FY 2021-22 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)

Quality Improvement Committee (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 QIC 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 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*	*1,969*		*26*	*2,026*		*22*	*2,126*		*26*	*2,197*		***69***	2,080	
Other	*23*			*22*			*17*			*12*			***25***		
Out of County/Unknown	88	1,698	N/A	71	1,562	N/A	75	1,409		93	1,299		**239**	1,492	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%**

Residential Areas	Fiscal Year 2021-2022													Avg Monthly Population FY2021-2022	Penetration Rate
	Q1	Pop	Pen Rate	Q2	Pop	Pen Rate	Q3	Pop	Pen Rate	Q4	Pop	Pen Rate	Undup Total		
Redding	1,230	34,650	3.5%	1,178	35,443	3.3%	1,224	36,249	3.4%	1,267	37,232	3.4%	**2,418**	35,894	6.7%
Shasta County (non-Redding)	548	23,623	2.3%	506	24,055	2.1%	548	24,587	2.2%	534	25,220	2.1%	**1,066**	24,371	4.4%
Non-Residential (Shasta Co.)	205	N/A	N/A	182	N/A	N/A	187	N/A	N/A	191	N/A	N/A	**482**	N/A	N/A
Homeless	*166*			*146*			*158*			*161*			***407***		
PO Box	*21*	*2,162*		*18*	*2,195*		*14*	*2,232*		*19*	*2,300*		***53***	2,222	
Other	*18*			*19*			*15*			*11*			***23***		
Out of County/Unknown	81	2,018	N/A	81	1,871	N/A	77	1,767	N/A	89	1,706	N/A	**237**	1,841	N/A
Grand Total (undup.)	**2,027**	**62,454**	**3.2%**	**1,902**	**63,564**	**3.0%**	**2,007**	**64,836**	**3.1%**	**2,028**	**66,458**	**3.1%**	**4,011**	**64,328**	**6.2%**

Evaluation: No specific baseline or target was 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 2020-2021						FY2020-2021 Monthly Avg. Population	Penetration Rate**	Fiscal Year 2020-2021						FY2020-2021 Monthly Avg. Population	Penetration Rate**
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Undup. Total*	Percent			Qtr 1	Qtr 2	Qtr 3	Qtr 4	Undup. Total*	Percent		
ANDERSON - 96007	226	243	272	242	494	46.0%	9,294	5.3%	261	235	251	250	479	44.7%	9,927	4.8%
SHASTA LAKE CITY - 96019	122	115	109	117	217	20.2%	3,891	5.6%	114	113	127	113	215	20.1%	4,242	5.1%
COTTONWOOD - 96022	90	67	70	57	139	13.0%	2,508	5.5%	65	70	60	70	138	12.9%	2,720	5.1%
North East	18	21	24	33	85	7.9%	3,669	2.3%	35	20	32	27	88	8.2%	3,947	2.2%
East	47	37	52	35	92	8.6%	2,264	4.1%	42	34	47	50	102	9.5%	2,450	4.2%
West	11	13	12	11	26	2.4%	635	4.1%	15	14	12	9	28	2.6%	660	4.2%
North	8	7	8	11	20	1.9%	416	4.8%	9	14	9	11	21	2.0%	426	4.9%

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 2020-21 and FY2021-22 were similar to FY 2019-20.

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
FY20- 21 Q 1	902	35	4,380	853	316	260	190	1,895	516	115	1,958	592	759	96	34	**12,901**
FY20- 21 Q 2	800	32	4,024	609	271	230	45	1,705	431	75	2,335	508	528	16	31	**11,640**
FY20- 21 Q 3	838	22	4,342	632	327	291	44	1,999	504	168	2,442	549	767	23	66	**13,014**
FY20- 21 Q 4	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**
FY21- 22 Q 1	758	31	4,114	622	352	167	63	1,434	460	122	2,293	459	798	22	18	**11,713**
FY21- 22 Q 2	746	25	3,762	683	344	188	24	1,575	401	111	2,072	497	780	67	10	**11,285**
FY21- 22 Q 3	696	24	3,683	803	282	175	34	1,711	396	124	2,211	448	848	78	11	**11,524**
FY21- 22 Q 4	790	26	4,223	492	310	81	18	1,250	321	100	2,022	342	704	8	7	**10,694**
FY21- 22 Total	**2,990**	**106**	**15,782**	**2,600**	**1,288**	**611**	**139**	**5,970**	**1,578**	**457**	**8,598**	**1,746**	**3,130**	**175**	**46**	**45,216**

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
FY20- 21 Q 1	326	12	2,044	406	175	156	13	842	38	26	1,055	254	224	59	10	**5,640**
FY20- 21 Q 2	284	14	1,888	313	150	164	22	838	71	27	1,132	238	180	30	16	**5,367**
FY20- 21 Q 3	336	12	1,765	323	116	181	12	961	146	35	1,037	235	274	99	5	**5,537**
FY20- 21 Q 4	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**
FY21- 22 Q 1	279	9	1,650	314	133	139	20	650	125	27	1,077	207	333	-		**4,963**
FY21- 22 Q 2	279	9	1,504	307	138	123	2	756	96	30	1,005	211	369	26		**4,855**
FY21- 22 Q 3	329	11	1,874	342	170	110	4	824	128	33	1,063	244	417	18		**5,567**
FY21- 22 Q 4	258	12	1,836	226	139	71	2	537	114	27	1,104	161	308	-		**4,795**
FY21- 22 Total	**1,145**	**41**	**6,864**	**1,189**	**580**	**443**	**28**	**2,767**	**463**	**117**	**4,249**	**823**	**1,427**	**44**	**-**	**20,180**

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

ANDERSON	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY20-21 Q 1	150	4	888	193	68	67	13	381	19		407	137	96	2		**2,425**
FY20-21 Q 2	132	6	865	205	63	76	22	400	42	1	533	118	83	22	5	**2,573**
FY20-21 Q 3	165	3	829	185	56	87	7	449	96	3	536	105	120	29		**2,670**
FY20-21 Q 4	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**
FY21-22 Q 1	144	4	733	182	54	73	10	310	63		503	106	124			**2,306**
FY21-22 Q 2	123	5	657	186	71	90	2	372	51	3	438	103	183			**2,284**
FY21-22 Q 3	125	3	784	178	74	67	4	408	63	9	519	111	199			**2,544**
FY21-22 Q 4	114	4	816	133	63	50	2	277	62	16	510	76	182			**2,305**
FY21-22 Total	**506**	**16**	**2,990**	**679**	**262**	**280**	**18**	**1,367**	**239**	**28**	**1,970**	**396**	**688**	**-**	**-**	**9,439**

SHASTA LAKE CITY	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY20-21 Q 1	77	3	596	85	40	49		203	14	17	332	41	74	31	3	**1,565**
FY20-21 Q 2	76	5	471	33	27	40		212	12	17	240	48	51	4	3	**1,239**
FY20-21 Q 3	67	4	435	38	20	58	1	236	9	10	228	45	71	17	5	**1,244**
FY20-21 Q 4	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**
FY21-22 Q 1	57	1	381	55	15	31	8	195	11	21	231	39	94			**1,139**
FY21-22 Q 2	56	2	381	49	26	16		194	16	16	262	41	116			**1,175**
FY21-22 Q 3	82	2	467	57	41	13		210	41	9	238	52	137			**1,349**
FY21-22 Q 4	70	3	543	54	29	17		127	31	8	292	45	81			**1,300**
FY21-22 Total	**265**	**8**	**1,772**	**215**	**111**	**77**	**8**	**726**	**99**	**54**	**1,023**	**177**	**428**	**-**	**-**	**4,963**

COTTONWOOD	Assess.	Bed Day	Case Man.	Coll.	Crisis	Family	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY20-21 Q 1	52	2	264	57	26	12		127		9	194	48	16	1		**808**
FY20-21 Q 2	34		177	38	14	17		125	5	9	131	53	9		1	**613**
FY20-21 Q 3	39	1	186	54	8	11		143	8	22	108	39	31	13		**663**
FY20-21 Q 4	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**
FY21-22 Q 1	30	2	193	40	21	16		82	28		95	32	53			**592**
FY21-22 Q 2	41	2	231	38	21	7		96	12		128	45	33			**654**
FY21-22 Q 3	46	1	208	51	16	16		88	10		118	32	30			**616**
FY21-22 Q 4	32	4	163	18	11	2		33	8		104	16	14			**405**
FY21-22 Total	**149**	**9**	**795**	**147**	**69**	**41**	**-**	**299**	**58**	**-**	**445**	**125**	**130**	**-**	**-**	**2,267**

Evaluation: No specific baseline or target was set. The ratio of the number of visits for the three cities for FY 2020-21 and FY2021-22 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 CY2020 and CY2021.

	2021 EQRO				
	Average Number of Eligibles per month	Number of Beneficiaries Served per Year	Penetration Rate	Small Counties	California
Total	68,885	2,541	3.69%	3.33%	3.31%
0-5	7,562	93	1.23%	1.03%	1.59%
6-17	15,567	933	5.99%	5.00%	5.20%
18-20	3,105	128	4.12%	4.29%	4.02%
21+	36,486	1,288	3.53%	4.15%	4.07%
65+	6,167	99	1.61%	2.09%	1.77%
White	46,193	1,818	3.94%	N/A	5.32%
Hispanic	7,447	215	2.89%	3.39%	3.29%
Ratio of Hispanic versus White PR			**1.68**	**#VALUE!**	**0.62**
Black	1,120	70	6.25%	N/A	6.83%
Asian or Pacific Islander *	2,649	63	2.38%	1.48%	1.90%
Alaskan Native or American Indian	1,861	54	2.90%	N/A	5.58%
Other **	9,616	321	3.34%	N/A	3.72%
Foster Care	N/A	N/A	42.10%	33.11%	43.54%

	2021 EQRO		
	Average Number of Eligibles per month	Number of Beneficiaries Served per Year	Penetration Rate
0-17	23,129	1,026	4.44%
18-64	39,591	1,416	3.58%
65+	6,167	99	1.61%
total	68,887	2,541	3.69%
White	46,193	1,818	3.94%
Hispanic	7,447	215	2.89%
Ratio of Hispanic versus White PR			**1.68**
Black	1,120	70	6.25%
Asian or Pacific Islander *	2,649	63	2.38%
Alaskan Native or American Indian	1,861	54	2.90%
Other **	9,616	321	3.34%
Foster Care	N/A	N/A	42.10%

EQRO age groups that were provided by the state changed this year and do not match MMEF data that are in the table below which is based on historical age groups. Also, not all small county penetration rates for all races were included and no

* 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 identified goals in 34 of the 36 tracked data points (94.4%).
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	Increase percentage of **Adult** beneficiaries who receive a face-to-face follow-up mental health practitioner appointment within 7 days of discharge from a psychiatric inpatient facility from 53.0% to 58.3% (a 10% increase over the FY18-19 baseline). Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health. Day of discharge follow-up services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.

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

Discharge Fiscal Year/Quarter*	Admit Count ǂ	Discharge Count ǂ	7 Day Follow up	7 Day Percent	Average Days	Median Days	30 Day Follow Up	30 Day Percent
FY21-22 Quarter 1	29	32	21	65.6%	5.3	6.0	30	93.8%
FY21-22 Quarter 2	33	32	20	62.5%	4.2	6.5	31	96.9%
FY21-22 Quarter 3	21	20	11	55.0%	7.4	7.0	20	100.0%
FY21-22 Quarter 4	30	30	17	56.7%	6.5	7.0	27	90.0%
Totals :	**113**	**114**	**69**	**60.5%**	**5.9**	**6.6**	**108**	**94.7%**

Objective 3.b	Increase percentage of **Youth** beneficiaries who receive a face-to-face follow-up mental health practitioner appointment within 7 days of discharge from a psychiatric inpatient facility from 70.8% to 77.9% (a 10% increase over the FY18-19 baseline). Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health. Day of discharge follow-up services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.

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

Discharge Fiscal Year/Quarter*	Admit Count ǂ	Discharge Count ǂ	7 Day Follow up	7 Day Percent	Average Days	Median Days	30 Day Follow Up	30 Day Percent
FY21-22 Quarter 1	15	17	13	76.5%	2.8	3.0	17	100.0%
FY21-22 Quarter 2	11	11	10	90.9%	3.4	5.0	11	100.0%
FY21-22 Quarter 3	9	8	7	87.5%	3.1	2.0	8	100.0%
FY21-22 Quarter 4	16	16	10	62.5%	3.2	4.0	15	93.8%
Totals :	**51**	**52**	**40**	**76.9%**	**3.1**	**3.5**	**51**	**98.1%**

Objective 3.c	Increase percentage of **Foster Care youth** beneficiaries who receive a face-to-face follow-up mental health practitioner appointment within 7 days of discharge from a psychiatric inpatient facility from 63.0% to 69.3% (a 10% increase over the FY18-19 baseline). Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health. Day of discharge follow-up services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.

Foster Youth beneficiary received a scheduled mental health practitioner appointment or service within 7 days after discharge from a psychiatric inpatient facility								
Discharge Fiscal Year/Quarter*	Admit Count ǂ	Discharge Count ǂ	7 Day Follow up	7 Day Percent	Average Days	Median Days	30 Day Follow Up	30 Day Percent
FY21-22 Quarter 1	3	3	3	100.0%	0.7	2.0	3	100.0%
FY21-22 Quarter 2	2	1	0	0.0%	0.0	11.0	1	100.0%
FY21-22 Quarter 3	1	2	2	100.0%	4.5	4.5	2	100.0%
FY21-22 Quarter 4	5	4	4	100.0%	0.8	2.0	4	100.0%
Totals :	**11**	**10**	**9**	**90.0%**	**1.5**	**4.9**	**10**	**100.0%**

Objective 3.d	Maintain psychiatric inpatient re-hospitalization within 30 days at 12.8% or less for **Adult beneficiaries**.

Adult Inpatient Clients with a Readmit within 30 Days of Discharge									
Discharge Fiscal Year/Quarter*	Non SCMH Adult Discharges	SCMH Adult Discharges	Percent of Discharges SCMH	Non SCMH 30 Day Re-Admissions		SCMH 30 Day Re-Admissions		Total 30 Day Re-Admissions	
				Count	Percent	Count	Percent	Count	Percent
FY21-22 Quarter 1	127	42	24.9%	12	9.4%	4	9.5%	16	9.5%
FY21-22 Quarter 2	110	52	32.1%	16	14.5%	13	25.0%	29	17.9%
FY21-22 Quarter 3	92	37	28.7%	13	14.1%	6	16.2%	19	14.7%
FY21-22 Quarter 4	131	57	30.3%	13	9.9%	15	26.3%	28	14.9%
Totals:	**460**	**188**	**40.9%**	**54**	**11.7%**	**38**	**20.2%**	**92**	**14.2%**

Objective 3.e	Maintain psychiatric inpatient re-hospitalization within 30 days at 12.2% or less for **Youth** beneficiaries.

Youth Inpatient Clients with a Readmit within 30 Days of Discharge

Discharge Fiscal Year/Quarter*	Non SCMH Adult Discharges	SCMH Adult Discharges	Percent of Discharges SCMH	Non SCMH 30 Day Re-Admissions		SCMH 30 Day Re-Admissions		Total 30 Day Re-Admissions	
				Count	Percent	Count	Percent	Count	Percent
FY21-22 Quarter 1	19	20	51.3%	1	5.3%	2	10.0%	3	7.7%
FY21-22 Quarter 2	23	13	36.1%	4	17.4%	1	7.7%	5	13.9%
FY21-22 Quarter 3	19	16	45.7%	0	0.0%	4	25.0%	4	11.4%
FY21-22 Quarter 4	22	26	54.2%	1	4.5%	2	7.7%	3	6.3%
Totals:	**83**	**75**	**90.4%**	**6**	**7.2%**	**9**	**12.0%**	**15**	**9.5%**

Objective 3.f	Maintain psychiatric inpatient re-hospitalization within 30 days at 0.0% or less for **Foster Care Youth** beneficiaries.

Foster Youth Inpatient Clients with a Readmit within 30 Days of Discharge

Discharge Fiscal Year/Quarter*	Non SCMH Adult Discharges	SCMH Adult Discharges	Percent of Discharges SCMH	Non SCMH 30 Day Re-Admissions		SCMH 30 Day Re-Admissions		Total 30 Day Re-Admissions	
				Count	Percent	Count	Percent	Count	Percent
FY21-22 Quarter 1	3	5	62.5%	1	33.3%	2	40.0%	3	37.5%
FY21-22 Quarter 2	0	1	100.0%	0	NA	0	0.0%	0	0.0%
FY21-22 Quarter 3	3	6	66.7%	0	0.0%	2	33.3%	2	22.2%
FY21-22 Quarter 4	1	7	87.5%	0	0.0%	0	0.0%	0	0.0%
Totals:	**7**	**19**	**271.4%**	**1**	**14.3%**	**4**	**21.1%**	**5**	**19.2%**

Objective 3.g	Maintain psychiatric inpatient re-hospitalization within 90 days at 22.4% or less for **Adult** beneficiaries.

Adult Inpatient Clients with a Readmit within 90 Days of Discharge									
Discharge Fiscal Year/Quarter*	Non SCMH Adult Discharges	SCMH Adult Discharges	Percent of Discharges SCMH	Non SCMH 90 Day Re-Admissions		SCMH 90 Day Re-Admissions		Total 90 Day Re-Admissions	
				Count	Percent	Count	Percent	Count	Percent
FY21-22 Quarter 1	127	42	24.9%	18	14.2%	8	19.0%	26	15.4%
FY21-22 Quarter 2	110	52	32.1%	25	22.7%	18	34.6%	43	26.5%
FY21-22 Quarter 3	92	37	28.7%	18	19.6%	7	18.9%	25	19.4%
FY21-22 Quarter 4	131	57	30.3%	23	17.6%	19	33.3%	42	22.3%
Totals:	**460**	**188**	**40.9%**	**84**	**18.3%**	**52**	**27.7%**	**136**	**21.0%**

Objective 3.h	Maintain psychiatric inpatient re-hospitalization within 90 days at 19.8% or less for **Youth** beneficiaries.

Youth Inpatient Clients with a Readmit within 90 Days of Discharge									
Discharge Fiscal Year/Quarter*	Non SCMH Adult Discharges	SCMH Adult Discharges	Percent of Discharges SCMH	Non SCMH 90 Day Re-Admissions		SCMH 90 Day Re-Admissions		Total 90 Day Re-Admissions	
				Count	Percent	Count	Percent	Count	Percent
FY21-22 Quarter 1	19	20	51.3%	4	21.1%	4	20.0%	8	20.5%
FY21-22 Quarter 2	23	13	36.1%	4	17.4%	3	23.1%	7	19.4%
FY21-22 Quarter 3	19	16	45.7%	3	15.8%	5	31.3%	8	22.9%
FY21-22 Quarter 4	22	26	54.2%	3	13.6%	5	19.2%	8	16.7%
Totals:	**83**	**75**	**90.4%**	**14**	**16.9%**	**17**	**22.7%**	**31**	**19.6%**

Objective 3.i	Maintain psychiatric inpatient re-hospitalization within 90 days at 27.0% or less for **Foster Care Youth** beneficiaries.

Foster Youth Inpatient Clients with a Readmit within 90 Days of Discharge									
Discharge Fiscal Year/Quarter*	Non SCMH Adult Discharges	SCMH Adult Discharges	Percent of Discharges SCMH	Non SCMH 90 Day Re-Admissions		SCMH 90 Day Re-Admissions		Total 90 Day Re-Admissions	
				Count	Percent	Count	Percent	Count	Percent
FY21-22 Quarter 1	3	5	62.5%	0	0.0%	2	40.0%	2	25.0%
FY21-22 Quarter 2	0	1	100.0%	0	NA	0	0.0%	0	0.0%
FY21-22 Quarter 3	3	6	66.7%	0	0.0%	2	33.3%	2	22.2%
FY21-22 Quarter 4	1	7	87.5%	0	0.0%	0	0.0%	0	0.0%
Totals:	**7**	**19**	**271.4%**	**0**	**0.0%**	**4**	**21.1%**	**4**	**15.4%**

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 business-hours test calls will have all necessary elements logged in Access to Services Journal (ASJ).

Test Call Report:

Test Calls FY 21-22				
		Number of Calls Required to be Logged	**Number of Calls where Requirements are Met**	**% of Calls Where Requirements Met**
FY 21-22				
Q1 (July-Sept)	Business	12	8	66.67%
	After Hours	4	1	25%
Q2 (Oct-Dec)	Business	8	8	100%
	After Hours	14	14	100%
Q3 (Jan-Mar)	Business	9	5	55.56%
	After Hours	3	2	66.67%
Q4 (Apr-Jun)	Business	7	6	85.17%
	After Hours	5	4	80%

Evaluation:	In FY 21-22, a total of 36 test calls were conducted, 27 calls met logging requirements. 77.42% of test calls were logged with all necessary elements. The goal has not been met for FY 2021-22. Training continues to be provided for internal staff (business hours).
Objective 4.b	90% of business-hours test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter and interpreter engages with the caller.
Evaluation:	In FY 21-22, a staff member was hired as a Mien interpreter, which allowed for the re-initiation of test calls requiring interpreter services. Three language-only, business hours, test calls were conducted by the MHP; all calls were successful in obtaining a correct language interpreter. The interpreter test calls were implemented as of Quarter 4 of FY 21-22. The MHP

	will continue this goal to allow for a more thorough analysis of the MHP's ability to meet interpretive service requirements
Objective 4.c	90% of after-hours test calls will have all necessary elements logged in Access to Services Journal (ASJ).

Evaluation:

Test Calls FY 21-22				
		Number of Calls Required to be Logged	**Number of Calls where Requirements are Met**	**% of Calls Where Requirements Met**
FY 21-22				
Q1 (July-Sept)	Business	12	8	66.67%
	After Hours	4	1	25%
Q2 (Oct-Dec)	Business	8	8	100%
	After Hours	14	14	100%
Q3 (Jan-Mar)	Business	9	5	55.56%
	After Hours	3	2	66.67%
Q4 (Apr-Jun)	Business	7	6	85.17%
	After Hours	5	4	80%

Evaluation:	In FY 21-22, a total of 26 after-hours test calls were conducted, 21 calls met logging requirements. 80.77% of test calls were logged with all necessary elements. The goal has not been met for FY 2021-22. Training continues to be provided for and for external contracted staff (after hours).

Objective 4.d	90% of after-hours test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter successfully engages with the caller.
Evaluation: In FY 21-22, a staff member was hired as a Mien interpreter, which allowed for the re-initiation of test calls requiring interpreter services. One language only, after hours, test call was conducted by the MHP; all calls were successful in obtaining a correct language interpreter. The interpreter test calls were implemented as of Quarter 4 of FY 21-22. The MHP will continue this goal to allow for a more thorough analysis of the MHP's ability to meet interpretive service requirements.	

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.
Evaluation	The Shasta County Health and Human Services Agency (HHSA) prepare a simplified customer survey to gather feedback from people who sought services from HHSA. Branch directors, including the mental health directors, collaborated in developing the survey. Questions include: • Was the staff kind and polite? "Yes/No" • Was the staff skilled and helpful? "Yes/No" • Did the staff offer help quickly? "Yes/No The survey is available in 25 different Shasta County locations. Distribution began on June 1st, 2022. The survey can be completed in the original paper format, or by using a smart device using a QR code that has been added to the survey. Survey results are captured and reported out by the HHSA's Director's office and are organized by service delivery location. To ensure all quality-of-care issues or other mental health related complaints are handled promptly, the Compliance and Quality Improvement team is responsible for collecting the surveys from the locations that provide mental health services. They are then reviewed by designated clinical staff, with oversight provided by the Quality Improvement Coordinator, prior to being sent on to be tabulated with the rest of

	the surveys. Complaints will be handled utilizing current grievances processes were applicable, including monitoring for trends and reporting at Quality Improvement Committee. The goal is partially met; the agency has implemented a survey and are receiving responses from consumers. Analyzing the data to prepare satisfaction baselines and determine specific goals are still in progress.

Beneficiary/Family Satisfaction	
Goal 6	Ensure clinical practices are safe, effective, and support wellness and recovery.
Objective 6.a	All newly hired staff, in job specifications that require it, will receive the clinical practice and documentation training within 90 days of hire. (Children's, Adult, and Medication Support Staff)
Evaluation	With CalAIM initiatives, the county has contracted with CalMHSA, who has prepared trainings that wrap in new requirements. All direct care staff, and others as assigned, are required to complete the trainings. This has been incorporated within the onboarding processed for new staff. Designated Utilization Review/Quality Assurance team clinical staff will provide follow up trainings tailored to individual classification needs. Staff completion of trainings will continue to be monitored and tracked by designated staff. Subject specific tip sheets are also available for staff for easy trouble shooting, updates will be made as needed with the implementation of CalAIM. Finally, program supervisors are provided with the trainings to utilize with supporting new and continuing staff. We were successful with using the Target Solutions/Vector Solutions learning management system for previous documentation trainings and will leverage this tool in the future as new internal trainings are developed.
Objective 6.b	Review medication practices for safety and effectiveness.
Evaluation	Specifically, on the HEDIS measures component of SB1291, the MHP currently uses SafeMeasures Medi-Cal reports and the Berkley CCWIP data reports on a monthly and quarterly basis to track psychotropic meds data including use of Psychotropic Medications, Use of Multiple Concurrent Psychotropic Medications, Ongoing Metabolic Monitoring on Children on Antipsychotic Medications, Children Authorized for Psychotropic Medications, Metabolic Screening for Children Newly on Antipsychotic. Shasta's longstanding workgroup that meets semi-annually to review these data reports and findings,

	monitor our youth's medications, and discuss policy or procedure needed changes has been put on hold due to staffing changes. When active, the workgroup consists of the clinical division chief, dedicated psychotropic medication public health nurse, supervising public health nurse, assigned JV-220 medical services clerk, and an analyst. The Supervising Nurse will revisit convening this group soon. In addition, the Utilization Management/Quality Assurance team is currently drafting new policies and procedures for a comprehensive medication monitoring audit plan for the MHP. A new auditing tool is also in development. The process will be piloted, and the policy finalized by December 2022. Evaluation, implementation of ongoing monitoring, and reporting to QIC is projected to be in place by July 2023.

Beneficiary/Family Satisfaction	
Goal 7	Evaluate beneficiary grievances, appeal, fair hearings, and change of provider requests for quality-of-care issues.
Objective 7	Grievance, appeal, expedited appeal, and change of provider Requests issues and resolutions will be reported to QIC quarterly and QIC will evaluate for quality-of-care issues.
Evaluation	All Grievances and Change of Provider Requests are reviewed and investigated by the Compliance & Quality Improvement team's 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. During the 2021-2022 fiscal year, there were a total of 31 beneficiary grievances/change of provider requests. All grievances were process timely. Any significant concerns, items resulting in system improvements, or general trends, were reported through the QIC quarterly. To further support the beneficiary grievance process, the Quality Improvement team offers 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 incorporated

	information regarding these processes and how to access beneficiary informing materials within the annual Compliance Training, which is required for all MHP funded staff.

Safety and Effectiveness of Medical and Clinical Practices	
Goal 8	Monitor appeals for timely resolution
Objective 8.a	100% of appeals will be resolved within the timeframes specified by state and federal regulating agencies
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. There were 2 appeals and no expedited appeals during fiscal year 21-22. All appeals were processed timely.

QI Committee Infrastructure and Activities	
Goal 9:	Strengthen the infrastructure and improve the practices and effectiveness of the Quality Improvement Program.
Objective 9.a	The QI Committee will increase stakeholder involvement in the QI Committee activities, decisions, and oversight.
Evaluation	This objective is ongoing. To increase stakeholder involvement, the designated Quality Improvement Coordinator for the MHP participates in various HHSA community committees to increase engagement with community members and stakeholders. As the community adjusts in moving away from the previous limitations brought on by COVID, we are beginning to see a return to community events, such as health fairs, which will increase opportunities for engagement with consumers and stakeholders from the community. As the MHP's provider network continues to expand, we will be looking for opportunities to expand committee involvement.

Objective 9.b	The QI Committee will assure participation of direct care staff in quality improvement (QI) activities, by having Program and Organizational Provider leads and Cultural Competency Coordinator report to the QI Committee with QI activities their staff/agencies are currently engaged in, and what programs and efforts are having a positive impact.
Evaluation	This objective is ongoing. The QI Committee maintains an agenda structure for its meeting to allow reporting of QI activities by all participants at the beginning of the meeting, to be captured in the minutes. Mental program management bring information to and from QIC committee meetings, sharing and receiving information from direct care staff through their various staff meetings. 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 also facilitates the Cultural Competency Committee allowing for information and discussion involving Cultural Competency initiatives to seamlessly flow to and from the QIC as well.

Attachment 1: EQRO Timeliness Measures

1): (EQRO TIMELINESS MEASURE 1.3) Maintain the percent of all clients with a first offered appointment (including assessment) within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 97.4% 10 business days or less (1,146 of 1,176).
2): (EQRO TIMELINESS MEASURE 1.3) Maintain the percent of adult clients with a first offered appointment (including assessment) within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 99.8% 10 business days or less (586 of 587).
3): (EQRO TIMELINESS MEASURE 1.3) Maintain the percent of youth clients with a first offered appointment (including assessment) within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 95.1% 10 business days or less (560 of 589).
4): (EQRO TIMELINESS MEASURE 1.3) Maintain the percent of Foster Care youth clients with a first offered appointment (including assessment) within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 98.0% 10 business days or less (146 of 149).

Measure 1-4: Date from first request for services to <u>first offered assessment</u> appointment or service within 10 business days. 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. The measure start date is the date of first contact recorded on the CSI assessment. The measure end date is the first offered appointment date recorded on the CSI assessment.

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	1,176	1,147	97.5%	1.3	0	3.7	0	45
	2020-2021 Q1	252	248	98.4%	0.9	0	2.8	0	23
	2020-2021 Q2	249	238	95.6%	1.9	0	3.9	0	25
	2020-2021 Q3	289	280	96.9%	1.8	0	3.3	0	22
	2020-2021 Q4	347	339	97.7%	2.1	0	4.6	0	67
	2020-2021	1,126	1,094	97.2%	1.7	0	3.8	0	67
	2021-2022 Q1	260	254	97.7%	1.5	0	3.0	0	25
	2021-2022 Q2	145	138	95.2%	2.3	0	3.4	0	16
	2021-2022 Q3	138	131	94.9%	3.8	0	21.7	0	252
	2021-2022 YTD	541	521	96.3%	2.3	0	11.3	0	252
Adults	2019-2020	587	586	99.8%	0.1	0	0.7	0	16
	2020-2021 Q1	127	127	100.0%	0.0	0	0.2	0	2
	2020-2021 Q2	103	103	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	129	129	100.0%	0.0	0	0.4	0	4
	2020-2021	461	461	100.0%	0.0	0	0.3	0	4
	2021-2022 Q1	132	132	100.0%	0.1	0	0.9	0	10
	2021-2022 Q2	67	67	100.0%	0.1	0	0.5	0	4
	2021-2022 Q3	74	74	100.0%	0.0	0	0.2	0	1
	2021-2022 YTD	272	272	100.0%	0.1	0	0.7	0	10
Youth	2019-2020	589	561	95.2%	2.5	0	4.8	0	45
	2020-2021 Q1	125	121	96.8%	1.7	0	3.8	0	23
	2020-2021 Q2	146	135	92.5%	3.3	1.5	4.6	0	25
	2020-2021 Q3	181	172	95.0%	2.9	2	3.8	0	22
	2020-2021 Q4	218	210	96.3%	3.4	2	5.4	0	67
	2020-2021	665	633	95.2%	2.9	2	4.6	0	67
	2021-2022 Q1	128	122	95.3%	2.9	2	3.7	0	25
	2021-2022 Q2	78	71	91.0%	4.2	3	3.7	0	16
	2021-2022 Q3	64	57	89.1%	8.1	2.5	31.3	0	252
	2021-2022 YTD	269	249	92.6%	4.5	2	15.8	0	252
Foster Youth	2019-2020	148	145	98.0%	1.4	0	3.0	0	24
	2020-2021 Q1	36	35	97.2%	1.0	0	3.1	0	17
	2020-2021 Q2	32	31	96.9%	1.2	0	3.5	0	19
	2020-2021 Q3	29	28	96.6%	0.8	0	2.5	0	12
	2020-2021 Q4	44	44	100.0%	1.5	0	2.2	0	9
	2020-2021	141	138	97.9%	1.1	0	2.8	0	19
	2021-2022 Q1	28	28	100.0%	2.4	2	2.3	0	7
	2021-2022 Q2	22	20	90.9%	3.0	2	3.2	0	11
	2021-2022 Q3	14	14	100.0%	2.4	2	2.3	0	8
	2021-2022 YTD	64	62	96.9%	2.6	2	2.7	0	11

5): (EQRO TIMELINESS MEASURE 1.4) Maintain the percent of **all** clients with a first accepted appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 95.8% 10 business days or less (1,075 of 1,122).
6): (EQRO TIMELINESS MEASURE 1.4) Maintain the percent of **adult** clients with a first accepted appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 99.5% 10 business days or less (576 of 579).
7): (EQRO TIMELINESS MEASURE 1.4) Maintain the percent of **youth** clients with a first accepted appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 91.9% 10 business days or less (499 of 543).
8): (EQRO TIMELINESS MEASURE 1.4) Maintain the percent of **Foster Care youth** clients with a first accepted appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 96.6% 10 business days or less (143 of 148).

Measure 5-8: Date from first request for services to <u>first accepted assessment appointment</u> or service within 10 business days. 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. The measure start date is the date of first contact recorded on the CSI assessment. The measure end date is the first accepted appointment date recorded on the CSI assessment.

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	1,075	1,026	95.4%	2.2	0	4.6	0	45
	2020-2021 Q1	229	223	97.4%	1.6	0	3	0	24
	2020-2021 Q2	235	223	94.9%	3.0	0	4	0	25
	2020-2021 Q3	265	251	94.7%	2.9	2	4	0	23
	2020-2021 Q4	328	309	94.2%	3.6	2	5	0	67
	2020-2021	1,046	995	95.1%	2.9	0	4.5	0	67
	2021-2022 Q1	249	231	92.8%	2.8	0	4.4	0	22
	2021-2022 Q2	132	118	89.4%	3.7	2	4.9	0	27
	2021-2022 Q3	132	123	93.2%	5.0	0	22.5	0	252
	2021-2022 YTD	511	470	92.0%	3.6	0	12.1	0	252
Adults	2019-2020	551	549	99.6%	0.4	0	1.6	0	16
	2020-2021 Q1	115	115	100.0%	0.5	0	1.5	0	8
	2020-2021 Q2	102	102	100.0%	0.5	0	1.6	0	8
	2020-2021 Q3	97	97	100.0%	0.4	0	1.2	0	6
	2020-2021 Q4	121	121	100.0%	0.3	0	0.9	0	5
	2020-2021	429	429	100.0%	0.4	0	1.3	0	8
	2021-2022 Q1	129	129	100.0%	0.4	0	1.5	0	10
	2021-2022 Q2	55	53	96.4%	1.3	0	3.2	0	16
	2021-2022 Q3	72	72	100.0%	0.8	0	2.0	0	10
	2021-2022 YTD	255	253	99.2%	0.7	0	2.1	0	16
Youth	2019-2020	524	477	91.0%	4.0	2	5.8	0	45
	2020-2021 Q1	114	108	94.7%	2.6	1	4.4	0	24
	2020-2021 Q2	133	121	91.0%	4.9	4	4.9	0	25
	2020-2021 Q3	168	154	91.7%	4.4	4	4.0	0	23
	2020-2021 Q4	207	188	90.8%	5.5	5	6.0	0	67
	2020-2021	617	566	91.7%	4.6	4	5.1	0	67
	2021-2022 Q1	120	102	85.0%	5.4	4	4.9	0	22
	2021-2022 Q2	77	65	84.4%	5.4	4	5.2	0	27
	2021-2022 Q3	60	51	85.0%	10.2	4.5	32.5	0	252
	2021-2022 YTD	256	217	84.8%	6.5	4	16.5	0	252
Foster Youth	2019-2020	147	142	96.6%	1.8	0	4.1	0	31
	2020-2021 Q1	36	35	97.2%	1.2	0	3.3	0	17
	2020-2021 Q2	32	31	96.9%	1.9	0	3.9	0	19
	2020-2021 Q3	29	26	89.7%	2.2	0	4.1	0	15
	2020-2021 Q4	43	41	95.3%	2.5	0	3.8	0	17
	2020-2021	140	133	95.0%	2.0	0	3.8	0	19
	2021-2022 Q1	27	24	88.9%	4.4	3	4.5	0	18
	2021-2022 Q2	22	18	81.8%	5.0	3.5	5.3	0	17
	2021-2022 Q3	13	13	100.0%	4.2	4	3.6	0	10
	2021-2022 YTD	62	55	88.7%	4.6	3.5	4.7	0	18

9): (EQRO TIMELINESS MEASURE 1.5) Maintain the percent of **all** clients with a kept assessment appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 95.6% 10 business days or less (959 of 1,003).
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) Maintain the percent of **youth** clients with a kept assessment appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 91.2% 10 business days or less (433 of 475).
12): (EQRO TIMELINESS MEASURE 1.5) Maintain the percent of **Foster Care youth** clients with a kept assessment appointment within 10 business days from the initial request for services at 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 96.6% 10 business days or less (141 of 146).

Measure 9-12: Date from first request for services to <u>first kept assessment appointment</u> or service within 10 business days. 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 a kept assessment appointment recorded in the CSI. The measure start date is the date of first contact recorded on the CSI assessment. The measure end date is the first kept appointment date recorded on the CSI assessment.

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	1,003	959	95.6%	2.0	0	4.5	0	45
	2020-2021 Q1	215	211	98.1%	1.4	0	3.3	0	24
	2020-2021 Q2	215	204	94.9%	2.7	0	4.4	0	25
	2020-2021 Q3	222	212	95.5%	2.3	0	3.5	0	23
	2020-2021 Q4	279	269	96.4%	2.8	0	5.3	0	67
	2020-2021	921	886	96.2%	2.3	0	4.3	0	67
	2021-2022 Q1	235	222	94.5%	2.4	0	3.9	0	18
	2021-2022 Q2	117	103	88.0%	3.7	1	5.1	0	27
	2021-2022 Q3	117	111	94.9%	4.4	0	23.5	0	252
	2021-2022 YTD	467	434	92.9%	3.2	0	12.4	0	252
Adults	2019-2020	528	526	99.6%	0.3	0	1.5	0	16
	2020-2021 Q1	113	113	100.0%	0.4	0	1.3	0	8
	2020-2021 Q2	102	102	100.0%	0.5	0	1.6	0	8
	2020-2021 Q3	97	97	100.0%	0.4	0	1.2	0	6
	2020-2021 Q4	120	120	100.0%	0.2	0	0.9	0	5
	2020-2021	426	426	100.0%	0.4	0	1.2	0	8
	2021-2022 Q1	128	128	100.0%	0.3	0	1.3	0	10
	2021-2022 Q2	54	52	96.3%	1.3	0	3.2	0	16
	2021-2022 Q3	71	71	100.0%	0.7	0	2.0	0	10
	2021-2022 YTD	252	250	99.2%	0.7	0	2.1	0	16
Youth	2019-2020	475	433	91.2%	3.9	2	5.7	0	45
	2020-2021 Q1	102	98	96.1%	2.4	0	4.3	0	24
	2020-2021 Q2	113	102	90.3%	4.8	4	5.1	0	25
	2020-2021 Q3	125	115	92.0%	3.8	3	3.9	0	23
	2020-2021 Q4	159	149	93.7%	4.8	4	6.3	0	67
	2020-2021	495	460	92.9%	4.0	3	5.2	0	67
	2021-2022 Q1	107	94	87.9%	4.9	4	4.5	0	18
	2021-2022 Q2	63	51	81.0%	5.7	5	5.5	0	27
	2021-2022 Q3	46	40	87.0%	10.2	2	36.7	0	252
	2021-2022 YTD	215	184	85.6%	6.3	4	17.6	0	252
Foster Youth	2019-2020	145	140	96.6%	1.8	0	4.1	0	31
	2020-2021 Q1	35	34	97.1%	1.1	0	3.3	0	17
	2020-2021 Q2	31	30	96.8%	2.0	0	4.0	0	19
	2020-2021 Q3	27	24	88.9%	2.0	0	4.1	0	15
	2020-2021 Q4	42	40	95.2%	2.4	0	3.7	0	17
	2020-2021	135	128	94.8%	1.9	0	3.8	0	19
	2021-2022 Q1	27	24	88.9%	4.4	3	4.5	0	18
	2021-2022 Q2	19	15	78.9%	4.4	3	4.8	0	16
	2021-2022 Q3	10	9	90.0%	4.0	3	4.5	0	13
	2021-2022 YTD	56	48	85.7%	4.4	3	4.6	0	18

13): (EQRO TIMELINESS MEASURE 1.6) Track and monitor the average, median, standard deviation, and range in business days from the initial request for services to the first kept clinical appointment for all clients.

14): (EQRO TIMELINESS MEASURE 1.6) Track and monitor the average, median, standard deviation, and range in business days from the initial request for services to the first kept clinical appointment for adult clients.
15): (EQRO TIMELINESS MEASURE 1.6 Track and monitor the average, median, standard deviation, and range in business days from the initial request for services to the first kept clinical appointment for youth clients.
16): (EQRO TIMELINESS MEASURE 1.6) Track and monitor the average, median, standard deviation, and range in business days from the initial request for services to the first kept clinical appointment for Foster Care youth clients.

Measure 13-16: Date from initial request for services to <u>first kept clinical appointment</u> 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. The measure end date is the earliest of the treatment start date recorded on the CSI assessment or the assessment service recorded in the services listing report that is with the client (face to face, or telephonic).

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	535	7.2	5	10.3	0	103
	2020-2021 Q1	122	5.5	4.5	6.2	0	37
	2020-2021 Q2	145	5.8	4	6.2	0	26
	2020-2021 Q3	141	6.1	3	9.5	0	76
	2020-2021 Q4	172	6.5	5	8.2	0	63
	2020-2021	575	6.1	4	7.8	0	76
	2021-2022 Q1	128	6.5	4	7.0	0	40
	2021-2022 Q2	75	5.1	2	7.0	0	31
	2021-2022 Q3	85	8.4	3	19.2	0	147
	2021-2022 YTD	287	6.7	4	12.1	0	147
Adults	2019-2020	158	4.1	2	6.3	0	56
	2020-2021 Q1	50	4.2	1.5	5.8	0	33
	2020-2021 Q2	51	2.8	1	3.6	0	14
	2020-2021 Q3	49	2.5	0	3.6	0	15
	2020-2021 Q4	49	3.2	1	3.7	0	13
	2020-2021	197	3.2	1	4.3	0	33
	2021-2022 Q1	46	3.2	2	3.5	0	13
	2021-2022 Q2	31	3.7	0	6.7	0	31
	2021-2022 Q3	49	4.1	1	10.1	0	69
	2021-2022 YTD	125	3.7	2	7.4	0	69
Youth	2019-2020	377	8.5	5	11.3	0	103
	2020-2021 Q1	72	6.5	5	6.4	0	37
	2020-2021 Q2	94	7.4	5	6.7	0	26
	2020-2021 Q3	92	8.1	5	11.0	0	76
	2020-2021 Q4	123	7.8	6	9.1	0	63
	2020-2021	378	7.5	5	8.7	0	76
	2021-2022 Q1	82	8.3	6	7.8	0	40
	2021-2022 Q2	44	6.0	3.5	7.1	0	23
	2021-2022 Q3	36	14.2	7	26.0	0	147
	2021-2022 YTD	162	9.0	5	14.3	0	147
Foster Youth	2019-2020	121	13.0	8	16.3	0	103
	2020-2021 Q1	22	9.8	8	9.0	0	37
	2020-2021 Q2	28	7.6	7	5.7	0	22
	2020-2021 Q3	21	12.2	6	18.6	0	76
	2020-2021 Q4	30	8.6	5	9.3	0	45
	2020-2021	101	9.3	7	11.3	0	76
	2021-2022 Q1	18	11.9	11.5	9.5	0	40
	2021-2022 Q2	14	11.1	11.5	8.4	0	23
	2021-2022 Q3	9	33.0	22	43.3	0	147
	2021-2022 YTD	41	16.3	12	23.5	0	147

18): (EQRO TIMELINESS MEASURE 1.7) Track and monitor the average, median, standard deviation, and range in business days from the first kept clinical appointment to the second kept clinical appointment for adult clients.
19): (EQRO TIMELINESS MEASURE 1.7) Track and monitor the average, median, standard deviation, and range in business days from the first kept clinical appointment to the second kept clinical appointment for youth clients.
20): (EQRO TIMELINESS MEASURE 1.7) Track and monitor the average, median, standard deviation, and range in business days from the first kept clinical appointment to the second kept clinical appointment for Foster Care youth clients.

Measure 17-20: Date from <u>first kept clinical appointment to second kept clinical appointment</u>.

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 treatment start date recorded on the CSI assessment. 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 first treatment service 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	490	8.7	5	8.3	0	52
	2020-2021 Q1	114	9.2	6	8.7	0	39
	2020-2021 Q2	131	8.7	6	8.0	0	40
	2020-2021 Q3	131	9.2	6	7.8	1	39
	2020-2021 Q4	158	9.3	5	9.9	0	49
	2020-2021	528	9.1	6	8.7	0	49
	2021-2022 Q1	111	11.2	7	11.2	0	75
	2021-2022 Q2	72	8.1	4	8.1	1	33
	2021-2022 Q3	65	9.3	6	8.5	1	32
	2021-2022 YTD	247	9.8	6	9.8	0	75
Adults	2019-2020	142	8.4	5	8.6	0	46
	2020-2021 Q1	50	11.5	9.5	9.9	0	39
	2020-2021 Q2	46	9.1	6	9.1	1	39
	2020-2021 Q3	37	10.6	7	9.6	1	39
	2020-2021 Q4	45	8.3	5	8.1	0	39
	2020-2021	175	9.8	7	9.3	0	39
	2021-2022 Q1	40	9.6	7	9.2	0	39
	2021-2022 Q2	36	9.6	8	9.0	1	33
	2021-2022 Q3	39	11.1	9	9.2	1	32
	2021-2022 YTD	114	10.1	8	9.2	0	39
Youth	2019-2020	348	8.8	5.5	8.2	1	52
	2020-2021 Q1	64	7.4	5	7.2	1	39
	2020-2021 Q2	85	8.5	6	7.4	0	40
	2020-2021 Q3	94	8.6	6	6.8	1	30
	2020-2021 Q4	113	9.8	5	10.5	1	49
	2020-2021	353	8.7	6	8.4	0	49
	2021-2022 Q1	71	12.2	7	12.2	1	75
	2021-2022 Q2	36	6.6	4	6.7	1	24
	2021-2022 Q3	26	6.7	5	6.3	1	23
	2021-2022 YTD	133	9.6	5	10.3	1	75
Foster Youth	2019-2020	108	9.6	6	9.9	1	52
	2020-2021 Q1	16	6.7	4.5	8.4	1	36
	2020-2021 Q2	28	9.5	8	6.2	1	21
	2020-2021 Q3	20	5.9	4	4.8	1	22
	2020-2021 Q4	29	6.3	5	6.0	1	28
	2020-2021	93	7.2	5	6.5	1	36
	2021-2022 Q1	17	12.3	9	10.2	1	41
	2021-2022 Q2	7	10.4	5	8.4	3	23
	2021-2022 Q3	3	11.0	12	7.0	2	19
	2021-2022 YTD	27	11.7	9	9.5	1	41

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 82.2% to 84.0% for FY 2021 - 2022. FY 2019 - 2020 baseline was 82.2% 15 business days or less (227 of 276).
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 90.9% to 91.8% for FY 2021 - 2022. FY 2019 - 2020 baseline was 90.9% 15 business days or less (190 of 209).
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 55.2% to 59.7% for FY 2021 - 2022. FY 2019 - 2020 baseline was 55.2% 15 business days or less (37 of 67).
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 80.0% to 82.0% for FY 2021 - 2022. FY 2019 - 2020 baseline was 80.0% 15 business days or less (4 of 5).

Measure 21-24: Date from <u>first request for services to first offered prescriber appointment</u> or service with a prescriber within 15 business days.

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. The measure start date is the date of first contact recorded on the CSI assessment. The measure end date is the scheduler appointment with a prescriber recorded in the scheduled services report 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	257	239	93.0%	6.5	6	5.5	0	22
	2020-2021 Q1	65	58	89.2%	8.8	9	5.9	0	22
	2020-2021 Q2	57	55	96.5%	4.9	4	4.0	0	18
	2020-2021 Q3	57	41	71.9%	10.0	9	6.8	0	22
	2020-2021 Q4	83	75	90.4%	7.4	6	5.5	0	21
	2020-2021	260	227	87.3%	7.8	7	5.9	0	22
	2021-2022 Q1	56	49	87.5%	7.9	6.5	5.4	0	22
	2021-2022 Q2	61	53	86.9%	8.1	7	5.2	0	20
	2021-2022 Q3	55	51	92.7%	7.5	7	5.1	0	20
	2021-2022 YTD	171	152	88.9%	7.9	7	5.2	0	22
Adults	2019-2020	204	193	94.6%	6.1	5	5.3	0	22
	2020-2021 Q1	53	46	86.8%	9.0	10	6.4	0	22
	2020-2021 Q2	49	47	95.9%	4.9	4	4.2	0	18
	2020-2021 Q3	41	29	70.7%	9.9	9	6.8	0	22
	2020-2021 Q4	60	55	91.7%	6.8	6	5.4	0	21
	2020-2021	201	175	87.1%	7.6	7	6.1	0	22
	2021-2022 Q1	40	34	85.0%	8.4	7.5	5.8	0	22
	2021-2022 Q2	36	31	86.1%	8.1	7.5	5.2	0	20
	2021-2022 Q3	43	39	90.7%	7.7	7	5.4	0	20
	2021-2022 YTD	118	103	87.3%	8.1	7	5.5	0	22
Youth	2019-2020	53	46	86.8%	8.1	8	5.8	0	20
	2020-2021 Q1	12	12	100.0%	7.8	7.5	2.5	3	12
	2020-2021 Q2	8	8	100.0%	5.0	6	1.9	2	7
	2020-2021 Q3	16	12	75.0%	10.4	12	6.5	0	22
	2020-2021 Q4	23	20	87.0%	9.0	10	5.5	0	18
	2020-2021	59	52	88.1%	8.6	8	5.3	0	22
	2021-2022 Q1	16	15	93.8%	6.8	6	4.1	1	17
	2021-2022 Q2	25	22	88.0%	8.1	7	5.3	0	18
	2021-2022 Q3	12	12	100.0%	6.7	7	3.8	1	13
	2021-2022 YTD	53	49	92.5%	7.4	6	4.7	0	18
Foster Youth	2019-2020	4	4	100.0%	7.5	7.5	4.0	3	12
	2020-2021 Q1	2	2	100.0%	8.5	8.5	1.5	7	10
	2020-2021 Q2	2	2	100.0%	4.5	4.5	1.5	3	6
	2020-2021 Q3	0	0	N/A	N/A	N/A	N/A	N/A	N/A
	2020-2021 Q4	2	1	50.0%	11.0	11	6.0	5	17
	2020-2021	6	5	83.3%	8.0	6.5	4.5	3	17
	2021-2022 Q1	3	3	100.0%	5.0	5	0.8	4	6
	2021-2022 Q2	0	0	N/A	N/A	N/A	N/A	N/A	N/A
	2021-2022 Q3	1	1	100.0%	4.0	4	0.0	4	4
	2021-2022 YTD	4	4	100.0%	4.8	4.5	0.8	4	6

25): (EQRO TIMELINESS MEASURE 1.9) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first offered psychiatric appointment for **all** clients.

26): (EQRO TIMELINESS MEASURE 1.9) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first offered psychiatric appointment for **Adult** clients.
27): (EQRO TIMELINESS MEASURE 1.9) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first offered psychiatric appointment for **youth** clients.
28): (EQRO TIMELINESS MEASURE 1.9) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first offered psychiatric appointment for **Foster Care youth** clients

Measure 25-28: Date from <u>appointment entered date to first offered prescriber appointment</u> or service with a prescriber.
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. The measure start date is the prescriber appointment entered date in the scheduled services report. The measure end date is the prescriber appointment scheduled date recorded in the scheduled services report.

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	240	4.4	3	4.3	0	20
	2020-2021 Q1	60	6.6	6	5.1	0	22
	2020-2021 Q2	56	3.7	3	3.1	0	15
	2020-2021 Q3	53	8.2	7	6.8	0	22
	2020-2021 Q4	76	5.8	5	4.5	0	18
	2020-2021	243	6.0	5	5.2	0	22
	2021-2022 Q1	52	6.4	5	4.8	0	22
	2021-2022 Q2	59	7.3	7	5.0	0	17
	2021-2022 Q3	55	6.8	6	4.9	0	19
	2021-2022 YTD	165	6.9	6	4.9	0	22
Adults	2019-2020	189	3.8	3	3.5	0	17
	2020-2021 Q1	48	6.8	6	5.6	0	22
	2020-2021 Q2	48	3.6	3	3.2	0	15
	2020-2021 Q3	40	8.6	7	6.9	0	22
	2020-2021 Q4	60	5.2	5	3.9	0	13
	2020-2021	194	5.9	4	4.6	0	22
	2021-2022 Q1	38	6.9	5.5	5.4	0	22
	2021-2022 Q2	35	7.3	6	4.9	0	16
	2021-2022 Q3	43	6.9	5	5.2	0	19
	2021-2022 YTD	115	7.1	4	4.8	0	22
Youth	2019-2020	51	6.5	5	6.0	0	20
	2020-2021 Q1	12	6.0	6	1.8	2	8
	2020-2021 Q2	8	4.0	4.5	2.4	0	7
	2020-2021 Q3	13	7.2	5	6.3	0	17
	2020-2021 Q4	16	8.1	7	5.6	0	18
	2020-2021	49	6.7	6	5.5	0	18
	2021-2022 Q1	14	5.0	5	2.2	1	10
	2021-2022 Q2	24	7.3	7	5.0	0	17
	2021-2022 Q3	12	6.4	7	3.5	1	11
	2021-2022 YTD	50	6.4	6	5.1	0	17
Foster Youth	2019-2020	4	6.0	5	3.1	3	11
	2020-2021 Q1	2	4.5	4.5	2.5	2	7
	2020-2021 Q2	2	4.5	4.5	1.5	3	6
	2020-2021 Q3	0	N/A	N/A	N/A	N/A	N/A
	2020-2021 Q4	2	11.0	11	6.0	5	17
	2020-2021	6	6.7	5.5	4.9	2	17
	2021-2022 Q1	3	5.0	5	0.8	4	6
	2021-2022 Q2	0	N/A	N/A	N/A	N/A	N/A
	2021-2022 Q3	1	4.0	4	0.0	4	4
	2021-2022 YTD	4	4.8	4.5	0.8	4	6

29): (EQRO TIMELINESS MEASURE 1.10) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first kept psychiatric appointment for **all** clients.
30): (EQRO TIMELINESS MEASURE 1.10) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first kept psychiatric appointment for **adult** clients.
31): (EQRO TIMELINESS MEASURE 1.10) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first kept psychiatric appointment for **youth** clients.
32): (EQRO TIMELINESS MEASURE 1.10) Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered vices to the first kept psychiatric appointment for **Foster Care youth** clients.

Measure 29-32: Date from <u>appointment entered date to first kept prescriber appointment</u> or service with a prescriber.
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. The measure start date is the prescriber appointment entered date in the scheduled services report. The measure end date is the prescriber appointment scheduled date recorded in the scheduled services report.

First Determination of Need to First Psychiatric Appointment Kept (Scheduler Appointment Entered Date) (1.10)	Quarter	Count of Kept Psychiatric Appointments Kept	Average Number of Business Days from First Psychiatric Appointment Kept (Scheduler Appointment Entered Date) to Kept Psychiatric Appointment Date	Median Number of Business Days from First Psychiatric Appointment Kept (Scheduler Appointment Entered Date) to Kept Psychiatric Appointment Date	Standard Deviation of Number or Business Days from First Psychiatric Appointment Kept (Scheduler Appointment Entered Date) to Kept Psychiatric Appointment Date	Minimum Number of Business Days from First Psychiatric Appointment Kept (Scheduler Appointment Entered Date) to Kept Psychiatric Appointment Date	Maximum Number of Business Days from First Psychiatric Appointment Kept (Scheduler Appointment Entered Date) to Kept Psychiatric Appointment Date
All Clients	2019-2020	238	4.8	4	4.9	0	21
	2020-2021 Q1	53	6.1	6	4.9	0	22
	2020-2021 Q2	51	4.3	4	3.4	0	15
	2020-2021 Q3	49	8.6	7	7.2	0	22
	2020-2021 Q4	67	7.8	7	5.6	0	21
	2020-2021	219	6.8	6	5.7	0	22
	2021-2022 Q1	48	8.6	7.5	6.1	0	24
	2021-2022 Q2	52	9.2	9	5.3	0	20
	2021-2022 Q3	41	8.2	8	5.6	0	22
	2021-2022 YTD	140	8.8	8.5	5.6	0	24
Adults	2019-2020	191	4.0	3	4.2	0	18
	2020-2021 Q1	42	6.0	5.5	5.3	0	22
	2020-2021 Q2	43	4.2	4	3.6	0	15
	2020-2021 Q3	34	8.2	5.5	7.2	0	22
	2020-2021 Q4	46	6.2	5.5	4.7	0	21
	2020-2021	164	6.1	5	5.4	0	22
	2021-2022 Q1	34	7.3	6.5	5.3	0	22
	2021-2022 Q2	32	8.9	8.5	5.1	0	20
	2021-2022 Q3	29	7.8	7	5.2	0	18
	2021-2022 YTD	94	8.1	7	5.2	0	22
Youth	2019-2020	47	8.0	7	6.2	0	21
	2020-2021 Q1	11	6.3	6	2.1	2	9
	2020-2021 Q2	8	4.8	6	2.4	0	7
	2020-2021 Q3	15	9.5	10	7.3	0	22
	2020-2021 Q4	21	11.3	13	5.9	0	19
	2020-2021	55	8.8	8	6.0	0	22
	2021-2022 Q1	14	11.9	9.5	6.6	3	24
	2021-2022 Q2	20	9.6	10	5.6	0	19
	2021-2022 Q3	12	9.2	9	6.2	1	22
	2021-2022 YTD	46	10.2	10	6.2	0	24
Foster Youth	2019-2020	4	10.3	10	3.3	6	15
	2020-2021 Q1	2	5.0	5	3.0	2	8
	2020-2021 Q2	2	6.5	6.5	0.5	6	7
	2020-2021 Q3	0	N/A	N/A	N/A	N/A	N/A
	2020-2021 Q4	1	6.0	6	0.0	6	6
	2020-2021	5	5.8	6	2.0	2	8
	2021-2022 Q1	3	11.0	9	5.1	6	18
	2021-2022 Q2	0	N/A	N/A	N/A	N/A	N/A
	2021-2022 Q3	1	18.0	18	0.0	18	18
	2021-2022 YTD	4	12.8	13.5	5.4	6	18

33): All clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days or less. (Standard is 48 hours for clients with prior authorization; 96 hours without prior authorization). Current FY 2019 - 2020 baseline

for urgent care data base is 99.5% (1,188 of 1,194) of Emergency Department (ED) visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 99.9% (8,133 of 8,143) of crisis assignments in Cerner received at least one service within 2 days.
34): All **adult** clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days or less. (Standard is 48 hours for clients with prior authorization; 96 hours without prior authorization). Current FY 2019 - 2020 baseline for urgent care data base is 99.5% (925 of 930) of ED visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 99.9% (6,918 of 6,928) of crisis assignments in Cerner received at least one service within 2 days.
35): All **youth** clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days or less. (Standard is 48 hours for clients with prior authorization; 96 hours without prior authorization). Current FY 2019 - 2020 baseline for urgent care data base is 99.6% (263 of 264) of ED visits that are not referred to an inpatient psychiatric facility are evaluated within 48 hours, and 100% (1,215 of 1,215) of crisis assignments in Cerner received at least one service within 2 days.
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 or less. (Standard is 48 hours for clients with prior authorization; 96 hours without prior authorization). Current FY 2019 - 2020 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% (66 of 66) of crisis assignments in Cerner received at least one service within 2 days.

Measure 33-36a: From eval capable date/time to face to face evaluation start date/time.

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 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	1,188	12.4	9.8	20.2	1,182	99.5%
	20/21-Q1	299	10.1	8.5	19.6	298	99.7%
	20/21-Q2	271	8.6	7.9	17.0	271	100.0%
	20/21-Q3	312	10.2	10.0	19.6	311	99.7%
	20/21-Q4	281	9.9	9.1	18.8	279	99.3%
	FY20/21	1,163	9.7	9.0	18.9	1,159	99.7%
	21/22Q1	267	10.9	10.8	19.4	265	99.3%
	21/22Q2	272	11.6	9.9	20.1	269	98.9%
	21/22Q3	308	9.3	5.9	19.3	306	99.4%
	FY21/22 YTD	847	10.5	9.1	19.8	840	99.2%
Adults	FY19/20	961	13.2	10.0	20.5	956	99.5%
	20/21-Q1	259	10.3	8.5	19.6	258	99.6%
	20/21-Q2	213	8.8	7.9	17.7	213	100.0%
	20/21-Q3	265	10.3	10.0	19.6	264	99.6%
	20/21-Q4	214	10.1	9.2	19.0	212	99.1%
	FY20/21	951	9.9	9.0	19.4	947	99.6%
	21/22Q1	215	11.2	10.5	20.6	213	99.1%
	21/22Q2	199	11.6	10.2	20.6	197	99.0%
	21/22Q3	259	9.4	5.1	20.3	257	99.2%
	FY21/22 YTD	673	10.6	8.7	20.5	667	99.1%
Youth	FY19/20	227	9.3	8.4	17.6	226	99.6%
	20/21-Q1	40	8.3	6.7	15.3	40	100.0%
	20/21-Q2	58	7.9	7.8	14.9	58	100.0%
	20/21-Q3	47	9.5	9.7	20.0	47	100.0%
	20/21-Q4	67	9.4	9.1	16.9	67	100.0%
	FY20/21	212	8.8	8.9	16.5	212	100.0%
	21/22Q1	52	9.6	11.9	15.2	52	100.0%
	21/22Q2	73	11.5	9.7	19.1	72	98.6%
	21/22Q3	49	8.8	9.5	16.4	49	100.0%
	FY21/22 YTD	174	10.2	10.1	17.4	173	99.4%
Foster Youth	FY19/20	11	8.0	9.6	13.9	11	100.0%
	20/21-Q1	3	6.1	5.2	11.6	3	100.0%
	20/21-Q2	4	9.7	11.4	12.2	4	100.0%
	20/21-Q3	8	11.9	11.7	17.8	8	100.0%
	20/21-Q4	5	7.8	9.1	12.2	5	100.0%
	FY20/21	20	9.6	10.6	15.0	20	100.0%
	21/22Q1	4	8.6	10.5	13.1	4	100.0%
	21/22Q2	7	6.7	4.9	12.8	7	100.0%
	21/22Q3	9	5.4	3.8	11.3	9	100.0%
	FY21/22 YTD	20	6.5	6.2	13.7	20	100.0%

Measure 33-36b: Date from assignment start date to first appointment or service with a practitioner.

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 Days from Service Request for Urgent Appointment to Actual Encounter	Median Days from Service Request for Urgent Appointment to Actual Encounter	Count of Urgent Encounters in 2 Days or Less of First Request	Percent of Urgent Encounters in 2 Days or Less of First Request (Section II, 4b)
All Clients	FY19/20	8,143	0.0	0.0	8143	100.0%
	20/21-Q1	2,348	0.0	0.0	2348	100.0%
	20/21-Q2	1,994	0.0	0.0	1994	100.0%
	20/21-Q3	2,238	0.0	0.0	2237	99.96%
	20/21-Q4	2,315	0.0	0.0	2315	100.0%
	FY20/21	8,895	0.0	0.0	8894	99.99%
	21/22Q1	2,290	0.0	0.0	2290	100.0%
	21/22Q2	2,268	0.0	0.0	2268	100.0%
	21/22Q3	2,298	0.0	0.0	2298	100.0%
	FY21/22 YTD	6,856	0.0	0.0	6856	100.0%
Adults	FY19/20	6,928	0.0	0.0	6928	100.0%
	20/21-Q1	2,059	0.0	0.0	2059	100.0%
	20/21-Q2	1,686	0.0	0.0	1686	100.0%
	20/21-Q3	1,875	0.0	0.0	1874	99.9%
	20/21-Q4	1,887	0.0	0.0	1887	100.0%
	FY20/21	7,507	0.0	0.0	7506	99.99%
	21/22Q1	1,885	0.0	0.0	1885	100.0%
	21/22Q2	1,707	0.0	0.0	1707	100.0%
	21/22Q3	1,821	0.0	0.0	1821	100.0%
	FY21/22 YTD	4,103	0.0	0.0	4103	100.0%
Youth	FY19/20	1,215	0.0	0.0	1215	100.0%
	20/21-Q1	289	0.0	0.0	289	100.0%
	20/21-Q2	308	0.0	0.0	308	100.0%
	20/21-Q3	363	0.0	0.0	363	100.0%
	20/21-Q4	428	0.0	0.0	428	100.0%
	FY20/21	1,388	0.0	0.0	1388	100.0%
	21/22Q1	405	0.0	0.0	405	100.0%
	21/22Q2	561	0.0	0.0	561	100.0%
	21/22Q3	477	0.0	0.0	477	100.0%
	FY21/22 YTD	1,443	0.0	0.0	1443	100.0%
Foster Youth	FY19/20	66	0.0	0.0	66	100.0%
	20/21-Q1	36	0.0	0.0	36	100.0%
	20/21-Q2	34	0.0	0.0	34	100.0%
	20/21-Q3	64	0.0	0.0	64	100.0%
	20/21-Q4	54	0.0	0.0	54	100.0%
	FY20/21	188	0.0	0.0	188	100.0%
	21/22Q1	58	0.0	0.0	58	100.0%
	21/22Q2	90	0.0	0.0	90	100.0%
	21/22Q3	121	0.0	0.0	121	100.0%
	FY21/22 YTD	269	0.0	0.0	269	100.0%