met, the MHP will implement strategies to meet goal.</td></tr>
<tr><td>Monitoring Method</td><td>1. Initial Request for Specialty Mental Health Services database
2. Test Call Log</td></tr>
<tr><td>Reporting Frequency</td><td>Quarterly</td></tr>
<tr><td>Responsible Partners</td><td>• QIC
• OPE
• Managed Care, Compliance and Quality Management</td></tr>
</table>

	• Front Office • Answering Service Contractor
Reference	• DHCS Annual Review Protocol (look up references) • DHCS Contract Exhibit A Attachment 1, 1. Provision of Services, 2. Availability and Accessibility of Services

Beneficiary/Family Satisfaction	
Goal 5	Conduct activities to assess beneficiary/family satisfaction.
Objective 5.	Develop and implement a method(s) for assessing beneficiary/family satisfaction and set goals for assessment activity and satisfaction ratings. Activities may include (but are not limited to) developing an effective survey, outreach, education, and/or focus groups. The committee will obtain participation from consumers, family members, organizational providers and Shasta County direct care, supervisory and management staff.
	Action Steps: 1. Conduct pilot of mailing Shasta County Service Satisfaction Survey to beneficiaries who discharge or are otherwise closed to services. 2. Evaluate effectiveness of pilot. 3. Explore ways to offer Shasta County Service Satisfaction Survey to beneficiaries such as via survey monkey through web link and on internet webpage, tablets provided at access points, and via follow up phone calls. 4. Work with Privacy Officer on offering survey in Qualtrics. 5. Create survey in Qualtrics. 6. Team with Access points on offering survey. 7. Work with Privacy Officer on HIPAA compliant procedure for satisfaction survey follow up calls.
Monitoring Method	1. Data on surveys completed from database. 2. Report to QI Committee from Children's and Organizational Providers.
Reporting Frequency	Semi-Annually
Responsible Partners	• Adult and Children's Programs • OPE • Managed Care, Compliance and Quality Management • QIC
Reference	• DHCS Annual Review Protocol (look up references) • DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. QI Program • Title 9, Section 1810.440
Evaluation	Collaborative efforts were made to revamp our customer satisfaction surveys, including suggestions for implementing surveys via electronic devices placed in Mental Health Plan (MHP)

	lobbies. However, staffing limitations to support the endeavor created an initial barrier. COVID-19 limitations have since stalled this idea. New ideas were pursued with the assistance of Behavioral Health Concepts, with intentions to include this as a potential Performance Improvement Project. This was determined to be nonviable. We are now exploring alternative delivery options as we pull through the pandemic, with multiple department heads, quality improvement staff, the MHP director, and the Quality Improvement Committee participating in the discussion. We aim to have a resolution within this fiscal year.

Beneficiary/Family Satisfaction	
Goal 6	Evaluate beneficiary grievances, appeal, fair hearings and change of provider requests for quality of care issues.
Goal 6.a	Grievance, appeal, expedited appeal, and change of provider Requests issues and resolutions will be reported to the QIC quarterly and the QIC will evaluate for quality of care issues.
	Action Steps: 1. Review grievances and change of provider requests quarterly. 2. Identify possible quality of care issues. 3. Share issues with concerned staff/programs. 4. Collaborate with staff/programs to address issues. 5. Managed Care, Compliance and Quality Management will prepare and present a report quarterly to the QIC documenting issues and trends of grievances and change of provider requests. 6. QIC will review report and evaluate for quality of care issues. 7. Any issues deemed appropriate for follow up will be addressed and outcomes will be tracked.
Monitoring Method	1. Managed Care, Compliance and Quality Management grievance and change of provider logs. 2. QIC meeting minutes. 3. Quality of Care Items for follow up on QIC Agendas. 4. Development of a recording process for issues identified, actions taken, and resolution.
Reporting Frequency	Quarterly
Responsible Partners	• Managed Care, Compliance and Quality Management • QIC • Programs and staff
References	• DHCS Annual Review Protocol (look up references) • DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. QI Program • Title 9, Section 1810.440
Evaluation	During the 2019-2020 fiscal year, there were a total of 26 beneficiary grievances, 14 of which were identified as quality of care concerns. The quality of care concerns included 10 identified as staff behavior concerns, 3 identified as treatment issues or concerns, and 1 medication concern. Investigation and

	resolution efforts continue to include a combination of phone and/or face-to-face interviews with beneficiary's, direct care staff, line staff supervisors and upper management, and chart review. During the 2020-2021 fiscal year, there were a total of 23 beneficiary grievances, 13 of which were identified as quality of care concerns. The identified quality of care concerns included 2 medication concerns, 9 staff behaviors or concerns, and 2 treatment issues/concerns. All Grievances, Appeals, Expedited Appeals, Fair Hearings, and Change of Provider Requests are reviewed and investigated by the Compliance & Quality Improvement team Mental Health Clinician, with oversight provided by the Quality Improvement Coordinator. Grievances are reported at least quarterly to the Quality Improvement Committee, where quality of care concerns and resolutions are discussed. In addition, all customer satisfaction surveys are reviewed for quality of care issues and are processed similarly. To further support the beneficiary grievance process, we are actively working to expand education and training around problem resolution mechanisms and practices, working to demystify the topic to promote staff facilitation and support of these essential tools available to beneficiaries. We have begun incorporating information regarding these processes and how to access beneficiary informing materials within the annual Compliance Training, required for all MHP funded staff. At least one presentation on the grievance process has been provided at an Adult Services: Crisis Residential staff meeting. We will continue to expand agency understanding of these processes and offer one-on-one or group trainings.

Beneficiary/Family Satisfaction	
Goal 7	Monitor appeals for timely resolution.
Goal 7.a	Resolve 100% of appeals within the timeframes specified by state and federal regulating agencies.
	Action Steps: 1. Managed Care, Compliance and Quality Management will prepare and present a report quarterly to the QIC on appeal issues, trends and resolutions.
Monitoring Method	Managed Care, Compliance and Quality Management appeal log
Reporting Frequency	Semi-Annually
Responsible Partners	• Managed Care, Compliance and Quality Management • QIC
Reference	• DHCS Annual Review Protocol (look up references) • DHCS Contract Exhibit A Attachment 1; 22. Quality Management Program, 23. QI Program • Title 9, Section 1810.440
Evaluation	All Appeals and Expedited Appeals are reviewed and investigated by the Compliance & Quality Improvement team Mental Health Clinician, with oversight provided by the Quality Improvement Coordinator. All appeals are reported at least quarterly to the Quality Improvement Committee. In FY 19/20 there were 2 appeals, one was upheld, and one was overturned. Both were completed within timeframes allotted, one of which utilized the 14-day extension. There were no appeals/expedited appeals in FY 20/21.

Safety and Effectiveness of Medical and Clinical Practices	
Goal 8	Ensure clinical practices are safe, effective and support wellness and recovery.
Objective 8.a.	All newly hired staff (Children's, Adult, and Medication Support Staff), in job specifications that require it, will receive the clinical practice and documentation training within 90 days of hire.
	Action Steps: 1. Programs will provide the clinical practice and documentation training and track who attends. 2. Programs will provide data on training attendance to Managed Care, Compliance and Quality Management. 3. Programs will provide refresher trainings as needed.
Evaluation	Designated Utilization Review/Quality Management team clinical staff provide EHR documentation training to all new direct care staff prior to being deployed to provide services. The documentation training is tailored to individual classification needs and is now available through the Target Solutions training delivery platform or in person. The use of the TargetSolutions platform also allows existing staff to easily access the training materials for follow up information as needed. Subject specific tip sheets are also available for staff for easy trouble shooting. Finally, program supervisors are provided with the trainings to utilize with new and continuing staff.
Objective 8.b	Review medication practices for safety and effectiveness.
	Action Steps: 1. Define the medication practices that will be evaluated for safety and effectiveness. 2. Develop data measures and collection methodologies to monitor medication practices. 3. Conduct audit of medication practices. 4. Evaluate data and report results to QIC. 5. MHP will take action if any safety or effectiveness issues are identified.
Monitoring Method.	1. Sign-in sheets for trainings. 2. EHR data on staff population who need training. 3. Medication practices monitoring tools. 4. Medication practices audit results.
Reporting Frequency	Documentation Training-Annually Medication Monitoring-Semi-Annually
Responsible Partners	• Outpatient Medication Support Services

	• Adult and Children's Service Branches • QI Committee • Managed Care, Compliance and Quality Management
Reference	• DHCS Annual Review Protocol (look up references) • DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. QI Program, 25. Practice Guidelines • Title 9, Section 1810.440
Evaluation	Due to staffing challenges which have been amplified by the COVID 19 pandemic, Med Monitoring is not currently taking place. However, the Utilization Review and Quality Management team is in the process of reviewing candidates to fill their Staff Nurse position, which will allow for Medication Monitoring to be picked back up in the coming months.

QI Committee Infrastructure and Activities	
Goal 9:	Strengthen the infrastructure and improve the practices and effectiveness of the QI Program.
Objective 9.a	The QIC will increase stakeholder involvement in the QI Committee activities, decisions and oversight.
	Action Steps: 1. QIC will create a plan for engaging in various activities to seek out and involve beneficiary and family members. This may include, but is not limited to, surveys, subgroups, reach out to organizations, hire consumer/family members. 2. Create action items with responsible parties and due dates. 3. Report back to QIC. 4. QIC will evaluate effectiveness.
Evaluation	In an effort to increase stakeholder involvement, the designated Quality Improvement Coordinator for the MHP has begun participating in various HHSA community committees to increase engagement with community members and stakeholders. While some community members and consumers have expressed interest and received invitations to the QIC meetings, they have yet to attend. These efforts will continue, with expansion to attending resource fairs and other community events as the community begins to open back up. The QIC recently discussed preparing flyers to be shared at these and other events, which we will be pursuing in the coming months.
Objective 9.b	The QIC will assure participation of direct care staff in QI activities, by having Program and Organizational Provider leads and Cultural Competency Coordinator report to the QI Committee what QI activities their staff/agencies are currently engaged in, and what programs and efforts are having a positive impact.
	Action Steps: 1. Program reports to QIC. 2. QIC will review for effectiveness.
Monitoring Method	1. QIC will evaluate on an ongoing basis the tools and methods for improving the effectiveness of the QI Program. 2. Sign-in sheets for meetings. 3. Program/Organizational Providers reports of QI activities.
Reporting Frequency	Identifying, tracking QI issues and assure participation of staff in QI activities- Quarterly Increase beneficiary and family member involvement- Semi-Annually Report of Cultural Competency Coordinator-Annually

Responsible Partners	• Children's Services • Adult Services • Medication Support Services • Organizational Providers • QI Committee • QI Program
Reference	• DHCS Annual Review Protocol (look up references) • DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. QI Program • Title 9, Section 1810.440
Evaluation	This objective is ongoing. The QI Committee maintains an agenda structure for its meeting to allow reporting of QI activities at the beginning of the meeting, to be captured in the minutes. Direct care staff participate regularly in ongoing quality improvement activities, both formally and informally. Both mental health programs discuss Quality Improvement activities with line staff through their various staff meetings, allowing for delivery and receipt of information pertaining to QI which program heads can then bring to and from the QIC. Direct care staff participate in the Cultural Competency Committee and take significant responsibility for developing and presenting the annual Cultural Competency Training provided to all staff. The QI Coordinator Co-Chairs the Cultural Competency Committee with the Ethnic Services Manager/Cultural Competency Coordinator. The QI coordinator is then able bring information and discussion involving Cultural Competency initiatives to and from the QIC.

Attachment 1: EQRO Timeliness Measures

***creating a baseline**
***(1):** (EQRO TIMELINESS MEASURE 1.3) Establish a baseline for percent of **all** clients with a first offered appointment (including assessment) within 10 business days from the initial request for services for FY 2019 -2020. FY 2019 - 2020 Quarter 1 96.0% 10 business days or less (289 of 301).
***(2):** (EQRO TIMELINESS MEASURE 1.3) Establish a baseline for percent of **adult** clients with a first offered appointment (including assessment) within 10 business days from the initial request for services for FY 2019 - 2020. FY 2019-2020 Quarter 1 100% 10 business days or less (159 of 159).
***(3):** (EQRO TIMELINESS MEASURE 1.3) Establish a baseline for percent of **youth** clients with a first offered appointment (including assessment) within 10 business days from the initial request for services for FY 2019 - 2020. FY 2019-2020 Quarter 1 91.5% 10 business days or less (130 of 142).
***(4):** (EQRO TIMELINESS MEASURE 1.3) Establish a baseline for percent of **Foster Care youth** clients with a first offered appointment (including assessment) within 10 business days from the initial request for services for FY 2019 - 2020**.** FY 2019 - 2020 Quarter 1 100% 10 business days or less (15 of 15).

Measure 1-4: Date from first request for services to first offered assessment appointment or service within 10 business days.
2019-2020 Baselines are All Clients, 97.2%; Adults, 99.8%; Youth, 94.6%; and Foster Youth, 98.6%. Recommend that Goals be set for all categories to maintain 95% or greater.
The population for this measure is those clients who had a CSI assessment with either a treatment start date or a closed-out date during the reporting period and an offered assessment appointment recorded in the CSI or an assessment service recorded in the Service Listing Report that occurred on or after the start date.
The measure start date is the date of first contact recorded on the CSI assessment, except:
1.) If the date of first contact is not recorded in the CSI, the CSI date is the start date.
2.) If the date of first contact is more than 7 days prior to the CSI date and the CSI date is less than or equal to the earliest of the first offered assessment date or assessment service, the CSI date is the start date.
The measure end date is the earlier of the first offered appointment date recorded on the CSI assessment, or the first assessment service recorded in the services listing report that is with the client (face to face, or telephonic) that is on or after the start date.

Initial Request to First Offered Appointment (Including Assessment) (1.3)	Quarter	Count of First Offered Appointments (Including Assessment)	Count of First Offered Appointments (Including Assessment) that were 10 Business Days or less from Initial Request	Percent of First Offered Appointments (Including Assessment) that were 10 Business Days or less from Initial Request (Section II, 1)	Average Number of Business Days from Initial Request to First Offered Appointment (Including Assessment)	Median Number of Business Days from Initial Request to First Offered Appointment (Including Assessment)	Standard Deviation of Number or Business Days from Initial Request to First Offered Appointment (Including Assessment)	Minimum Number of Business Days from Initial Request to First Offered Appointment (Including Assessment)	Maximum Number of Business Days from Initial Request to First Offered Appointment (Including Assessment)
All Clients	2019-2020	1,185	1152	97.2%	1.4	0	4.6	0	90
	2020-2021 Q1	251	247	98.4%	0.9	0	2.9	0	24
	2020-2021 Q2	253	242	95.7%	2.0	0	3.9	0	25
	2020-2021 Q3	289	280	96.9%	1.8	0	3.3	0	22
	2020-2021 Q4	283	280	98.9%	1.7	0	2.8	0	17
	2020-2021	1,065	1038	97.5%	1.6	0	3.3	0	25
Adults	2019-2020	588	587	99.8%	0.1	0	0.7	0	16
	2020-2021 Q1	128	128	100.0%	0.1	0	0.8	0	9
	2020-2021 Q2	104	104	100.0%	0.0	0	0.4	0	4
	2020-2021 Q3	108	108	100.0%	0.0	0	0.0	0	0
	2020-2021 Q4	124	124	100.0%	0.0	0	0.4	0	4
	2020-2021	458	458	100.0%	0.0	0	0.5	0	9
Youth	2019-2020	597	565	94.6%	2.7	0	6.2	0	90
	2020-2021 Q1	123	119	96.7%	1.7	0	3.9	0	24
	2020-2021 Q2	149	138	92.6%	3.3	2	4.6	0	25
	2020-2021 Q3	181	172	95.0%	2.9	2	3.8	0	22
	2020-2021 Q4	159	156	98.1%	3.1	2	3.1	0	17
	2020-2021	607	580	95.6%	2.8	2	3.9	0	25
Foster Youth	2019-2020	148	146	98.6%	0.9	0	2.1	0	11
	2020-2021 Q1	35	34	97.1%	0.9	0	3.0	0	17
	2020-2021 Q2	31	30	96.8%	1.2	0	3.6	0	19
	2020-2021 Q3	27	26	96.3%	0.9	0	2.5	0	12
	2020-2021 Q4	36	36	100.0%	1.6	0	2.3	0	9
	2020-2021	129	126	97.7%	1.2	0	2.9	0	19

Goals met for Measures 1-4

***(5):** (EQRO TIMELINESS MEASURE 1.4) Establish a baseline for percent of **all** clients with a first accepted appointment within 10 business days from the initial request for services for FY 2019 -2020. FY 2019 - 2020 Quarter 1 94.2% 10 business days or less (260 of 276).
***(6):** (EQRO TIMELINESS MEASURE 1.4) Establish a baseline for percent of **adult** clients with a first accepted appointment within 10 business days from the initial request for services for FY 2019 - 2020. FY 2019 - 2020 Quarter 1 99.3% 10 business days or less (150 of 151).
***(7):** (EQRO TIMELINESS MEASURE 1.4) Establish a baseline for percent of **youth** clients with a first accepted appointment within 10 business days from the initial request for services for FY 2019 -2020. FY 2019 - 2020 Quarter 1 88.0% 10 business days or less (110 of 125).
***(8):** (EQRO TIMELINESS MEASURE 1.4) Establish a baseline for percent of **Foster Care youth** clients with a first accepted appointment within 10 business days from the initial request for services for FY 2019 - 2020. FY 2019 -2020 Quarter 1 100% 10 business days or less (12 of 12).
Measure 5-8: Date from first request for services to first accepted assessment appointment or service within 10 business days. 2019-2020 Baselines are All Clients, 96.4%; Adults, 99.5%; Youth, 93.2%; and Foster Youth, 98.6%. Recommend that Goal be set that All Clients, Adult, and Foster Care Youth maintain 95% or greater, and that Youth improve by 10% to 93.9%. The population for this measure is those clients who had a CSI assessment with either a treatment start date or a closed-out date during the reporting period and an accepted assessment appointment recorded in the CSI or an assessment service recorded in the Service Listing Report that occurred on or after the start date. The measure start date is the date of first contact recorded on the CSI assessment, except: 1.) If the date of first contact is not recorded in the CSI, the CSI date is the start date. 2.) If the date of first contact is more than 7 days prior to the CSI date and the CSI date is less than or equal to the earliest of the first offered assessment date or assessment service, the CSI date is the start date. The measure end date is the earlier of the first accepted appointment date recorded on the CSI assessment, or the first assessment service recorded in the services listing report that is with the client (face to face, or telephonic) that is on or after the start date.

Initial Request to First Accepted Appointment (Including Assessment) (1.4)	Quarter	Count of Accepted Appointments (Including Assessment)	Count of Accepted Appointments (Including Assessment) that were 10 Business Days or less from Initial Request	Percent of Accepted Appointments (Including Assessment) that were 10 Business Days or less from Initial Request	Average Number of Business Days from Initial Request to Accepted Appointment Date (Including Assessment)	Median Number of Business Days from Initial Request to Accepted Appointment Date (Including Assessment)	Standard Deviation of Number or Business Days from Initial Request to Accepted Appointment Date (Including Assessment)	Minimum Number of Business Days from Initial Request to Accepted Appointment (Including Assessment) Date	Maximum Number of Business Days from Initial Request to Accepted Appointment Date (Including Assessment)
All Clients	2019-2020	1,126	1,086	96.4%	1.5	0	5.0	0	90
	2020-2021 Q1	240	235	97.9%	1.0	0	3	0	24
	2020-2021 Q2	241	230	95.4%	2.1	0	4	0	25
	2020-2021 Q3	278	267	96.0%	2.1	0	4	0	23
	2020-2021 Q4	278	268	96.4%	2.4	0	4	0	30
	2020-2021	1,026	989	96.4%	1.9	0	3.8	0	30
Adults	2019-2020	581	578	99.5%	0.1	0	1.2	0	19
	2020-2021 Q1	125	125	100.0%	0.1	0	0.8	0	9
	2020-2021 Q2	104	104	100.0%	0.0	0	0.4	0	4
	2020-2021 Q3	108	108	100.0%	0.0	0	0.1	0	1
	2020-2021 Q4	122	122	100.0%	0.0	0	0.4	0	4
	2020-2021	453	453	100.0%	0.0	0	0.5	0	9
Youth	2019-2020	545	508	93.2%	3.0	0	6.8	0	90
	2020-2021 Q1	115	110	95.7%	1.9	0	4.2	0	24
	2020-2021 Q2	137	126	92.0%	3.7	2	5.0	0	25
	2020-2021 Q3	170	159	93.5%	3.5	3	4.1	0	23
	2020-2021 Q4	156	146	93.6%	4.2	3	4.6	0	30
	2020-2021	573	536	93.5%	3.4	2	4.6	0	30
Foster Youth	2019-2020	147	145	98.6%	1.0	0	2.6	0	22
	2020-2021 Q1	35	34	97.1%	1.0	0	3.3	0	17
	2020-2021 Q2	31	30	96.8%	1.4	0	3.7	0	19
	2020-2021 Q3	27	25	92.6%	1.3	0	3.4	0	12
	2020-2021 Q4	36	34	94.4%	2.8	0	5.8	0	30
	2020-2021	129	123	95.3%	1.7	0	4.3	0	30

Goals met for Measures 5-8.

(9): (EQRO TIMELINESS MEASURE 1.5) Increase the percent of **all** clients with a kept assessment appointment within 10 business days from the initial request for services from 86.7% to 88.0%. FY 2019 - 2020 Quarter 1 95.9% 10 business days or less (282 of 294).
(10): (EQRO TIMELINESS MEASURE 1.5) Maintain the percent of **adult** clients with a kept assessment appointment within 10 business days from the initial request for services at 91.3% or higher. FY 2019 - 2020 Quarter 1 98.7% 10 business days or less (153 of 155).
(11): (EQRO TIMELINESS MEASURE 1.5) Increase the percent of **youth** clients with a kept assessment appointment within 10 business days from the initial request for services from 80.9% to 82.8%. FY 2019 - 2020 Quarter 1 92.8% 10 business days or less (129 of 139).
(12): (EQRO TIMELINESS MEASURE 1.5) Increase the percent of **Foster Care youth** clients with a kept assessment appointment within 10 business days from the initial request for services from 61.9% to 65.7%. FY 2019 - 2020 Quarter 1 100% 10 business days or less (13 of 13).

Measure 9-12: Date from first request for services to first kept assessment appointment or service within 10 business days.
2019-2020 Baselines are All Clients, 96.8%; Adults, 99.5%; Youth, 94.0%; and Foster Youth, 99.3%. Recommend that Goal be set that All Clients, Adult, and Foster Care Youth maintain 95% or greater, and that Youth improve by 10% to 94.6%.
The population for this measure is those clients who had a CSI assessment with either a treatment start date or a closed-out date during the reporting period and an kept assessment appointment recorded in the CSI or an assessment service recorded in the Service Listing Report that occurred on or after the start date.
The measure start date is the date of first contact recorded on the CSI assessment, except:
1.) If the date of first contact is not recorded in the CSI, the CSI date is the start date.
2.) If the date of first contact is more than 7 days prior to the CSI date and the CSI date is less than or equal to the earliest of the first offered assessment date or assessment service, the CSI date is the start date.
The measure end date is the earlier of the first kept appointment date recorded on the CSI assessment, or the first assessment service recorded in the services listing report that is with the client (face to face, or telephonic) that is on or after the start date and was kept by the client.

Initial Request to First Appointment Kept (Including Assessment) (1.5)	Quarter	Count of Appointments Kept (Not Assessment)	Count of Appointments Kept (Including Assessment) that were 10 Business Days or less from Initial Request	Percent of Appointments Kept (Including Assessment) that were 10 Business Days or less from Initial Request (Section II, 2)	Average Number of Business Days from Initial Request to Appointment Kept (Including Assessment)	Median Number of Business Days from Initial Request to Appointment Kept (Including Assessment)	Standard Deviation of Number or Business Days from Initial Request to Appointment Kept (Including Assessment)	Minimum Number of Business Days from Initial Request to Appointment Kept (Including Assessment)	Maximum Number of Business Days from Initial Request to Appointment Kept (Including Assessment)
All Clients	2019-2020	1,111	1,076	96.8%	1.3	0	4.5	0	90
	2020-2021 Q1	236	232	98.3%	0.8	0	2.9	0	24
	2020-2021 Q2	233	223	95.7%	1.7	0	3.8	0	24
	2020-2021 Q3	262	249	95.0%	1.9	0	3.7	0	23
	2020-2021 Q4	265	256	96.6%	2.1	0	3.7	0	22
	2020-2021	986	950	96.3%	1.6	0	3.6	0	24
Adults	2019-2020	576	573	99.5%	0.2	0	1.3	0	19
	2020-2021 Q1	125	125	100.0%	0.1	0	0.8	0	9
	2020-2021 Q2	104	104	100.0%	0.0	0	0.4	0	4
	2020-2021 Q3	108	108	100.0%	0.0	0	0.1	0	1
	2020-2021 Q4	122	122	100.0%	0.0	0	0.4	0	4
	2020-2021	453	453	100.0%	0.0	0	0.5	0	9
Youth	2019-2020	535	503	94.0%	2.6	0	6.1	0	90
	2020-2021 Q1	111	107	96.4%	1.6	0	4.1	0	24
	2020-2021 Q2	129	119	92.2%	3.0	0	4.7	0	24
	2020-2021 Q3	154	141	91.6%	3.3	2	4.3	0	23
	2020-2021 Q4	143	134	93.7%	3.9	3	4.3	0	22
	2020-2021	533	497	93.2%	3.0	1	4.5	0	24
Foster Youth	2019-2020	147	146	99.3%	0.8	0	2.4	0	22
	2020-2021 Q1	35	34	97.1%	0.8	0	3.1	0	17
	2020-2021 Q2	31	30	96.8%	1.0	0	3.6	0	19
	2020-2021 Q3	26	24	92.3%	1.0	0	3.1	0	12
	2020-2021 Q4	36	35	97.2%	2.0	0	3.6	0	17
	2020-2021	128	123	96.1%	1.3	0	3.4	0	19

Goals met for Measures 9, 10, and 12. Not met for Measure 11.

(13): (EQRO TIMELINESS MEASURE 1.6) Increase the percent of **all** clients who kept first clinical appointment (not including an assessment) within 10 business days from the initial request for services from 38.0% to 44.2%. FY 2019 - 2020 Quarter 1 65.5% 10 business days or less (74 of 113).
(14): (EQRO TIMELINESS MEASURE 1.6) Increase the percent of **adult** clients who kept first clinical appointment (not including an assessment) within 10 business days from the initial request for services from 57.1% to 61.4%. FY 2019 -2020 Quarter 1 74.1% 10 business days or less (40 of 54).
(15): (EQRO TIMELINESS MEASURE 1.6) Increase the percent of **youth** clients who kept first clinical appointment (not including an assessment) within 10 business days from the initial request for services from 21.8% to 29.6%. FY 2019 -2020 Quarter 1 57.6% 10 business days or less (34 of 59).
(16): (EQRO TIMELINESS MEASURE 1.6) Increase the percent of **Foster Care youth** clients who kept first clinical appointment (not including an assessment) within 10 business days from the initial request for services from 0% to 10%. FY 2019 -2020 Quarter 1 75.0% 10 business days or less (6 of 8).

Measure 13-16: Date from first request for services to first kept treatment appointment or service. Track average, median, standard deviation, and range in business days for first request for services to the first kept treatment appointment or service.
The population for this measure is those clients who had a CSI assessment with a treatment start date during the reporting period recorded in the CSI.
The measure start date is the date of first contact recorded on the CSI assessment, except:
1.) If the date of first contact is not recorded in the CSI, the CSI date is the start date.
2.) If the date of first contact is more than 7 days prior to the CSI date and the CSI date is less than or equal to the earliest of the first offered assessment date or assessment service, the CSI date is the start date.
The measure end date is the earlier of the treatment start date recorded on the CSI assessment, or the first treatment service recorded in the services listing report that is with the client (face to face, or telephonic) that is on or after the start date, was kept by the client, and is on or after the assessment end date.

Initial Request for SMHS to First Clinical Service Appointment (Not Assessment) (1.6)	Quarter	Count of First Clinical Service Appointments (Not Assessment)	Average Number of Business Days from Initial Request to First Clinical Service Appointments (Not Assessment)	Median Number of Business Days from Initial Request to First Clinical Service Appointments (Not Assessment)	Standard Deviation of Number of Business Days Initial Request to First Clinical Service Appointments (Not Assessment)	Minimum Number of Business Days from Initial Request to First Clinical Service Appointments (Not Assessment)	Maximum Number of Business Days from Initial Request to First Clinical Service Appointments (Not Assessment)
All Clients	2019-2020	548	17.1	14	16.1	0	110
	2020-2021 Q1	123	14.1	9	13.8	0	69
	2020-2021 Q2	146	15.5	12	13.0	0	62
	2020-2021 Q3	141	15.8	11	15.8	0	92
	2020-2021 Q4	150	17.0	14	14.1	0	70
	2020-2021	555	15.7	12	14.3	0	92
Adults	2019-2020	159	6.8	4	8.3	0	65
	2020-2021 Q1	51	6.5	6	6.1	0	33
	2020-2021 Q2	52	4.1	3.5	3.8	0	14
	2020-2021 Q3	49	4.9	4	4.6	0	22
	2020-2021 Q4	46	5.0	4	4.1	0	18
	2020-2021	196	5.1	4	4.9	0	33
Youth	2019-2020	389	21.4	18	16.6	0	110
	2020-2021 Q1	72	19.5	16	15.2	0	69
	2020-2021 Q2	94	21.8	18	11.9	1	62
	2020-2021 Q3	92	21.6	17	16.5	0	92
	2020-2021 Q4	104	22.2	19	13.7	0	70
	2020-2021	359	21.5	18	14.4	0	92
Foster Youth	2019-2020	122	27.9	23	21.6	0	110
	2020-2021 Q1	21	29.1	24	17.4	9	69
	2020-2021 Q2	27	25.7	27	9.3	8	39
	2020-2021 Q3	19	34.5	32	23.3	9	92
	2020-2021 Q4	28	27.6	28	13.7	3	61
	2020-2021	95	28.8	27	16.3	3	92

Goals met for Measures 13-16.

(17): (EQRO TIMELINESS MEASURE 1.7) Increase the percent of **all** clients with a second clinical service appointment within 10 business days of the first clinical service appointment from 70.6% to 73.5%. FY 2019 - 2020 Quarter 1 73.2% 10 business days or less (60 of 82).
(18): (EQRO TIMELINESS MEASURE 1.7) Increase the percent of **adult** clients with a second clinical service appointment within 10 business days of the first clinical service appointment from 59.7% to 63.8%. FY 2019 - 2020 Quarter 1 71.8% 10 business days or less (28 of 39).
(19): (EQRO TIMELINESS MEASURE 1.7) Increase the percent of **youth** clients with a second clinical service appointment within 10 business days of the first clinical service appointment from 77.4% to 79.7%. FY2019 - 2020 Quarter 1 74.4% 10 business days or less (32 of 43).
(20): (EQRO TIMELINESS MEASURE 1.7) Increase the percent of **Foster Care youth** clients with a second clinical service appointment within 10 business days of the first clinical service appointment from 80.0% to 82.0%. FY 2019 - 2020 Quarter 1 85.7% 10 business days or less (6 of 7).

Measure 17-20: Date from first appointment or service to second treatment appointment or service. Track average, median, standard deviation, and range in business days for first kept treatment appointment or service to the date of the second treatment service. The population for this measure is those clients who had a CSI assessment with a treatment start date during the reporting period recorded in the CSI. The measure start date is the earlier of the treatment start date recorded on the CSI assessment, or the first treatment service recorded in the services listing report that is with the client (face to face, or telephonic), was kept by the client, and was on or after the assessment end date. The measure end date is the date of the next treatment service recorded in the services listing report that is with the client (face to face, or telephonic), that is after the start date and was kept by the client.

First to Second Clinical Service Appointment (1.7)	Quarter	Count of Second Clinical Services	Average Number of Business Days from First Clinical Service to Second Clinical Service	Median Number of Business Days from First Clinical Service to Second Clinical Service	Standard Deviation of Number or Business Days from First Clinical Service to Second Clinical Service	Minimum Number of Business Days from First Clinical Service to Second Clinical Service	Maximum Number of Business Days from First Clinical Service to Second Clinical Service
All Clients	2019-2020	450	7.0	5	5.1	0	22
	2020-2021 Q1	95	6.9	5	5.0	0	20
	2020-2021 Q2	117	6.7	5	5.0	0	20
	2020-2021 Q3	107	6.8	5	5.1	1	22
	2020-2021 Q4	70	5.6	4	5.0	1	20
	2020-2021	386	6.5	5	5.0	0	22
Adults	2019-2020	105	6.9	5	5.6	0	21
	2020-2021 Q1	37	8.9	9	5.4	0	19
	2020-2021 Q2	38	5.8	4	5.2	1	20
	2020-2021 Q3	30	8.1	6.5	6.2	1	22
	2020-2021 Q4	29	6.3	4	5.3	1	20
	2020-2021	132	7.2	6	5.6	0	22
Youth	2019-2020	345	7.0	5	4.9	0	22
	2020-2021 Q1	58	5.5	5	4.1	1	20
	2020-2021 Q2	79	7.1	5	4.9	0	19
	2020-2021 Q3	77	6.3	5	4.6	1	20
	2020-2021 Q4	41	5.1	4	4.6	1	20
	2020-2021	254	6.2	5	4.6	0	20
Foster Youth	2019-2020	105	6.5	5	4.4	1	19
	2020-2021 Q1	15	6.0	5	4.5	1	16
	2020-2021 Q2	26	6.9	5.5	4.5	1	17
	2020-2021 Q3	18	7.1	5.5	4.6	2	18
	2020-2021 Q4	14	2.9	1.5	2.3	1	8
	2020-2021	73	6.0	5	4.5	1	18

Goals met for Measures 17-20.

(21): (EQRO TIMELINESS MEASURE 1.8) Increase the percent of **all** clients with a first offered psychiatric appointment within 15 days of first request for services from 67.6% to 70.9%. FY 2019 - 2020 Quarter 1 74.6% 15 business days or less (50 of 67).
(22): (EQRO TIMELINESS MEASURE 1.8) Increase the percent of **adult** clients with a first offered psychiatric appointment within 15 days of first request for services from 69.6% to 72.6%. FY 2019 - 2020 Quarter 1 81.5% 15 business days or less (44 of 54).
(23): (EQRO TIMELINESS MEASURE 1.8) Increase the percent of **youth** clients with a first offered psychiatric appointment within 15 days of first request for services from 57.8% to 62.0%. FY 2019 - 2020 Quarter 1 46.2% 15 business days or less (6 of 13).
(24): (EQRO TIMELINESS MEASURE 1.8) Increase the percent of **Foster Care youth** clients with a first offered psychiatric appointment within 15 days of first request for services from 0% to 10%. FY 2019 - 2020 Quarter 1 100% 15 business days or less (2 of 2).

Measure 21-24: Date from first request for services to first offered prescriber appointment or service with a prescriber within 15 business days. 2019-2020 Baselines are All Clients, 73.7%; Adults, 85.5%; Youth, 44.3%; and Foster Youth, 60.0%. Recommend that Goals be set for 10% improvement for all categories (76.3%, 86.9%, 49.9%, and 64.0% respectively). The population for this measure is those clients who had a CSI assessment with a treatment start date or a closed-out date during the reporting period, and a scheduler appointment with a prescriber recorded in the scheduled services report or a service with a prescriber recorded in the services listing report. The measure start date is the date of first contact recorded on the CSI assessment, except: 1.) If the date of first contact is not recorded in the CSI, the CSI date is the start date. 2.) If the date of first contact is more than 7 days prior to the CSI date and the CSI date is less than or equal to the earliest of the first offered assessment date or assessment service, the CSI date is the start date. The measure end date is the earlier of the scheduler appointment with a prescriber recorded in the scheduled services report or a service with a prescriber recorded in the services listing report that is with the client (face to face, or telephonic) that is after the start date.

Initial Request to First Offered Psychiatric Appointment (1.8)	Quarter	Count of First Offered Psychiatric Appointments	Count of First Offered Psychiatric Appointments that were 15 Business Days or less from Initial Request	Percent of First Offered Psychiatric Appointments that were 15 Business Days or less from Initial Request (Section II, 3)	Average Number of Business Days from Initial Request to First Offered Psychiatric Appointment	Median Number of Business Days from Initial Request to First Offered Psychiatric Appointment	Standard Deviation of Number or Business Days from Initial Request to First Offered Psychiatric Appointment	Minimum Number of Business Days from Initial Request to First Offered Psychiatric Appointment	Maximum Number of Business Days from Initial Request to First Offered Psychiatric Appointment
All Clients	2019-2020	308	227	73.7%	11.7	8.5	12.0	0	73
	2020-2021 Q1	84	58	69.0%	15.3	12	13.1	0	66
	2020-2021 Q2	76	55	72.4%	12.8	7	13.1	0	56
	2020-2021 Q3	78	36	46.2%	17.4	17.5	11.2	0	52
	2020-2021 Q4	82	64	78.0%	10.9	8	10.9	0	71
	2020-2021	316	211	66.8%	14.1	10.5	12.4	0	71
Adults	2019-2020	220	188	85.5%	8.5	7	8.6	0	43
	2020-2021 Q1	67	46	68.7%	15.2	13	13.5	0	66
	2020-2021 Q2	64	47	73.4%	12.3	7	13.2	0	56
	2020-2021 Q3	57	27	47.4%	16.6	17	10.7	0	45
	2020-2021 Q4	61	54	88.5%	8.0	6	6.5	0	28
	2020-2021	246	172	69.9%	13.0	9	11.9	0	66
Youth	2019-2020	88	39	44.3%	19.8	17	15.0	0	73
	2020-2021 Q1	17	12	70.6%	15.8	10	11.2	5	43
	2020-2021 Q2	12	8	66.7%	16.0	11	12.3	3	45
	2020-2021 Q3	21	9	42.9%	19.7	18	12.2	1	52
	2020-2021 Q4	21	10	47.6%	19.1	16	15.9	0	71
	2020-2021	70	39	55.7%	17.8	13.5	13.4	0	71
Foster Youth	2019-2020	10	6	60.0%	24.2	14.5	23.5	0	73
	2020-2021 Q1	2	2	100.0%	10.5	10.5	0.5	10	11
	2020-2021 Q2	1	1	100.0%	8.0	8	0.0	8	8
	2020-2021 Q3	0	0	N/A	N/A	N/A	N/A	N/A	N/A
	2020-2021 Q4	3	1	33.3%	43.0	53	27.9	5	71
	2020-2021	6	4	66.7%	26.3	10.5	25.8	5	71

Goals met for Measures 23 and 24. Did not meet 21 and 22.

(25): (EQRO TIMELINESS MEASURE 1.9) Maintain the percent of **all** clients with a first offered psychiatric appointment within 15 days of first determination of need at 93.5% or higher. FY 2019 - 2020 Quarter 1 92.9% 15 business days or less (52 of 56).
(26): (EQRO TIMELINESS MEASURE 1.9) Maintain the percent of **Adult** clients with a first offered psychiatric appointment within 15 days of first determination of need at 96.4% or higher. FY 2019 - 2020 Quarter 1 100% 15 business days or less (44 of 44).
(27): (EQRO TIMELINESS MEASURE 1.9) Increase the percent of **youth** clients with a first offered psychiatric appointment within 15 days of first determination of need from 76.3% to 78.7%. FY 2019 - 2020 Quarter 1 66.7% 15 business days or less (8 of 12).
(28): (EQRO TIMELINESS MEASURE 1.9) Increase the percent of **Foster Care youth** clients with a first offered psychiatric appointment within 15 days of first determination of need from 0% to 10%. FY 2019 -2020 Quarter 1 100% 15 business days or less (2 of 2).

Measure 25-28: Date from appointment entered date to first offered prescriber appointment or service with a prescriber. Track average, median, standard deviation, and range in business days for first kept treatment appointment or service to the date of the second treatment service.

The population for this measure is those clients who had a CSI assessment with a treatment start date or a closed-out date during the reporting period and an appointment with a prescriber that was recorded in the scheduled services report or a service with a prescriber that was recorded in the services listing report.

The measure start date is the prescriber appointment entered date in the scheduled services report. If there is no prescriber appointment recorded in scheduler, the case will be excluded.

The measure end date is the earlier of the prescriber appointment scheduled date recorded in the scheduled services report or date of the service with a prescriber recorded in the services listing report that is with the client (face to face, or telephonic) and is after the start date.

First Determination of Need to First Offered Psychiatric Appointment (Scheduler Appointment Entered Date) (1.9)	Quarter	Count of First Offered Psychiatric Appointments	Average Number of Business Days from First Determination of Need (Scheduler Appointment Entered Date) to First Offered Psychiatric Appointment	Median Number of Business Days from First Determination of Need (Scheduler Appointment Entered Date) to First Offered Psychiatric Appointment	Standard Deviation of Number or Business Days from First Determination of Need (Scheduler Appointment Entered Date) to First Offered Psychiatric Appointment	Minimum Number of Business Days from First Determination of Need (Scheduler Appointment Entered Date) to First Offered Psychiatric Appointment	Maximum Number of Business Days from First Determination of Need (Scheduler Appointment Entered Date) to First Offered Psychiatric Appointment
All Clients	2019-2020	292	5.8	4	7.5	0	42
	2020-2021 Q1	79	9.2	7	8.1	0	36
	2020-2021 Q2	74	7.8	5	10.2	0	43
	2020-2021 Q3	77	10.8	11	7.7	0	27
	2020-2021 Q4	81	7.6	7	7.1	0	42
	2020-2021	307	8.9	7	8.4	0	43
Adults	2019-2020	208	4.0	3	3.8	0	25
	2020-2021 Q1	62	10.1	8	8.8	0	36
	2020-2021 Q2	63	8.3	4	10.9	0	43
	2020-2021 Q3	57	11.2	10	8.0	0	27
	2020-2021 Q4	60	6.1	6	4.6	0	21
	2020-2021	239	9.0	7	8.7	0	43
Youth	2019-2020	84	10.4	6	11.4	0	42
	2020-2021 Q1	17	5.9	6	2.6	0	9
	2020-2021 Q2	11	5.3	6	2.4	0	9
	2020-2021 Q3	20	9.5	11	6.6	0	19
	2020-2021 Q4	21	11.7	13	10.5	0	42
	2020-2021	68	8.5	7	7.4	0	42
Foster Youth	2019-2020	10	14.4	8.5	15.1	0	39
	2020-2021 Q1	2	5.0	5	3.0	2	8
	2020-2021 Q2	1	7.0	7	0.0	7	7
	2020-2021 Q3	0	N/A	N/A	N/A	N/A	N/A
	2020-2021 Q4	3	22.0	24	17.2	0	42
	2020-2021	6	13.8	7.5	14.8	0	42

Goals met for Measures 25-28.

(29): (EQRO TIMELINESS MEASURE 1.10) Maintain the percent of **all** clients with a kept psychiatric appointment within 15 days of first determination of need at 91.3% or higher. FY 2019 - 2020 Quarter 1 90.6% 15 business days or less (48 of 53).
(30): (EQRO TIMELINESS MEASURE 1.10) Maintain the percent of **adult** clients with a kept psychiatric appointment within 15 days of first determination of need at 93.4% or higher. FY 2019 -2020 Quarter 1 100% 15 business days or less (41 of 41).
(31): (EQRO TIMELINESS MEASURE 1.10) Increase the percent of **youth** clients with a kept psychiatric appointment within 15 days of first determination of need from 77.4% to 79.7%. FY 2019 - 2020 Quarter 1 58.3% 15 business days or less (7 of 12).
(32): (EQRO TIMELINESS MEASURE 1.10) Increase the percent of **Foster Care youth** clients with a kept psychiatric appointment within 15 days of first determination of need from 0% to 10%. FY 2019 - 2020 Quarter 1 100% 15 business days or less (2 of 2).

Measure 29-32: Date from appointment entered date to first kept prescriber appointment or service with a prescriber. Track average, median, standard deviation, and range in business days for first kept treatment appointment or service to the date of the second treatment service.

The population for this measure is those clients who had a CSI assessment with a treatment start date or a closed-out date during the reporting period and a kept appointment with a prescriber that was recorded in the scheduled services report or a service with a prescriber that was recorded in the services listing report that was kept by the client.
The measure start date is the prescriber appointment entered date in the scheduled services report. If there is no prescriber appointment recorded in scheduler, the case will be excluded.
The measure end date is the earlier of the prescriber appointment scheduled date recorded in the scheduled services report or date of the service with a prescriber recorded in the services listing report that is with the client (face to face, or telephonic) and is after the start date.
The measure end date is the earlier of the prescriber appointment scheduled date recorded in the scheduled services report or date of the service with a prescriber recorded in the services listing report that is with the client (face to face, or telephonic) and is after the start date.

(33): All clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days (Standard is 48 hours for non-authorization; 96 hours for authorization). Current FY 2018 - 2019 baseline for urgent care data base is 99.5% (1,320 of 1,327) of Emergency Department (ED) visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 100% (5,500 of 5,500) of crisis assignments in Cerner received at least one service within 2 days FY 2019 - 2020 Quarter 1 Urgent Care 99.1% two business days or less (323 of 326)/crisis assignments 100% (1,442 of 1,442).
(34): All **adult** clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days. (Standard is 48 hours for non-authorization; 96 hours for authorization) Current FY 2018 - 2019 baseline for urgent care data base is 99.4% (1,092 of 1,099) of ED visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 100% (4,554 of 4,554) of crisis assignments in Cerner received at least one service within 2 days FY 2019 - 2020 Quarter 1 Urgent Care 98.9% two business days or less (266 of 269)/crisis assignments 100% (1,245 of 1,245).
(35): All **youth** clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two2 days (Standard is 48 hours for non-authorization; 96 hours for authorization). Current FY 2018 - 2019 baseline for urgent care data base is 100% (228 of 228) of ED visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 100% (946 of 946) of crisis assignments in Cerner received at least one service within 2 days FY 2019 - 2020 Quarter 1 Urgent Care 100% two business days or less (57 of 57)/crisis assignments 100% (197 of 197).
(36): All **Foster Care youth** clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days (Standard is 48 hours for non-authorization; 96 hours for authorization). Current FY 2018 - 2019 baseline for urgent care data base is 100% (11 of 11) of ED visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 100% (54 of 54) of crisis assignments in Cerner received at least one service within 2 days FY 2019 - 2020 Quarter 1 Urgent Care N/A% two business days or less (0 of 0)/crisis assignments 100% (3 of 3).

Measure 33-36a: From eval capable date/time to face to face evaluation start date/time. All, Adult, Youth, and Foster Care Youth clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days. (Standard is 48 hours for non-authorization; 96 hours for authorization). Current FY 2018 - 2019 baseline for urgent care data base is 99.5% (1,320 of 1,327), 100% (228 of 228), 99.4% (1,092 of 1,099), and 100% (11 of 11) respectively of ED visits that are not referred to an inpatient psychiatric facility and are evaluated within 48 hours.
The population for this measure is all clients in the Urgent Care Database who were not admitted to an Inpatient Psychiatric Facility or CCRC.

The measure start date is the Eval Capable Date/Time, if provided, or the Medical Clearance Date/Time. If the Eval Capable Date/Time and the Medical Clearance Date/Time were not recorded the start point used was the ER arrival Date/Time.
The measure end date is the Face to Face Evaluation Start Date/Time.
Cases excluded: those that do not have an evaluation start date recorded in the UC database; and those that were POAs or listed as AAA/AWOL/AMA.

Service Request for Urgent Appointment to Actual Encounter (Urgent ED Visit) (2.3)	Quarter	Count of Urgent Encounters	Average Hours from Service Request for Urgent Appointment to Actual Encounter	Median Hours from Service Request for Urgent Appointment to Actual Encounter	90th Percentile Hours from Service Request for Urgent Appointment to Actual Encounter	Count of Urgent Encounters in 48 Hours or Less of First Request	Percent of Urgent Encounters in 48 Hours or Less of First Request (Section II, 4a)
All Clients	FY19/20	1,199	0.5	0.4	0.8	1,195	99.7%
	20/21-Q1	302	0.4	0.3	0.8	301	99.7%
	20/21-Q2	276	0.4	0.3	0.7	276	100.0%
	20/21-Q3	310	0.4	0.4	0.8	309	99.7%
	20/21-Q4	277	0.4	0.4	0.8	275	99.3%
	FY20/21	1,165	0.4	0.4	0.8	1,161	99.7%
Adults	FY19/20	936	0.5	0.4	0.8	933	99.7%
	20/21-Q1	250	0.4	0.4	0.8	249	99.6%
	20/21-Q2	211	0.4	0.3	0.7	211	100.0%
	20/21-Q3	248	0.4	0.4	0.8	247	99.6%
	20/21-Q4	199	0.4	0.4	0.8	197	99.0%
	FY20/21	908	0.4	0.4	0.8	904	99.6%
Youth	FY19/20	263	0.4	0.3	0.7	262	99.6%
	20/21-Q1	52	0.4	0.3	0.6	52	100.0%
	20/21-Q2	65	0.3	0.3	0.6	65	100.0%
	20/21-Q3	62	0.4	0.4	0.9	62	100.0%
	20/21-Q4	78	0.4	0.4	0.7	78	100.0%
	FY20/21	257	0.4	0.4	0.7	257	100.0%
Foster Youth	FY19/20	11	0.3	0.4	0.6	11	100.0%
	20/21-Q1	3	0.3	0.2	0.5	3	100.0%
	20/21-Q2	3	0.4	0.5	0.5	3	100.0%
	20/21-Q3	5	0.5	0.4	0.8	5	100.0%
	20/21-Q4	4	0.3	0.3	0.5	4	100.0%
	FY20/21	15	0.4	0.4	0.7	15	100.0%

Measure 33-36b: Date from assignment start date to first appointment or service with a practitioner. All, Adult, Youth, and Foster Care Youth clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days. (Standard is 48 hours for non-authorization; 96 hours for authorization). Current FY 2018 - 2019 baseline for crisis assignments in Cerner received at least one service within 2 days are 100% (1,442 of 1,442), 100% (1,245 of 1,245), 100% (946 of 946), and 100% (54 of 54) respectively.
The population for this measure is all clients with a Crisis Assignment recorded in Cerner during the reporting period. The start point for the measure is the Open Date of the Crisis Assignment and the end point is the date of the first service within the Assignment recorded in Cerner. The measure is in days.

Service Request for Urgent Appointment to Actual Encounter (Crisis Assignments) (2.3)	Quarter	Count of Urgent Encounters	Average Hours from Service Request for Urgent Appointment to Actual Encounter	Median Hours from Service Request for Urgent Appointment to Actual Encounter	Count of Urgent Encounters in 48 Hours or Less of First Request	Percent of Urgent Encounters in 48 Hours or Less of First Request (Section II, 4b)
All Clients	**FY19/20**	**8,143**	**0.000**	**0**	**8,133**	**99.9%**
	20/21-Q1	2,348	0.000	0	2,348	100.0%
	20/21-Q2	1,994	0.000	0	1,994	100.0%
	20/21-Q3	2,234	0.000	0	2,234	100.0%
	20/21-Q4	2,315	0.000	0	2,315	100.0%
	FY20/21	**8,891**	**0.000**	**0**	**8,891**	**100.0%**
Adults	**FY19/20**	**6,928**	**0.000**	**0**	**6,918**	**99.9%**
	20/21-Q1	2,059	0.000	0	2,059	100.0%
	20/21-Q2	1,686	0.000	0	1,686	100.0%
	20/21-Q3	1,872	0.000	0	1,872	100.0%
	20/21-Q4	1,887	0.000	0	1,887	100.0%
	FY20/21	**7,504**	**0.000**	**0**	**7,504**	**100.0%**
Youth	**FY19/20**	**1,215**	**0.000**	**0**	**1,215**	**100.0%**
	20/21-Q1	289	0.000	0	289	100.0%
	20/21-Q2	308	0.000	0	308	100.0%
	20/21-Q3	362	0.000	0	362	100.0%
	20/21-Q4	428	0.000	0	428	100.0%
	FY20/21	**1,387**	**0.000**	**0**	**1,387**	**100.0%**
Foster Youth	**FY19/20**	**66**	**0.000**	**0**	**66**	**100.0%**
	20/21-Q1	29	0.000	0	29	100.0%
	20/21-Q2	20	0.000	0	20	100.0%
	20/21-Q3	41	0.000	0	41	100.0%
	20/21-Q4	43	0.000	0	43	100.0%
	FY20/21	**133**	**0.000**	**0**	**133**	**100.0%**

Goals met for Measures 33-36.