SYBH Quality Assessment and Performance Improvement Evaluation

Fiscal Year 22-23

Tammy Andersen

SUTTER-YUBA BEHAVIORAL HEALTH https://www.suttercounty.org/government/county-departments/health-and-human- services/sutter-yuba-behavioral-health/quality-improvement

Client Satisfaction Monitoring

Client satisfaction monitoring included several activities designed to help SYBH leadership detect consumer satisfaction with essential components such as services, treatment, customer service, and access. The client satisfaction monitoring system included a routine review of the client problem resolutions, the Consumer Perception Survey results, and Change of Provider Requests. In addition, the quality program created a framework to use benchmarks and targets to ensure client satisfaction is achieved and the monitoring system is effective.

Evaluation of FY 22/23:

FY 22/23 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 1: Ensure all timeliness standards are achieved for all complaints received through the problem-resolution process	The QA Staff Analyst to prepare an annual report for the July 2023 Quality Improvement (QIC) meeting to include in notable trends.	Completed: The FY 22/23 closed with a total of 45 total grievance cases for all categories. Of the 45 cases, 2 were past due. Our timeliness compliance rate is 93%. There were a total of 3 Appeals for all categories. All Appeal cases were resolved within the 30 day timeliness standard. In order to increase our timeliness standard to 100% this goal will remain in the FY 23/24 plan. See Tables 1-2. An annual report was prepared for the July 2023 QIC meeting that included notable trends. The most significant trend noted is the category of billing disputes represented 44% of all cases. The other types demonstrated no concerning patterns as the quality of care and customer service cases were low in numbers and had no common root cause. Trend analysis will remain a goal in the FY 23/24 QAPI.
	The QA Staff Analyst to monitor cases at risk of being out of compliance quarterly during October, January, April, and July.	Completed: Grievances and Appeals were monitored quarterly for cases being at risk of being out of compliance. During the reviews the investigators were contacted regarding any cases that were at risk of being out of compliance. The individuals conducting the investigation were made aware of the due date and strategies were developed to help resolve the grievances. Monitoring cases will remain a goal in the FY 23/24 QAPI.

Goal 2: Monitor Client Satisfaction through the semi-annual Consumer perception Survey	Collect the Findings and analyze the data upon release from State contracted entity overseeing the CPS surveys. • Meet or exceed 80% overall satisfaction rate. • Meet or exceed 80% satisfaction with access to language. • Meet or exceed 80% satisfaction with cultural sensitivity. • Meet or exceed 80% satisfaction with cultural sensitivity.	Completed: The CPS survey was administered during a week in May 2022 and the results were provided in February 2023 and analyzed. The overall satisfaction rate goal of 80% was met. 95% of families, 85.19% of youth, 81.43%of adults and 100% of older adults for a total of 86.92% of participants of the survey felt satisfaction with overall services. The satisfaction with access to language goal of 80% was met. 100% of families, 96%of youth, 79.45% of adults and 93.75% of older adults for a total of 87.68% of participants of the survey felt satisfaction with access. The overall satisfaction with cultural appropriateness goal of 80% was met. 100% of families, 92% of youth, 70.58% of adults and 100% of older adults for a total of 83% of participants of the survey felt satisfaction with cultural appropriateness of services. The overall satisfaction with access in preferred written language goal of 80% was met. 100% of families, youth, adults, and older adults agreed that they received access in their preferred written language. See Table 3 We have fallen short of our goal with adult access and adult cultural appropriateness the CPS results will be monitored and remain a goal in the FY 23/24 QAPI.
	Distribute/notify/share the results with all leadership and staff.	Completed: The results of the 2022 Consumer Perception Survey were shared during the Quality Improvement Committee to leadership. A powerpoint of the results was shared with all staff and the results were posted on the Sutter County website. Results were only shared once due to the frequency of the survey changing from twice a year to once a year. See Figures 1-4. Sharing results from the CPS will remain a goal in FY 23/24 QAPI.

Goal 3: Monitor consumer satisfaction through change of provider requests.	Quarterly analysis of change of provider requests. • Identify providers that represent 25% or more of total requests. • Trend analysis of reasons for requests of those representing 25% or more of all requests.	Completed: Change in provider requests were analyzed quarterly during the QIC meetings. For FY 22-23, There were no providers on the log that surpassed the minimum threshold of 25% of change of provider requests. Two providers were at 22% but the reasons for the provider change requests varied. See Figures 5-6. The two largest categories in the reasons cited for the request are needs not being addressed, representing 41% of the total requests. and client doesn't feel listed to represent 28% of request reasons making it the second-highest cause for the request. There were no concerning trends related to reasons. Clients who cited needs not being addressed and not feeling listened to, were re-assigned to another provider, as were clients who preferred a different gender and those who preferred not to have telecare. The medication concerns had a trend of clients being concerned about the medication they were prescribed. While QIC sheds light on the trends, prescribing practices are monitored through our Medication monitoring Committee, where expertise and analysis on these topics is more fitting, and the participants have proper qualifications. See Table 4.
	Results to be shared and trends/interventions developed around concerns or trends. • Annual results to be shared with QIC.	Completed The change in provider requests were reviewed quarterly during the QIC in order to analyze for trends and develop any necessary interventions to address concerns or trends in a timely manner. During the FY 22-23 year there were no concerns that needed to be addressed. The annual data was shared after the end of the fiscal year.
	Discuss goals not met to determine appropriate intervention.	For FY 23-24, we will continue to monitor the change of provider requests quarterly. We will continue to monitor those Providers that account for 25% or more of total change requests and have a trend analysis of reasons for the change requests made. Monitoring consumer satisfaction through change of provider requests will remain a goal in FY 23/24 QAPI.

Access and Timeliness

The Access and Timeliness monitoring system will be composed of activities that help SYBH leadership gauge and monitor for barriers people may face when seeking care. These components together help tell a story of our ability to meet our communities' behavioral health needs and demands. The activities include monitoring our 24/7 access line, cultural competence presence and training, timeliness to accessing service targets and monitoring, and watching the provider network to ensure it is adequate to meet the community needs.

Evaluation of FY 22/23:

FY 22/23 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 4: Improve the compliance rate of test call compliance	Institute one formal training for access line staff to take upon hire and annually after that. • 1 training developed, uploaded, and assigned in Relias. • Training adopted as part of onboarding for PES Staff.	Completed A training was developed, uploaded, and assigned annually to PES staff in Relias. The training is also provided to all test callers prior to making their test calls. The training was adopted as part of onboarding for new PES staff.
	Include PES Staff in test call rotation as a training mechanism. 12 test calls completed in FY 22-23	Completed: PES Staff were added to the test call rotation schedule beginning in December 2023. Twenty five test calls were completed in FY 22-23. Of the 25 test calls three were made in Spanish and one in Punjabi. There were no test calls made in Hmong. Sixteen calls were made during business hours and 9 were made. after hours. Nineteen of the calls made tested for Specialty Mental Health Services, 6 of them tested for urgent services and zero tested for Problem resolution.

	Report test call outcomes to PES leadership. • 4 quarterly reports to PES leadership.	Completed: A quarterly outcome report was shared at the QIC Meeting of which PES leadership attended. The quarterly outcome report was shared during the September 2022, January 2022, April 2023, and July 2023 QIC Meetings. There were also one occasion that a test call outcome needed to be addressed immediately. PES leadership was emailed the outcome of the test call so that it could be addressed with the PES team. This shall be a continued goal in the 23/24 QAPI.
	Report test call results to QIC. • Annual outcomes and analysis share with QIC.	Completed: The annual outcomes and analysis was shared with the QIC during the July 2023 QIC Meeting. Ninety-two (92%) of test calls met the verbal requirements and 60% met the written requirements. SYBH will continue to monitor the test calls and provide quarterly updates during the QIC meetings in FY 23/24 to monitor the verbal and written requirements. See Tables 5-7. Annual outcomes and analysis will continue to be share with QIC during FY23/24. This shall be a continued goal in the 23/24 QAPI.
Goal 5: Monitor the timeliness of access to services to ensure compliance with all timeliness measures.	Continue Development of the timeliness dashboard for routine timeliness monitoring of non-urgent services. • 1 new monitoring system for post-hospitalization follow-up appointments within 7 days to be aligned with State qualifiers and parameters. • 1 new monitoring system for post-hospitalization follow-up appointments within 30 days to be aligned with State qualifiers and parameters.	In-Progress: The timeliness dashboard continues in the development phase due to implementation of a new EHR in April 2023. A monitoring system for post-hospitalization follow-up appointments within 7 days was developed. Due to the new EHR that SYBH began using in April 2023 a new dashboard is being developed that will pull data from the old EHR and the new EHR. A monitoring system for post-hospitalization follow-up appointments within 30 days was developed. Due to the new EHR that SYBH began using in April 2023 a new dashboard is being developed that will pull data from the old EHR and the new EHR.

	• 1 developed system monitoring the number of hours between urgent requests and appointments.	A monitoring system for the number of hours between urgent requests and appointments was developed. Due to the new EHR that SYBH began using in April 2023 a new dashboard is being developed that will pull data from the old EHR and the new EHR. Development of the timeliness dashboard for routine timeliness monitoring of non-urgent services will continue as a goal for FY 23/24 QAPI
	Conduct root cause analysis for data entry and workflow issues related to all timeliness systems. • 1 root cause analysis of psychiatry data quality issues.	Completed A root cause analysis was conducted, and the analysis showed that staff were not aware of the service/form in the EHR that they need to complete when a client is being referred to our asks for medication services. Getting staff trained on how to use the form and a monitoring system will be developed in FY 23-24. It was also determined that Youth Services have an internal process to determine urgent cases and procedures in place to meet the timeliness measure of those cases, however adult services does not have a process for urgent cases. Developing an internal process for Adult Services will be added as a goal for FY 23-24 QAPI.
	Develop action plans as needed for timeliness measure not actively being monitored (urgent requests, psychiatry, post-hospitalization follow-up). • 1 action plan to address psychiatry data quality issues.	In-Progress An action plan was developed to train staff on completing the Access to Services – Meds form/service in the EHR. A workflow process and training for adult urgent services will be developed during FY 23/24 to ensure quality psychiatry timeliness data is available for monitoring. This shall be a continued goal in the 23/24 QAPI.
	Develop resources for accurate data entry for applicable staff to include guidance and definitions. • One resource developed for staff on accurate data entry.	Completed A training was developed as well as a workflow document and terms and definitions document that will help ensure staff are accurately entering timeliness data.

	Review timeliness dashboard to monitor for access and data quality issues at QIC and Dashboard D Development Meetings. • At least 6 meetings where timeliness monitoring and/or timeliness data quality are discussed. • 85% of clients being offered or receiving an assessment appointment 10 days from request to first appointment. • 80% of clients received their first treatment appointment within 60 days. • 85% of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service. • Elimination of youth outpatient waitlist. • Elimination of adult outpatient waitlist.	In-Progress The timeliness dashboard data were reviewed quarterly at the QIC. In April SYBH changed to a new EHR and due to the change, the timeliness data was not available to review for the last quarter of FY22-23. The dashboard is being updated so that the last quarter data from one EHR will combine with the data from the first three quarters. See Tables 8-10. July 2022 through April 2023 data was reviewed and 91.95% of clients were being offered or received an assessment appointment 10 days from request to first appointment. July 2022 through April 2023 data was reviewed and 77.47% of clients received a delivered service 10 days from request to first appointment. The data was not reviewed for having first treatment appointment within 60 days. Due to staff not completing the Access to Services – Meds form/service in the EHR the data was not reliable. Staff will be trained during FY 23-24. Youth outpatient waitlist still exists. Adult outpatient waitlist still exists. Monitoring the timeliness of access to services to ensure compliance with all timeliness measures will continue as a goal for FY 23-24 QAPI.
Goal 6: Monitor the provider network adequacy	Monitor the number of providers monthly. • 1 analysis of the anticipated needs shared with QIC.	Completed: SYBH began monitoring the number of providers monthly through the 274 form. Our network adequacy certification meets or exceeds the State-required ratios and standards. SYBH will continue to monitor the number of providers monthly.

	Develop a streamlined reporting system to support the transition to the 274 Project. • 1 system for accurate provider reporting to feed to the 274. • Participation in the 274 submissions by all target deadlines.	Completed The system for accurate provider reporting was created and has been in use since December 2022 and used to feed the 274. SYBH has been participating in the 274 submissions had has met all target deadlines. SYBH has been in production since January 2023 and submits a file to DHSC on a monthly basis and will continue to submit the 274 on a monthly basis throughout FY 23/24
	Use the annual Meds anticipated needs data to inform the number of providers that must be maintained throughout the year.	Based on the estimated needs data used to inform the number of providers that must be maintained, the SYBH provider network exceeds the State-required ratios. See Tables 11-12. SYBH will continue to monitor the anticipated needs data to inform the number of providers that must be maintained during FY 23-24 and will remain a QAPI goal.
Goal 7: Ensure a culturally competent workforce	Monitor penetration rates for trends. • Annual analysis of penetration rates share with both QIC and CCC.	Completed An annual analysis of penetration rates were conducted in in January 2023. The information was shared with the QIC and the CCC. There continues to be a decrease in the foster care penetration rate, as well as the Hispanic/Latino penetration rate and a small decrease in the API penetration rate. See Figures 7-9. An annual analysis of penetration rates will continue as a goal in FY 23/24 QAPI.
	Conduct a study on the Foster Care penetration rate decrease to determine the root cause. • 1 root cause analysis of the Foster Care penetration rate drop. • 1 action plan to address the Foster Care penetration rate if applicable.	Not Started A root cause analysis has not been started and will remain a goal in the FY 23-24 QAPI plan. An action plan has not been developed yet and this will remain a goal in the FY 23-24 QAPI plan.

	Increase outreach to the Hispanic/Latino and API population. • Increase our penetration rates for the Latino/Hispanic and API populations by 1%.	On-going Outreach to the Hispanic/Latino and API population is on-going through the Prevention Early Intervention (PEI) program and the Latino Outreach Community Center. This shall be a continued goal in the 23/24 QAPI. The most current penetration rate data from 2021 continues to show a decrease for the Latino/Hispanic population from 2.71% to 2.36% and is lower than both the State and Small County average. The API penetration rate data from 2021 also continues to show a decrease, from 1.80% to 1.73% it is lower than the State Average and higher than the Small County average. This will remain a goal in FY 23/24 QAPI.

Utilization and Care Quality

Utilization and care quality monitoring activities encapsulate indicators related to authorizations for routine and hospitalization services and care quality HEDIS measures related to medication and readmission rates. Utilization monitoring utilizing various indicators of our authorization system allows us to look for trends of over and under-utilization while also monitoring for inconsistencies or trends that may impact care quality. In addition, implementing measures aligning with HEDIS measurement monitoring standards allows us to monitor care quality issues.

Evaluation of FY22/23 Goals:

FY 22/23 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 8: Ensure compliance with NOABD issuance.	Conduct a process review of NOABD issuance and tracking system. • 1 system analysis	Completed An audit was conducted in October 2022 to serve as the baseline for compliance. The audit period was 1.1.22-8.31.22.
	Identify process and knowledge gaps in the system. • 1 implemented action plan.	Completed A planning meeting was held on 11.29.22 to outline the issues identified and determine the action plan to address them. A plan to develop and administer a training to address each element and the requirements was the approach decided.

	Reinstitute routine monitoring system in URC. • 1-2 URC Meetings that have reviewed NOABD issuance rates and compliance monitoring results.	In progress This tracking has yet to be routinely integrated into URC. This shall be a continued goal in the 23/24 QAPI.
	Develop formal training for staff on NOABD issuance. • 1 implemented mandatory staff training on NOABDs.	Completed A mandatory training was conducted for all applicable BH Staff on December 6th, 2022, and in Relias to be completed by the end of January 2023.
	Conduct sample audits to monitor compliance. • 1 sample audit system developed.	Completed A follow-up audit was conducted in April 2023 to reveal improvement in compliance but still some remaining gaps. Targeted trainings were conducted with the areas still out of compliance in May 2023. Overall-compliance has improved. It is recommended that measurable compliance rates be identified and set as goals and to continue routine audits along with instituting the routine monitoring in URC that is in progress to ensure compliance issues are readily identified.
Goal 9: Ensure consistency in the authorization system.	Develop a cohesive and effective monitoring system for all authorization types. • ICC • IHBS • TFC • TBS • SARS • TARS	In progress Our tracking system has been re-instituted to share data of the authorizations across the system. Some of the primary data sources are needing to be redeveloped in order to include all the relevant data once previously shared. Though the monitoring system has been re-instituted, this shall remain a goal in order to sustain cohesion and consistent monitoring to include data for all authorization types.
	Create Benchmark and standards for each authorization type to monitor against and share the findings at URC. • At least 2 meetings of results being share with URC.	In progress-This data was shared at 1 URC meeting. Overall, It is recommended It is recommended to continue to work on this goal and set some new measurable goals around reporting be included in the 23/24 QAPI.

Goal 10: Ensure compliance with concurrent review standards.	Learn how to run reports from the system being used by the contractor conducting concurrent review. • 2 reports developed from Atrezzo.	Completed: Five reports are now available in Kepro's portal (Atrezzo): "Summary of Days Report": to analyze approval/denial rates of out-of-house facilities. "Readmission Report": details days before patient readmission. Can filter date range as needed for identified benchmarks. "NOABD Provider Report": lists NOABDs sent; includes pertinent information to ensure regulatory compliance, such as determination date and date sent. "Census Report": patient census of all beneficiaries placed out-of-house who have a submitted case in Atrezzo. Allows for county live-monitoring of case submissions and status. "Billing/Admin Report": provides a summary of patient time in treatment (e.g., admission and discharge dates, approved vs denied days, TAR control number, who TAR was sent to, etc.).
	Analyze the results and share finding with URC. • At least 2 meetings of results being share with URC.	Completed: URC regularly reviews aspects of concurrent review. Areas of focus include: SYBH PHF total denied and extended days, PHF denied/extended days by reason. The SYBH medical director provides final approval of all recommended denials to ensure compliance with Title 9. PHI is not shared during URC in order to protect client privacy and to avoid case consultation; rather, numeric data and overall trends are discussed (total patient days, total admissions and discharges, average length of stay, etc.) Goal: URC has recently begun to further refine data to differentiate youth vs adults placed out-of-house, comparing TAR submissions per month, and differentiating this from actual number of patients hospitalized per month. URC plans to make this a

		consistent practice. Furthermore, it has been recently requested by participants that SYBH data is similar to that of our contracted provider(s) in order to best analyze utilization of services across the board.
Goal 11: Implement a system for **monitoring and documenting the review of the indicators from California Child Welfare Indicators Project**	Implement a monitoring system for Children and Adolescents using AB1229 HEDIS Measures. • 1 monitoring system for follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications. • 1 monitoring system for the use of multiple concurrent psychotropic medications for children and adolescents. • 1 monitoring system for metabolic monitoring for children and adolescents on antipsychotics. • 1 monitoring system for the use of first-line psychosocial care for children and adolescents on antipsychotics.	In progress: There has been a delay in the creation of the monitoring dashboard due to the change to a new EHR. A tracking spreadsheet for follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications was created. However, the monitoring dashboard is still being developed. A tracking spreadsheet for the use of multiple concurrent psychotropic medications was created. However, the monitoring dashboard is still being developed. A tracking spreadsheet for metabolic monitoring was created. However, the monitoring dashboard is still being developed. A tracking spreadsheet for the use of first-line psychosocial care was created. However, the monitoring dashboard is still being developed. This will remain a goal in the 23/24 QAPI.
Goal 12: Monitor Hospital readmission rates.	Identify tracking issues. • 1 plan to address tracking issues.	In progress The plan to address tracking issues is to develop a dashboard that tracks hospital readmission rates from the EHR. Due to the change to a new EHR the dashboard is still in the development stage. This shall remain a goal in the 23/24 QAPI.
	Align benchmarks with State standards. • Readmission rate within 7 days post-hospitalization. • Readmission rates within 30 days post-hospitalization.	In progress The dashboard is being developed to track readmission rates within 7 days post-hospitalization. The dashboard is being developed to track readmission rates within 30 days post-hospitalization. This shall remain a goal in the 23/24 QAPI.

	Share readmission rates with URC routinely.	No completed Once the readmission dashboard has been developed the readmission rates will be shared at the URC meetings. See Figure 10. This shall remain a goal in the 23/24 QAPI

Performance Improvement Projects

Evaluation of FY22/23 Goals:

FY 22/23 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 13: Implement Clinical PIP to improve the rate of Post-Psychiatric Hospitalization follow-up within 7 days.	Increase the rates of follow-up services within 7 days to post-psychiatric hospitalized clients from 46% to 57%. • Post-psychiatric follow-up services within 7 days rate.	In progress The 2021 rate of follow-up services within 7 days to post-psychiatric hospitalized clients was 43.16% and the rates for July 2022 through March 2023 had decreased to 36.14% This shall remain a goal in the 23/24 QAPI.
	Conduct root cause analysis to identify contributing factors. • 1 root cause analysis.	Completed An analysis was done, and it found that discharge documentation and P&P language indicated that follow-up appointments needed to be made within 21 days post psychiatric hospitalization. The documentation was updated to reflect the 7-day standard and staff were informed that the target standard was to schedule follow-up appointment within 7 days. SYBH is also working on developing a spreadsheet to track reminder calls for the follow-up appointment and is implementing 3 reminders prior to the appointment unless the appointment falls within 3 days post-psychiatric hospitalization. See Figure 11-12. This shall remain a goal in the 23/24 QAPI.
	Plan interventions and implement. • 1 list of CPT and HCPCS codes that qualify as follow-up.	In progress A list of CPT and HCPCS codes that qualify as follow-up was developed and shared with staff scheduling the follow-up appointments and Kingsview, who is developing the dashboard to track the follow-up appointments.

	• 1 developed PIP write-up. including baseline data.	The PIP write-up, including baseline data was begun and will be completed once the dashboard has been completed and an analysis completed regarding the results after all of the interventions have been implemented. This shall remain a goal in the 23/24 QAPI.
Goal 14: Implement non-clinical PIP to improve communication with families regarding hospital transfer and step-down services.	Survey to develop baseline data. • 1 pre-survey to look further into issues identified by the consumer focus group.	Not started: The implementation of the non-clinical PIP to improve the communication with families regarding hospital transfer and step-down service has not been implemented. SYBH was able to substitute the BHQIP PIP follow up after ED visit for mental illness as the non-clinical PIP. SYBH will still be pursuing improving communication with families regarding hospital transfer and step-down services by gathering additional data from beneficiaries and family members of beneficiaries regarding their experiences. Once additional data has been collected SYBH will determine if the current communication practices are sufficient, or improvement is warranted. This shall remain a goal in the 23/24 QAPI.
	Conduct root cause analysis. • 1 developed PIP write-up including baseline data.	Not started Baseline data will need to be collected before the root cause can be analyzed and the PIP writeup completed. This shall remain a goal in the 23/24 QAPI.
	Plan interventions.	Not started: No interventions have been developed at this time as baseline data still needs to be collected and analyzed. This shall remain a goal in the 23/24 QAPI.
	Conduct follow-up surveys to evaluate improvement efforts. • 1 post survey after interventions have been implemented.	Not started A follow-up survey will be collected if the baseline data and analysis finds interventions to be warranted. This shall remain a goal in the 23/24 QAPI.

Figures and Tables

Table 1: Grievance Timeliness Data

Grievance Timeliness	Logged (1 business day)	Acknowledgment Letter (5 business days)	Resolution letter (90 days)	Maximum duration beyond due date	Total Grievances	Inpatient	Outpatient
FY 21/22	95%	90%	90%	29 days	20		
FY 22/23	100%	100%	93%	49 days	45	25 (7 individuals)	16
Appeal Timeliness	Logged (1 business day)	Acknowledgment Letter (5 business days)	Resolution Letter (30 business days)	Maximum duration beyond due date	Total Appeals		
FY 21/22	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FY 22/23	100%	100%	100%	0	3	0	3

Table 2: Grievance Category Analysis

Grievance Categories	FY 21/22	FY 22/23	FY 22/23
Financial	15	11	24%
Quality of Care	5	5	11%
Staff Behavior Concerns	4	7	15%
Patients' Rights Concern	0	16	44%
Medication Concern	0	8	20%
Confidentiality	0	1	2%
Access	0	2	4%
Discrimination	0	1	2%
Other	0	5	11%

Appeal Categories			
Decrease in Services	0	2	66%
Termination of Services	0	1	33%

Figure 1: Consumer Perception Survey Family Data

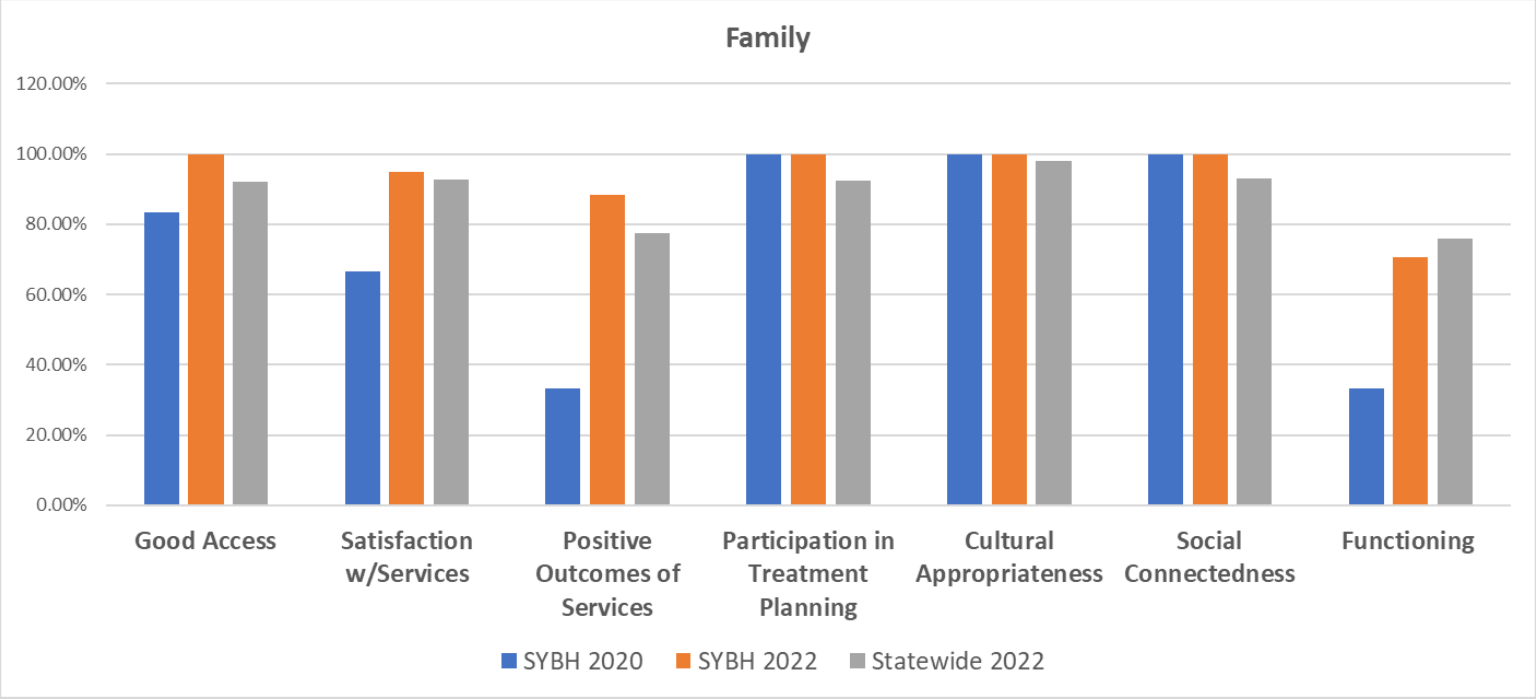


Figure 2: Consumer Perception Youth Data

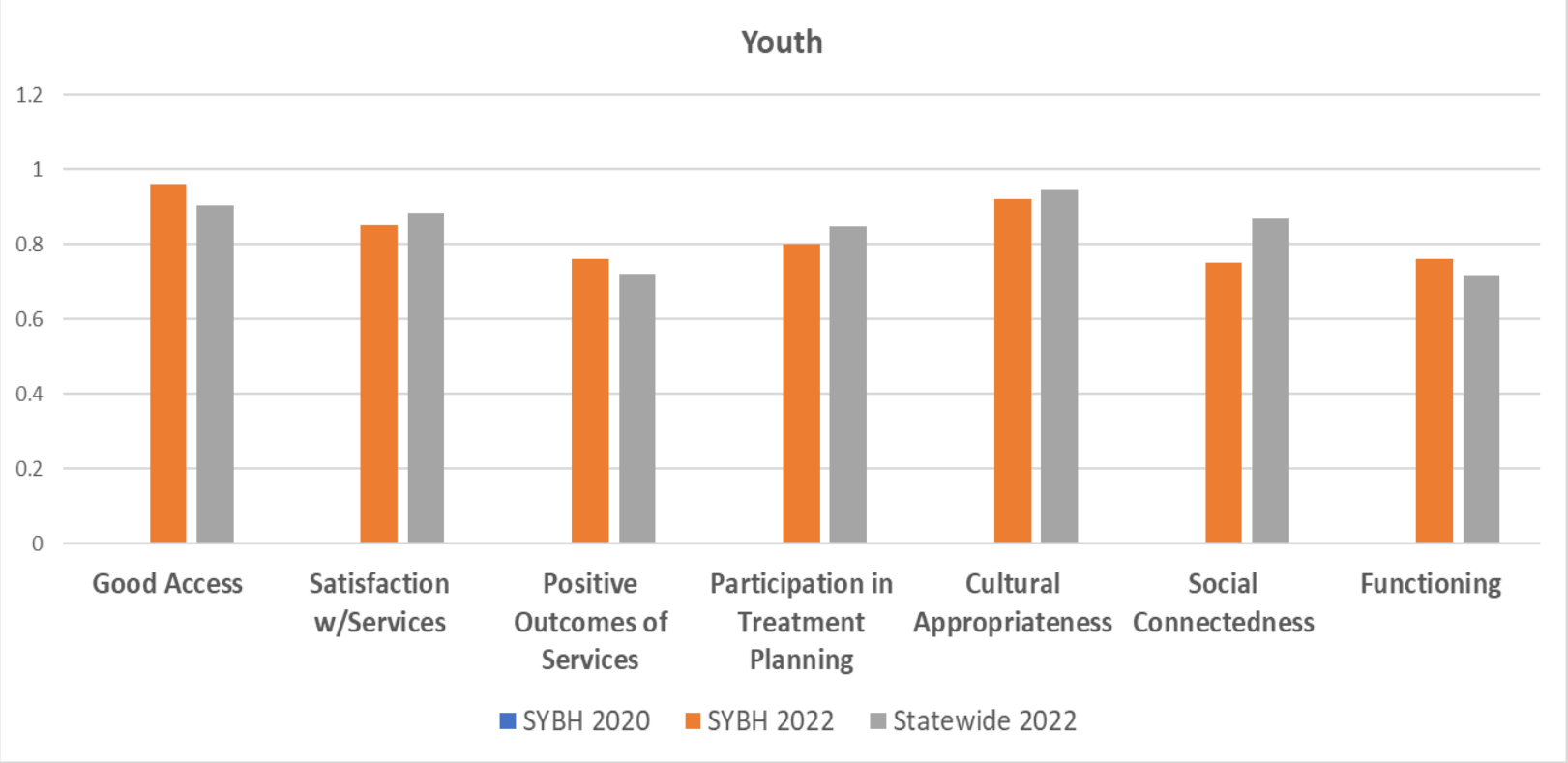


Figure 3: Consumer Perception Survey

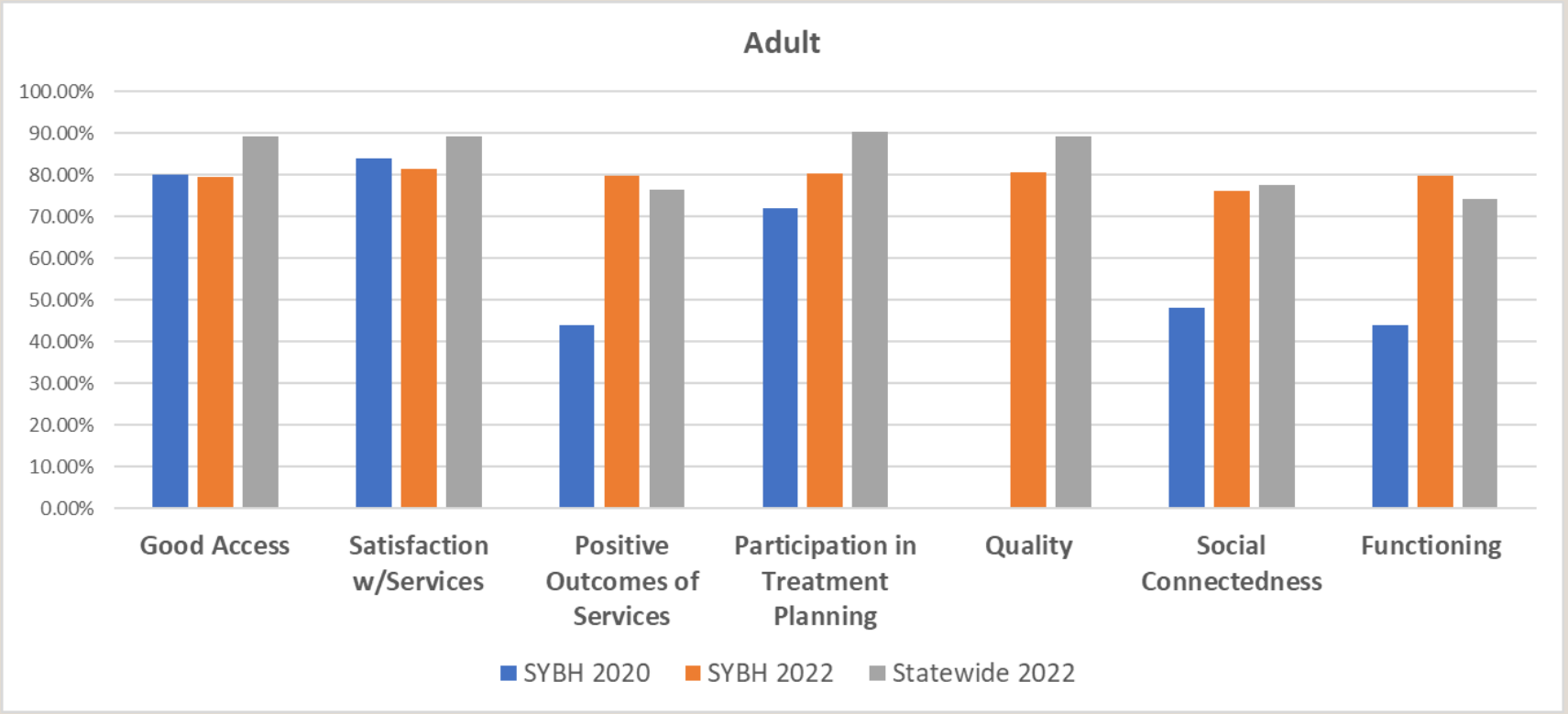


Figure 4: Consumer Perception Survey Older Adult Data

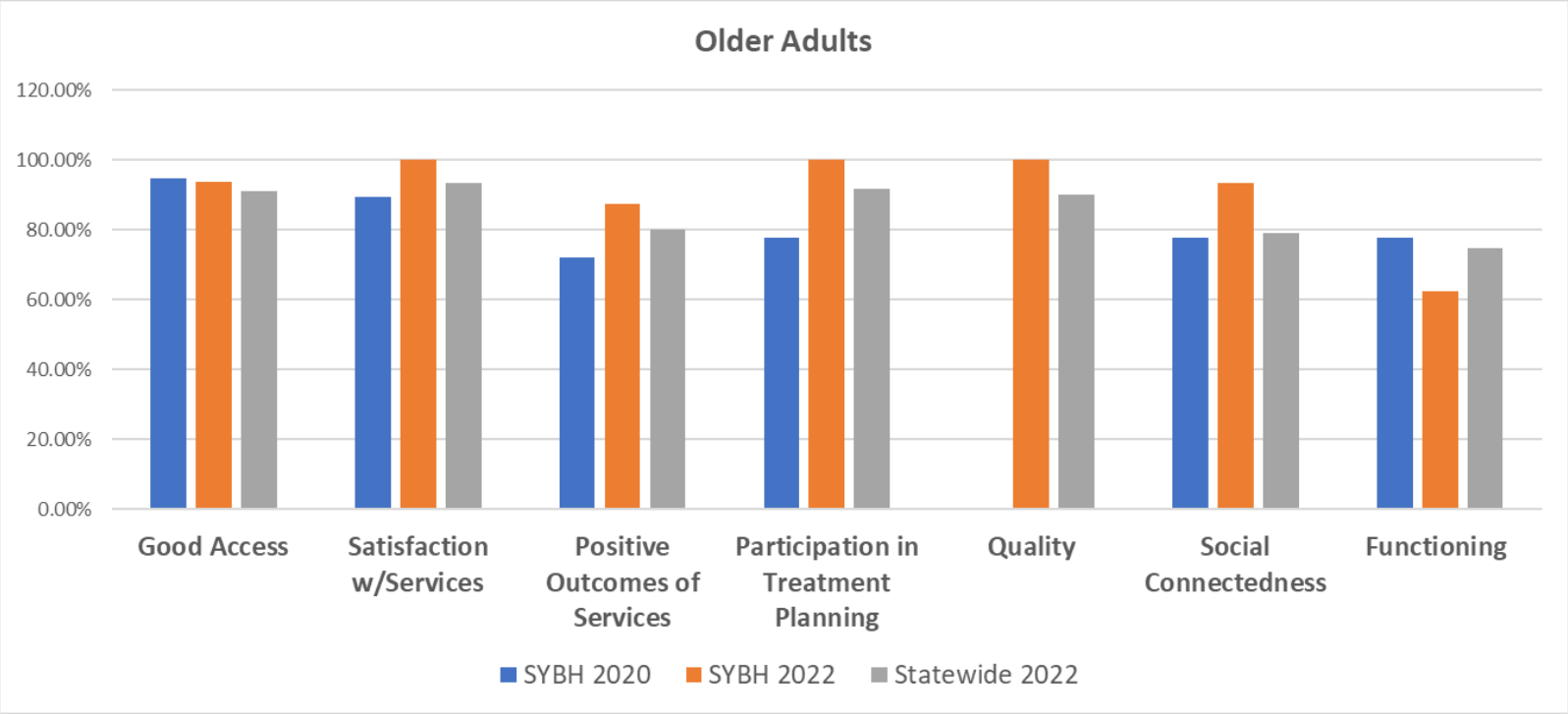


Table 3: Consumer Perception Survey QUAPI Goals Review

QUAPI GOALS	FAMILY	YOUTH	ADULTS	OLDER ADULTS
MEET OR EXCEED 80% OVERALL SATISFACTION RATE	95% EXCEED	85.19% EXCEED	81.43% EXCEED	100% EXCEED
MEET OR EXCEED 80% SATISFACTION WITH ACCESS	100% EXCEED	96% EXCEED	79.45% NOT MET	93.75% EXCEED
MEET OR EXCEED 80% SATISFACTION WITH CULTURAL APPROPRIATENESS	100% EXCEED	92% EXCEED	70.58% NOT MET	100% EXCEED
MEET OR EXCEED 80% RECEIVED ACCESS IN PREFERRED WRITTEN LANGUAGE	100% EXCEED	100% Exceed	100% Exceed	100% Exceed

Figure 5: Provider change request

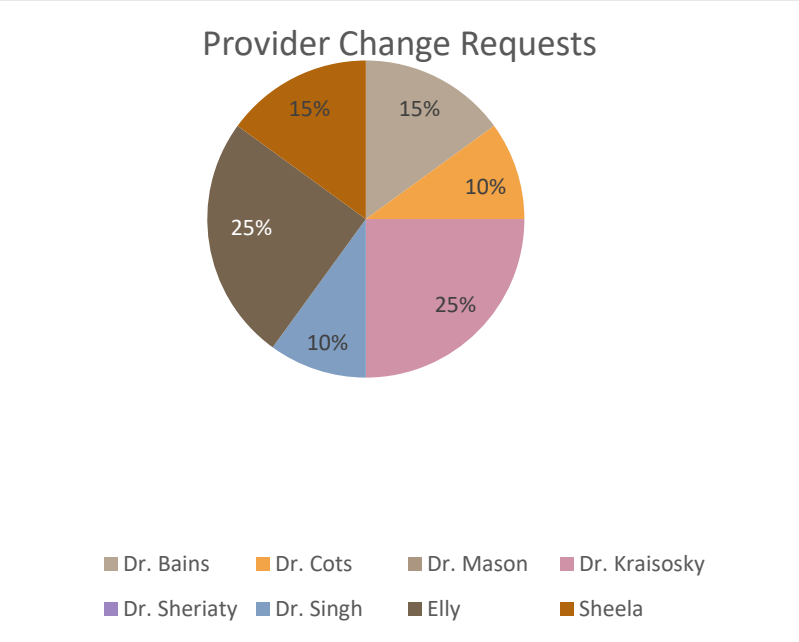


Table 4: Provider change request

Doctor	Frequency	Frequency Distribution
Dr. Bains	3	15%
Dr. Cots	2	10%
Dr. Mason	0	0%
Dr. Kraisosky	5	25%
Dr. Sheriaty	0	0%
Dr. Singh	2	10%
Elly Willerup	5	25%
Sheela Zachariah	3	15%

Figure 6: Change Reason by Provider

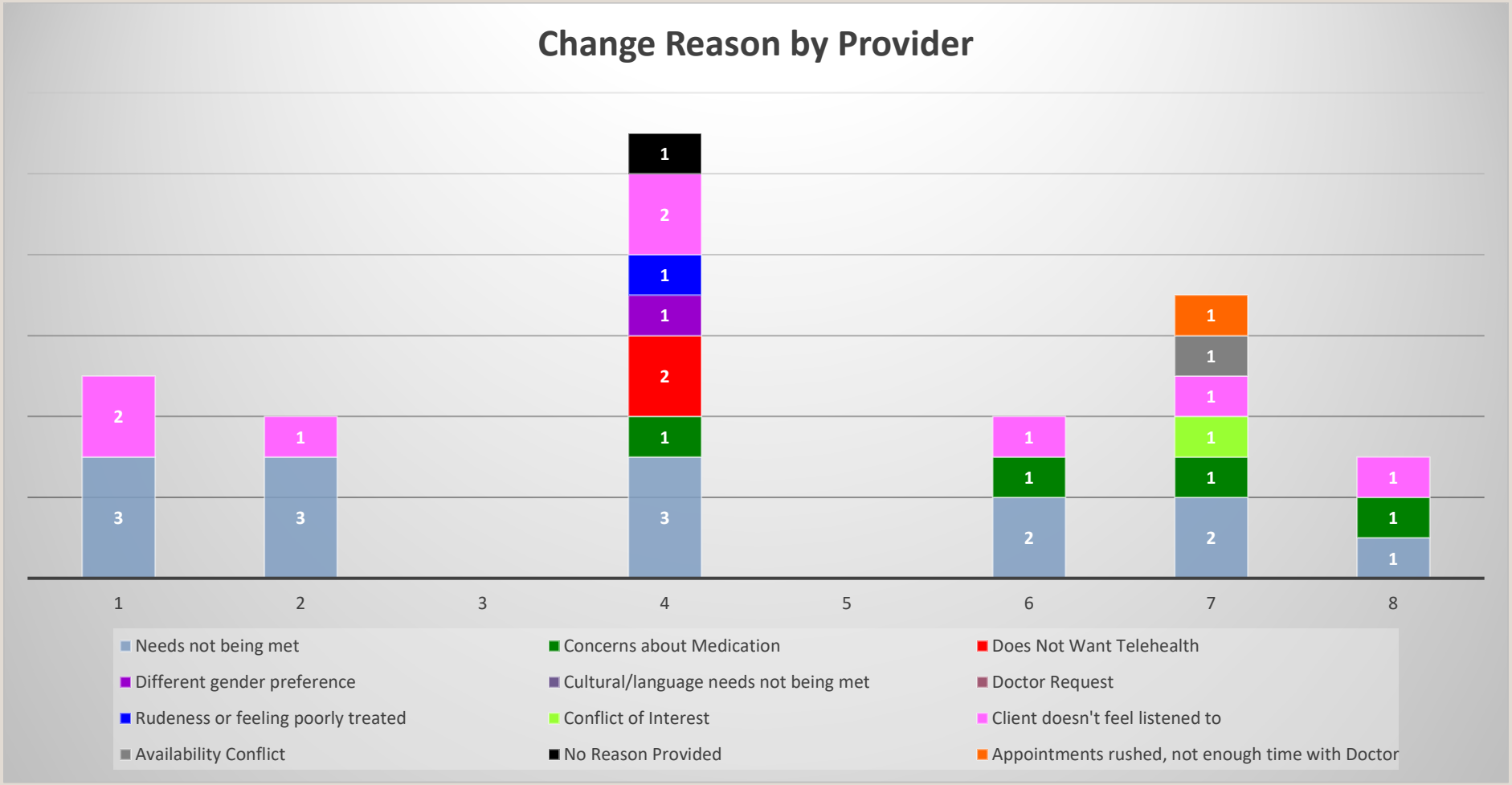


Table 5: Test Call Compliance Results

FY 22-23 Test Calls	Number of calls completed	Verbal Requirements met	Written Requirements met
Q1	2	100%	50%
Q2	4	100%	75%
Q3	9	100%	55%
Q4	10	80%	60%
Totals	25	92%	60%

Table 6: Test Call Verbal Requirements

FY 22-23 Test Calls	Language Capability	How to access SMH	Info. about services to treat urgent condition	How to use the problem resolution and fair hearing process.
Q1	1 Spanish	100%	100%	N/A
Q2	1 Punjabi	100%	100%	N/A
Q3	2 Spanish	100%	N/A	N/A
Q4	N/A	71%	100%	N/A
Totals	4	89%	100%	N/A

Table 7: Test Call Written Requirements

FY 22-23 Test Calls	Name of Beneficiary	Date of the Request	Initial Disposition
Q1	50%	50%	50%
Q2	75%	100%	100%
Q3	55.56%	55.56%	55.56%
Q4	60%	70%	70%
Totals	60%	68%	68%

Table 8: Timeliness to First Non-Urgent, Non Psychiatry Appointment

Timeliness to First Non-Urgent Appointment				
First Appointment Offered July 2022-April 2023				
	All Services	Adult Services	Children's Services	Foster Care
Count of first service request	1640	1185	455	13
Count of first offered appointments that meet the 10-business day standard	1508	1156	352	10
Percent of first offered appointments that meet the 10-business day standard	91.95%	97.55%	77.36%	77%

Table 9: Timeliness to First Non Urgent, Non Psychiatry Delivered Services

First Delivered Service - July 2022-April 2023				
	All Services	Adult Services	Children's Services	Foster Care
Count of First Service request	1305	955	350	12
Count of first delivered services that meet 10-business day standard	1011	850	161	5
Percentage of first delivered services that meet 10-business day standard	77.47%	89.01%	46.00%	42%

Table 10: Timeliness to First Non Urgent Offered Appointment

Timeliness to First Non-Urgent Psychiatry				
First Offered Appointment July 2022-April 2023				
	All Services	Adult Services	Children's Services	Foster Care Services
Count of initial psychiatry service request	390	336	54	0
Count of first offered appointments that met the 15-business day standard	325	316	9	N/A
Percent of first offered appointment that meet the 15-business day standard	83.33%	94.05%	16.67%	N/A

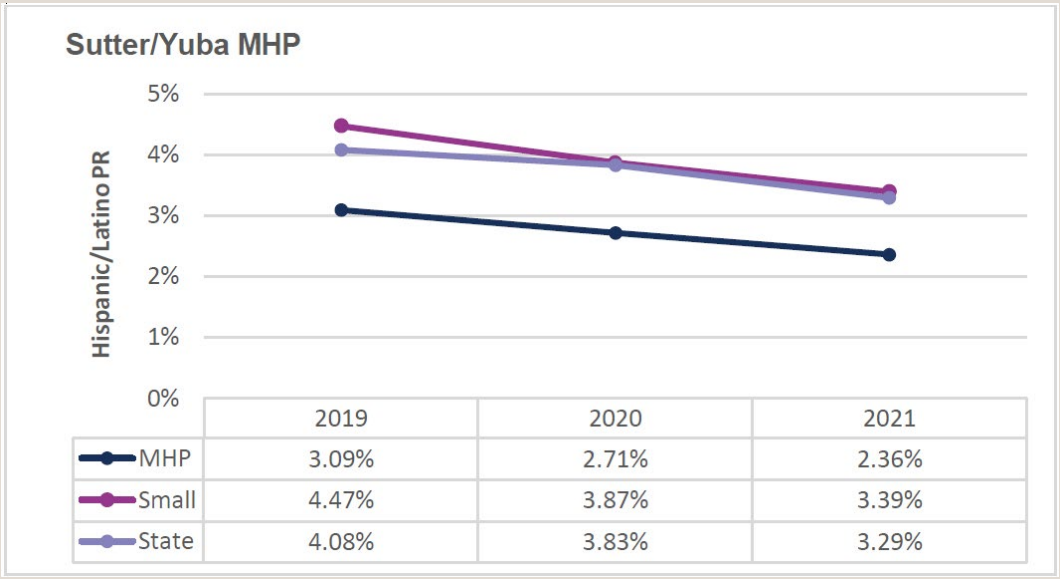
Table 11: Number of providers

Age Group Served	Licensed Psychiatrist	Licensed Physicians	Licensed Psychologists	Licensed Clinical Social Workers	Marriage and Family Therapists	Registered Nurses	Certified Nurse Specialists	Nurse Practitioners	Licensed Vocational Nurses	Psychiatric Technicians	Mental Health Rehabilitation Specialists	Physician Assistants	Pharmacists	Occupational Therapists	Licensed Professional Clinical Counselor	Associate Clinical Social Worker	Associate Marriage Family Therapist	Associate Professional Clinical Counselor	Other Qualified Providers	Total
0-20	3.2	0.0	0.0	5.4	8.3	0.0	0.0	0.3	0.7	1.0	14.0	0.0	0.0	0.0	0.0	10.5	11.1	0.0	12.8	**67.2**
21+	4.3	0.0	0.0	7.2	2.2	0.0	0.0	1.3	3.2	5.0	0.0	0.0	0.0	0.0	0.0	1.5	0.9	0.0	12.6	**38.1**
All Ages	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Total FTEs	**7.5**	**0.0**	**0.0**	**12.6**	**10.5**	**0.0**	**0.0**	**1.5**	**3.8**	**6.0**	**14.0**	**0.0**	**0.0**	**0.0**	**0.0**	**12.0**	**12.0**	**0.0**	**25.4**	**105.3**

Table 12: Number of providers that must be maintained.

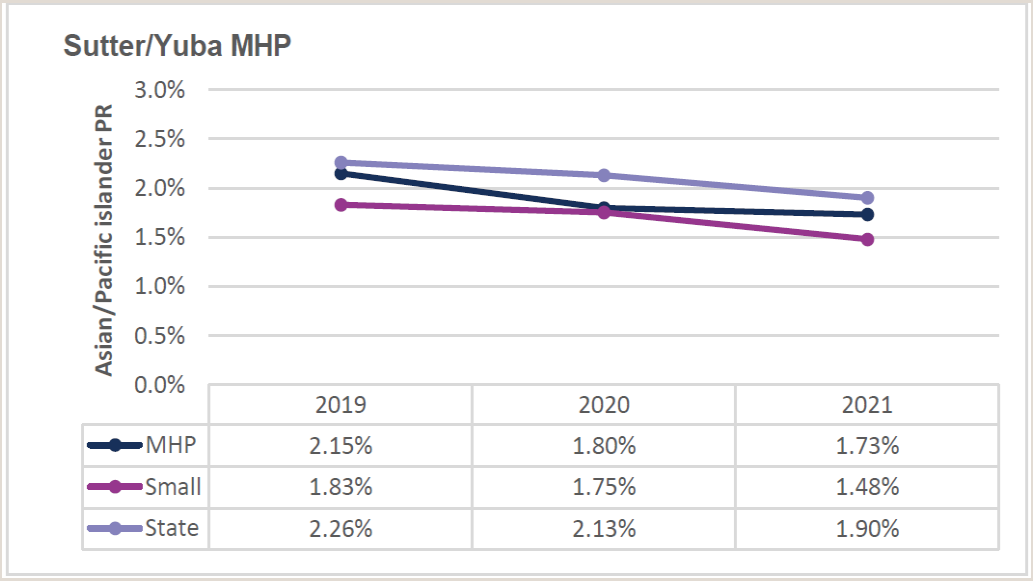
Service Category	Standard	Estimated Need Population	# of Full Time Equivalency Providers Needed to Meet the Ratio Standard	# of FTE SYBH Providers
Psychiatry Provider Capacity – Adults	1:524	1,459	2.78	4.3
Psychiatry Provider Capacity – Children/Youth	1:323	669	2.07	3.2
Outpatient SMHS Provider Capacity – Adults	1:85	2,177	25.61	33.9
Outpatient SMHS Provider Capacity – Children/Youth	1:43	2,307	53:65	74.1

Figure: 7: Hispanic/Latino Penetration Rate CY 2019-21 (Figure provided by BHC in 2023 EQRO Final Report)



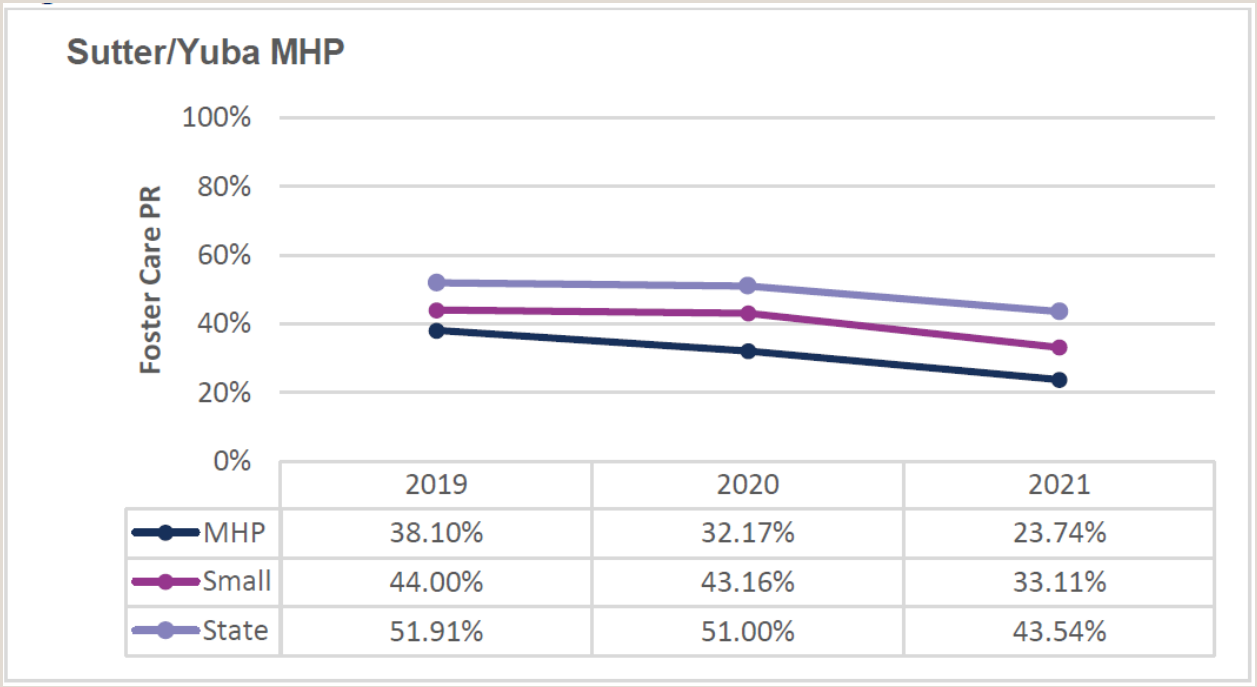
	2019	2020	2021
MHP	3.09%	2.71%	2.36%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

Figure 8: Asian/Pacific Islander Penetration Rate CY 2019-2021 (Figure provided by BHC in 2023 EQRO Final Report)



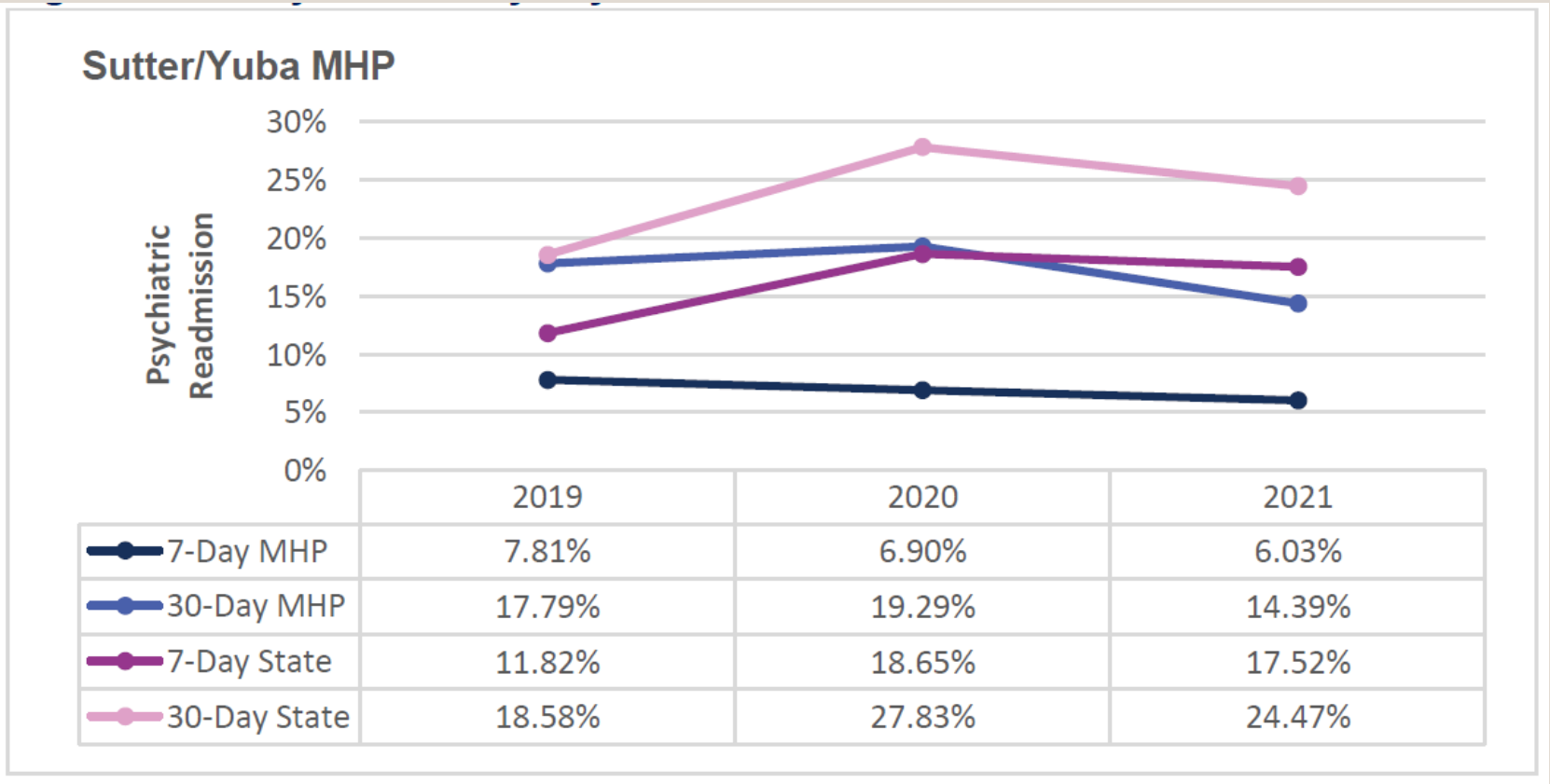
	2019	2020	2021
MHP	2.15%	1.80%	1.73%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

Figure 9: Foster Care Penetration Rate CY 2019-2021 (Figure provided by BHC in 2023 EQRO Final Report)



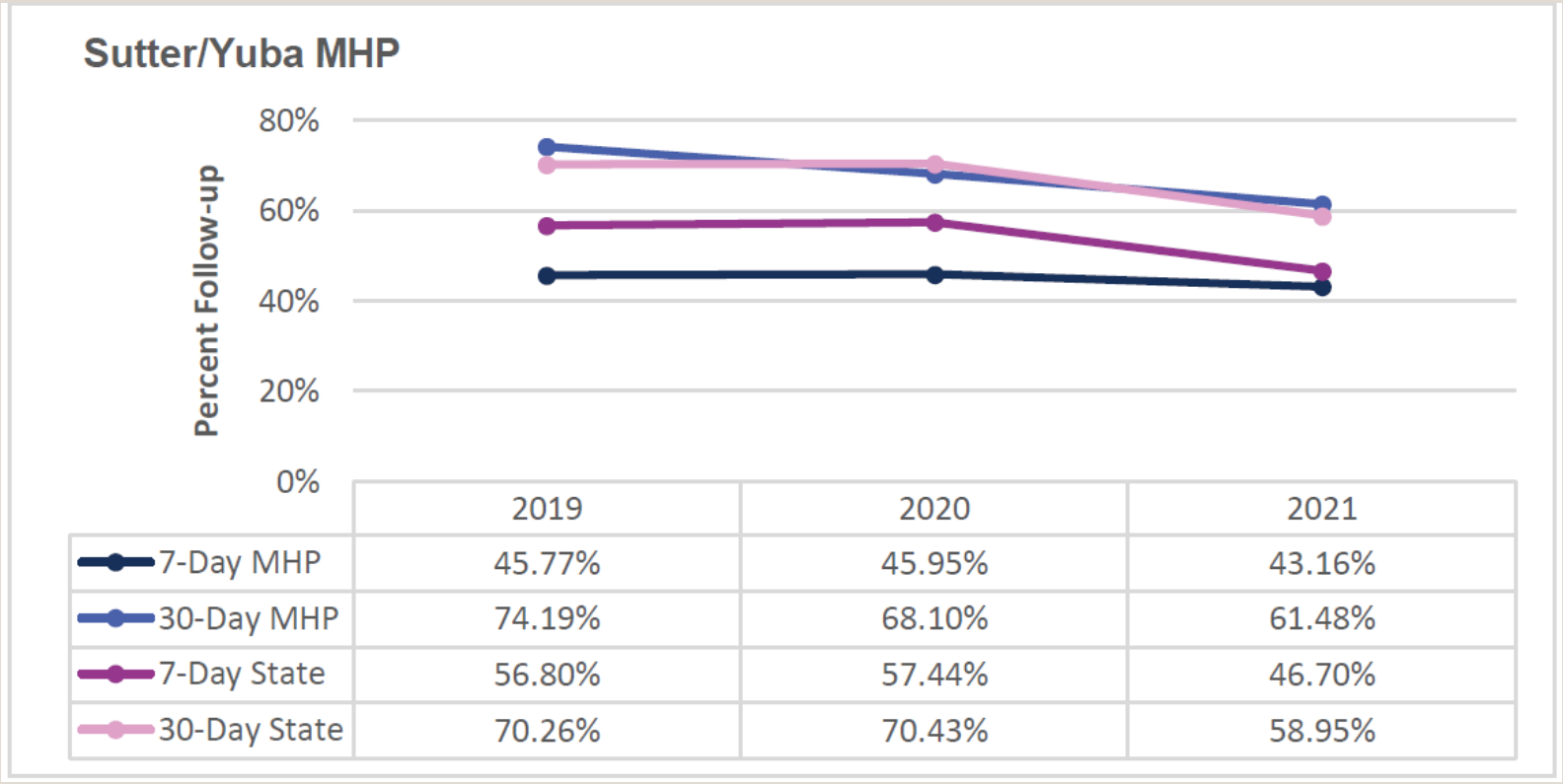
	2019	2020	2021
MHP	38.10%	32.17%	23.74%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

Figure 10: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-2021 (Figure provided by BHC in 2023 EQRO Final Report)



	2019	2020	2021
7-Day MHP	7.81%	6.90%	6.03%
30-Day MHP	17.79%	19.29%	14.39%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

Figure 11: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21 (Figure provided by BHC in 2023 EQRO Final Report



	2019	2020	2021
7-Day MHP	45.77%	45.95%	43.16%
30-Day MHP	74.19%	68.10%	61.48%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

Figure 12: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019- March 2023