Shasta County Mental Health Plan
Quality Improvement Work Plan
Fiscal Year 2021-2022

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Quality Improvement Program Overview

A. Quality Improvement Program Characteristics

In accordance with the California Code of Regulations requirements in Title 9, Section 1810.440 and in accordance with the terms of the contract with the California Department of Health Care Services (DHCS), Shasta County Health and Human Services Agency (HHSA) through its Mental Health Plan (MHP) has established a Quality Improvement (QI) Program and develops an Annual Quality Improvement Work Plan (QIWP) which describes the quality improvement activities, goals, and objectives for the MHP.

The purpose of the QIWP is to provide up-to-date information that can be utilized by internal and external stakeholders as a resource and practical tool for informed decision making and planning. It includes QI projects, activities, and processes as required by the MHP contract with DHCS.

It is the goal of Shasta County HHSA to build a structure that ensures overall quality of services. This goal is accomplished by realistic and effective QI activities and data-driven decision making, collaboration amongst staff, including consumers and family members, and utilization of technology for data and analysis. Through data collection and analysis, significant trends are identified and policy and system-level changes are implemented, when appropriate.

Additionally, Shasta County HHSA strives to follow our Vision, Mission and Values, as follows:

Our Vision:

Healthy people in thriving and safe communities.

Our Mission:

To engage individuals, families, and communities to protect and improve health and wellbeing.

Our Values:

Collaboration: Working together to achieve meaningful results
Adaptability: Embracing change
Respect: Honoring and serving others
Excellence: Providing high-quality service to our customers and community

B. Quality Improvement Program Components

The QI Coordinator is responsible for facilitating Quality Improvement Committee (QIC) meetings and ensuring participants receive up-to-date information.

The QIC is responsible for monitoring the MHP effectiveness. This involves review and evaluation of Quality Management (QM) and QI activities, auditing, tracking, and monitoring, communication of findings, implementation of needed actions, ensuring follow-up for QM program processes, and recommending policy or procedural changes related to these activities.

The QIC monitors:

- 24/7 Crisis Line Response
- Accessibility to Services
- Assessments of Beneficiary and Provider Satisfaction
- Clinical Documentation and Chart Review
- Credentialing Process/Monitoring
- Cultural Competency Activities
- Notices of Adverse Beneficiary Determinations
- Performance Improvement Projects
- Practice Guidelines
- Resolution of Grievances, Appeals and Fair Hearings
- Resolution of Provider Appeals
- Training
- Utilization Management/Review

The QIC is comprised of representatives from Adult and Children's Services; Mental Health Services Act (MHSA) Advisory Committee; Compliance and Quality Improvement; Utilization Review and Quality Assurance; Fiscal; Business Office; Outcomes, Planning & Evaluation (OPE); Patients' Rights; contracted providers and consumers and family members.

It is the goal of the QIC to build a structure that ensures the overall quality of services, including detecting both underutilization of services and overutilization of services. This is accomplished by realistic and effective quality improvement activities; data-driven decision making; collaboration

amongst staff, including consumers and family member participants; and utilization of technology for data analysis. Executive management and program leadership must be present to ensure that analytical findings are used to establish and maintain the overall quality of the service delivery system and organizational operations.

The QIC meets monthly to monitor the status of the above items and make recommendations for improvement. Meeting reminders, information, and minutes are sent in advance and are also available on the HHSA share drive. These minutes reflect all activities, reports and decisions made by the QIC. The QIC ensures that client confidentiality is protected during meetings, in minutes and all other communications related to QIC activities.

Each participant is responsible for communicating QIC activities, decisions, policy or procedural changes to their program areas, and reporting back to the QIC on action items, questions, and/or areas of concern. To ensure that ongoing communication and progress is made to improve service quality, the QIC defines goals and objectives on an annual basis that may be directed toward improvement in any area of operation providing specialty mental health services.

C. Quality Improvement Committees and Sub Committees

The QI Work Plan is evaluated and updated annually by the QI Coordinator, QIC, and MHP Management Team. The QI Coordinator is responsible for finalization and submission of the QI Work Plan but will rely on the input and subject matter expertise of program and other work groups as needed to ensure an appropriate plan is written. In addition, QIC will collaborate with other stakeholders, work groups, and committees including but not limited to:

- MHP Cultural Competency Committee (CCC)
- Compliance Committee
- Medical Staff Meetings
- Mental Health Alcohol and Drug Programs Board
- MHP Community Education Committee
- MHP & Public Guardian Placement Meetings
- MHP Clinical Care Meetings
- MHP Electronic Health Records (EHR)

- MHP Management Team
- MHSA Advisory Committee
- Organizational Provider Meetings
- Performance Improvement Process Committees
- Performance Improvement Project Workgroup
- Shasta County Continuum of Care
- Suicide Prevention Workgroup
- Utilization Review Committee

Quality Improvement Program Components

A. Evaluation of Overall Effectiveness

An evaluation of the overall effectiveness of the QI program is completed routinely, as well annually.

QI activities have accomplished the following:

- Contributed to improving clinical care
- Contributed to timely access to services
- Contributed to improving client services
- QI activities have been completed or are in process
- Incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services

B. QIC Meetings

The QIC meetings may include, but are not limited to, the following agenda items:

- Review reports to help identify trends in client care, timeliness of access, timeliness of medication treatment plan submissions, services, and trends related to the utilization review and authorization functions
- Review and evaluate summary results of QI activities, including progress on the development and implementation of the two (2) Performance Improvement Projects (PIP)
- Review data from Access Logs showing responsiveness of the 24-hour access line

- Assess client satisfaction surveys results for assuring access, quality, and outcomes
- Review any issues related to grievances and/or appeals: the QIC reviews appropriateness of the Shasta County MHP response and significant trends that may influence policy- or program-level actions, including personnel actions
- Review any provider appeals, requests for State Fair Hearings, as well as review results of such hearings
- Review cultural competency issues or concerns
- Review HIPAA compliance issues or concerns
- Monitor issues over time and make certain recommended activities are implemented, completing the QI feedback loop

C. Performance Improvement Plan (PIP)

A PIP is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The CMS External Quality Review protocol mandates that the assigned External Quality Review Organization (EQRO) validate one clinical and one non-clinical PIP for each MHP.

As a part of the EQRO requirements and mandated by the CCR, Title 42, the QIC is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. To be responsive and transformative, Shasta County MHP will continue its work on PIP's focused on:

1. Clinical PIP (Applied Behavioral Analysis)

Shasta County's MHP Children's Services Branch will be implementing Applied Behavioral Analysis (ABA) in youth diagnosed with depression and anxiety to decrease risk behaviors and improve treatment efficacy. The Children's mental health team reviewed outcomes of Child and Adolescent Needs and Strengths (CANS) data from fiscal year 2019 to 2020. The data around anxious behaviors lead the team to explore mental health treatment methods to decrease anxious behaviors. Literature review demonstrates that impulsivity, negative self-talk, and trauma have been linked to increased symptoms of anxiety and risk of suicide behavior.

As a result, the team looked for approaches that would help improve treatment results. The team examined the topic of Applied Behavioral Analysis, an intervention aimed at teaching desired behaviors or response by using positive reinforcement, as an intervention to improve functioning for children and youth experiencing anxiety symptoms.

2. Non-Clinical PIP (Outcome Measures Tool)

Shasta County's MHP Adult's Services Branch will be implementing the use of Milestones of Recovery Screening (MORS) combined with Determinants of Care Assessments to improve accuracy of appropriate level of care placement as evidenced by increased engagement rates and decreased hospitalization rates by the end of this two-year study. Upon working with the Outpatient Clinic, the discovery was made that there are several clients that have not moved up or down within our continuum of care.

Currently, the MORS tool is not effective as a tool and does not inform treatment needs. This PIP will allow us to ensure we are referring our clients to the appropriate level of care if it be within our own programs or outside to Lower Level of Care (LLOC). The Milestones of Recovery Levels of Service (Recovery Based Spectrum of Care) which we shall refer to as MORS 2 will allow us to identify level of service/services needed, inform treatment, and measure outcomes monthly.

D. Inclusion of Cultural and Linguistic Competency in QI Activities

The Shasta County MHP recognizes and incorporates the value of racial, ethnic, cultural, and linguistic diversity into the fabric of our planning and development of processes while maintaining an active MHP CCC.

The CCC is co-chaired by the MHP's Quality Improvement Coordinator, allowing for an open line of communication between the CCC and the QIC. This communication flow allows for a broad representation of ideas and concerns throughout the MHP and promotes the adoption of the CCC's objectives into QI activities.

Data Collection

A. Data Collection Sources and Types

Shasta County utilizes data from various sources as part of the decision-making process including, but not limited to, the following data sources and types:

a. EHR reports
b. Treatment Authorization Requests (TAR) and Inpatient Logs
c. Client Grievance/Appeals Logs
d. Change of Provider Logs
e. Special reports/findings from DHCS or studies in response to contract requirements
f. EQRO Review results
g. Triennial Medi-Cal Audit results
h. Utilization of Services
i. Test Call Logs
j. Compliance Log
k. Urgent Care Data Database

Shasta County's MHP utilizes EHRs to obtain standardize reports including but not limited to Server Credentials Report, Client Roster Report, Client Services Listing, Assessment and Treatment Plans Listing, Assessment Measures Report, and the Scheduled Services Report. We use these standardized reports to analyze and track timeliness measures, i.e., Client Services Information (CSI) measures and quality of care measure, and outcome measures. These reports are reviewed with a workgroup within the QIC where any trends can be identified and brought to the QIC committee for discussion. Deficiencies are reviewed to determine new policy changes that may need to be adopted and implemented to improve timely access, MHP effectiveness, and outcome measures.

Changes to data tracking policies are reviewed by the respected department heads and feedback is provided at QIC subcommittee meetings. Upon implementation, efficacy, and effectiveness of changes are discussed at the QIC meetings and reviewed as needed. Minutes and documentation of these activities are kept.

Quality Improvement Activities Goals and Data

The following goals and objectives are based upon the DHCS Managed Care contract requirements for QI Work Plans and Title 9 requirements in the areas outlined below.

A. Service Delivery – Capacity & 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	Reporting Frequency	Responsible for Information
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.	Annually	OPE

Goal 2: *Maintain adequate capacity for timely delivery of routine and urgent specialty mental health services.*

Objective	Reporting Frequency	Responsible for Information
Objective 2.a: Track and monitor EQRO timeliness measurement. Meet or exceed identified goals in 34 of the 36 tracked data points (94.4%). See Attachment A.	Quarterly	OPE

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	Reporting Frequency	Responsible for Information
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	Quarterly	OPE

services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.		
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.	Quarterly	OPE
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.	Quarterly	OPE
Objective 3.d: Maintain psychiatric inpatient re-hospitalization within 30 days at 12.8% or less for Adult beneficiaries.	Quarterly	OPE

Objective 3.e: Maintain psychiatric inpatient re-hospitalization within 30 days at 12.2% or less for Youth beneficiaries.	Quarterly	OPE
Objective 3.f: Maintain psychiatric inpatient re-hospitalization within 30 days at 0.0% or less for Foster Care youth beneficiaries.	Quarterly	OPE
Objective 3.g: Maintain psychiatric inpatient re-hospitalization within 90 days at 22.4% or less for Adult beneficiaries.	Quarterly	OPE
Objective 3.h: Maintain psychiatric inpatient re-hospitalization within 90 days at 19.8% or less for Youth beneficiaries.	Quarterly	OPE
Objective 3.i: Maintain psychiatric inpatient re-hospitalization within 90 days at 27.0% or less for Foster Care youth beneficiaries.	Quarterly	OPE

Goal 4: *Ensure access to after-hours care and the effectiveness of the 24/7 toll free number.*

Objective	Reporting Frequency	Responsible for Information
Objective 4.a: 90% of business-hours test calls will have all necessary elements logged in Access to Services Journal (ASJ).	Quarterly	Compliance and Quality Improvement
Objective 4.b: 90% of business-hours test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter successfully engages with the caller.	Quarterly	Compliance and Quality Improvement
Objective 4.c: 90% of after-hours test calls will have all necessary elements logged in Access to Services Journal (ASJ).	Quarterly	Compliance and Quality Improvement
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.	Quarterly	Compliance and Quality Improvement

B. Monitor Beneficiary Satisfaction

Goal 5: *Conduct activities to assess beneficiary/family satisfaction.*

Objective	Reporting Frequency	Responsible for Information
Objective 5.a: 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 and family members, organizational providers and Shasta County direct care, supervisory and management staff.	Semi-Annually	Compliance/ Quality Improvement

C. Safety and Effectiveness of Practices

Goal 6: *Ensure clinical practices are safe, effective, and support wellness and recovery.*

Objective	Reporting Frequency	Responsible for Information
Objective 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).	Annually	Utilization Review and Quality Assurance
Objective b: Review medication practices for safety and effectiveness.	Semi-Annually	Utilization Review and Quality Assurance

D. Provider Appeals

Goal 7: *Evaluate beneficiary grievances, appeal, fair hearings and change of provider requests for quality of care issues.*

Objective	Reporting Frequency	Responsible for Information
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.	Quarterly	Compliance and Quality Improvement

Goal 8: *Monitor Appeals for Timely Resolution*

Objective	Reporting Frequency	Responsible for Information
100% of appeals will be resolved within the timeframes specified by state and federal regulating agencies	Quarterly	Compliance and Quality Improvement

E. QIC Activities

Goal 9: *Strengthen the infrastructure and improve the practices and effectiveness of the Quality Improvement Program.*

Objective	Reporting Frequency	Responsible for Information
Objective a: The QI Committee will increase stakeholder involvement in the QI Committee activities, decisions, and oversight.	Semi-Annually	QIC Members
Objective 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.	Quarterly	QIC Members

F. Expanding Data Monitoring in FY21-22

Goal 10: *Implement mechanisms that will allow for easy capturing and reporting of data necessary to evaluate beneficiary services.*

Objective	Reporting Frequency	Responsible for Information
Objective a: Capture no-show rates for clinicians	Semi-Annually	OPE
Objective b: Capture no-show rates for psychiatric appointments	Semi-Annually	OPE
Objective c: Capture no-show rates for med appointments	Semi-Annually	OPE
Objective d: Report data from outcome tools (CANS/MORS2)	Semi-Annually	OPE
Objective e: HEDIS measures related to medication monitoring	Semi-Annually	OPE

Attachment A – EQRO 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).
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).
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 95% or higher for FY 2021 - 2022. FY 2019 - 2020 baseline was 99.6% 10 business days or less (526 of 528).

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).
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.
17): (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 **all** clients.
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.
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).
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
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.
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.