SYBH Quality Assessment and Performance Improvement Evaluation

Fiscal Year 23-24

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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 23/24:

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 1: Ensure all timeliness standards are achieved for all complaints received through the problem-resolution process FY 23/24.	Annual report to QIC and SUDS QIC for all grievances, appeals, and State Fair Hearings to include % of problem/resolutions resolved by their respective timeliness standard.	Completed: The annual grievance/appeal report was reviewed at the July 2024 QIC meetings. Recommend goal to continue for monitoring purposes.
	4 quarterly reviews of cases to include % of each grievance/appeal category and any notable trends. Individual cases will be reviewed in individual program QIC meetings and SUDS QA. (KPI 1.2-PRquarterly)	Completed: Grievance/appeal report was reviewed quarterly at the QIC meetings and SUDS QA.
	Develop training on Problem Resolutions and investigating grievances/appeals to be provided to new staff and management and annually thereafter.	Completed; A training was developed for new staff who take the virtual training when on-boarding and annually thereafter. A separate training was developed for Managers who take it annually. The Manager's trainings is available quarterly in person as needed.
	Analyze billing disputes/financial grievances and develop interventions to decrease the amount of billing disputes/financial grievances from 44% of all grievances to 25%.	Completed: SYBH received 4 grievances/appeals regarding billing disputes/financial grievances decreasing from 44% to 17%. Recommending this goal continue due to the decrease in billing dispute/financial grievance/appeals may be attributed to a delay in billing due to change in EHR and payment reform.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 2: Monitor client satisfaction through the semi-annual Consumer Perception Survey	Results shared with staff annually and posted to the Sutter County website. (KPI 2.1-CPSshare)	Completed: Results of the 2023 CPS were shared in the April 2024 QIC meeting and sent to staff for review. The Results were also posted to the Sutter County website. Recommend goal to continue for monitoring purposes.
	Collect the findings and analyze the data upon release from State contracted entity overseeing the CPS surveys. • Meet or exceed 80% adult overall satisfaction rate. • Meet or exceed 80% adult satisfaction with cultural sensitivity.	Completed: Results of the 2023 CPS survey found that overall satisfaction rate and the satisfaction with cultural sensitivity exceed the 80% satisfaction rate for each category.
	Develop action plan and interventions to increase satisfaction with positive outcomes of services/functioning for youth and adults.	No Started: Will work on this intervention during FY24/25.
	Implement program codes for administering CPS for analysis of results on a program level and develop baseline measures for MH and SUDS programs.	Completed: Codes were used during the administration of the 2024 CPS and will be used to analyze the 2024 CPS data by program.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 3: Monitor consumer satisfaction through Change of Provider Requests	Trend analysis of reasons for requests of those representing 25% or more of all requests. Identify providers that represent 25% or more total requests. Share analysis quarterly with QIC.	Completed: An analysis was completed and reviewed quarterly with the QIC members. Recommend goal to continue for monitoring purposes.
	Discuss goals not met to determine appropriate intervention.	Completed: No interventions were recommended.
	Evaluate the change of providers staff training model to determine if additional training is needed for therapists.	Completed: A change in provider training was developed and added to the QA Academy training schedule and staff will receive the training at onboarding and annually thereafter.

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 23/24:

FY 23/24 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 4: Improve the compliance rate of test call compliance	Ensure 12 test calls are completed in FY 23/24. Ensure at least one test call annually in Hmong and Punjabi and one per quarter in Spanish. Assign one test caller per quarter to test on the problem resolution process.	Completed: 29 test calls were completed during FY23/24 Completed: 1 test call was made in Hmong, 2 in Punjabi and 4 in Spanish. Completed: a total of 5 test calls were made on the Problem Resolution process. Recommend goal to continue for monitoring purposes.
	Provide 4 quarterly reports to PES leadership and an annual outcome and analysis with QIC.	Completed. Test calls were analyzed quarterly and presented at the QIC quarterly meetings which include PES leadership.
	Increase in test calls meeting verbal requirements from 92% to 100%. Increase in test calls meeting written requirements from 60% to 100%.	Completed: while we are short of the goal of 100% of test calls meeting the verbal requirements the percentage did increase from 92% to almost 97%. Completed: while SYBH fell short of the goal of 100% of test calls meeting the written requirements the percentage did increase from 60% to almost 83%.

FY 23/24 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 5: Monitor timeliness of access to services to ensure compliance with all timeliness measures	Develop workflow/Trainings and action plans as needed for the following: • Psychiatry data • Adult urgent process • Continue development of the timeliness dashboard development for routine timeliness monitoring of non-urgent services. • Post-hospitalization follow-up • SUDS timeliness measures.	In progress: workflows and trainings were developed for Psychiatry, and SUDs timeliness. Forms to collect the timeliness data for Psychiatry and SUDs were developed and are currently in use. Adult services is working on defining urgent and developing a workflow for determining and providing urgent appointments. Timeliness dashboard was created but will need to be updated to capture data from the new Access to Services form. Post-hospitalization follow-up dashboard was created but is not tracking data from all hospitals that are used. Kingsview the EHR vendor is working on the issue. Recommend goal to continue for monitoring purposes.
	Develop Monitoring Systems for the following: • Psychiatry • Non-Psychiatry • SUDS • Urgent • Post-hospitalization follow-up	In progress: monitoring systems (dashboards) have been developed for Psychiatry and Non-Psychiatry both urgent and non-urgent as well as the post -hospitalization follow-up. A monitoring system (dashboard) will need to be developed during the next fiscal year.
	Analyze timeliness data and share with QIC quarterly focus on meeting the following standards: • 80% of MH and SUDS clients being offered or receiving an assessment appointment 10 days from request to first appointment • 80% of MH and SUDS clients receive their first treatment appointment within 60 days • 85% of new clients with a receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service	Completed; Timeliness was analyzed and shared during the QIC quarterly meetings. SYBH exceeded the goal of 80% of non-psychiatry MH and SUDS client being offered an assessment withing 10 business days from the request for services. SYBH did not track clients receiving their first treatment appointment within 60 days as we are know tracking the first treatment appointment offered date. The follow up appointment should be offered within 10 business days of the first billable service.

	• 80% of new clients receiving Opioid Treatment program services within 3 business days of request.	SYBH fell short of the goal of 80% of psychiatry clients being offered an appointment within 15 business days of the request for services. SYBH exceeded the goal of 80% new clients receiving Opioid Treatment program services within 3 business days of request.

FY 23/24 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 6: Monitor the provider network adequacy	Monitor the number of providers monthly • Participation in the monthly 274 submissions	Completed: The monthly 274 was submitted on-time for each month during the FY23/24 Recommend goal to continue for monitoring purposes.
	Provide analysis of the anticipated needs and shared with QIC • Use the annual Meds anticipated needs data to inform the number of providers that must be maintained throughout the year	Completed; Anticipated number of providers were reviewed during the QIC meetings.

FY 23/24 Goal	Planned Intervention and Measurement	FY 22/23 Evaluation
Goal 7: Ensure a culturally competent workforce	Ensure beneficiary/client forms are translated into Spanish, Punjabi and Hmong and easily available to clients. • Create a translated materials inventory and storage platform. • Update SYBH website to ensure client accessibility to beneficiary materials in Spanish and Hmong.	Completed: Necessary forms are being translated into Spanish, Punjabi and Hmong and are stored on the P Drive. The SYBH website was updated to include information in Spanish and Hmong. Recommend goal to continue for monitoring purposes.
	Utilize the penetration rates to monitor for trends • Conduct a root cause study on the FC	In Progress: SYBH developed a form to accurately track foster youth, SYBH staff were trained on how to utilize the form and the subcontractor Youth

	penetration rate decrease.	for change has a training coming up. Once the form is being utilize data specifically to foster youth can be used to determine penetration rates and a root cause analysis.
	Ensure leadership is informed of trends: • Annual analysis of penetration rates shared with both QIC and CCC • Annual analysis of cultural competence workforce shared with QIC, CCC and HR. • Annual analysis of cultural competence services shared with QIC and CCC. Annual analysis of participation in the Building Communities through Health workshops provided for the African American community. • Develop cultural competence staff survey to administer annually. • Develop cultural competence client survey to administer annually. • Participate in Building Communities through Health committee to develop educational workshops on accessing BH services for the AA community. • Develop evaluation for educational workshops to gather information on what workshop topics are needed in the African American community	In Progress: annual penetration rates were shared during the 2024 External Quality Review. Penetration rates have not been available from the EHR due to the change to a new system. Kingsview will be working on providing penetration rates in the future. The SYBH DEIC is working on retrieving data from the EHR so that an analysis can be completed. SYBH participated in the Building Community through Health workshop that was offered in 2024. Information from all SYBH programs were shared with the community who attended the workshop. SYBH is developing the staff survey and should be ready to administer during FY25/26. SYBH is developing the client survey and should be ready to administer it during FY25/26. SYBH's ESM regularly participates in the Building Communities through Health committee that changed its name to Connecting Cultures Collaborative and whose mission changed to developing economic opportunity for the African American community.

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 FY23/24 Goals:

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 8: Ensure compliance with NOABD issuance.	Conduct a process review of financial liability NOABD issuance. • Identify process and knowledge gaps in the financial liability NOABD issuance. • Develop formal training for staff on financial liability NOABD issuance	The FY 23/24 intervention related to evaluating process and knowledge gaps in the issuance of financial liability NOABD is still in progress due to the lack of timely technical assistance from DHCS on the appropriate timeframe to issue the NOABD. As of 8/15/24, this agency has been actively working with and awaiting guidance from DHCS leadership for over one year without resolution. Without this needed technical assistance clarification on this issue it has not been possible to provide staff with correct guidance on how is issue these documents properly. Once this technical assistance has been provided, the agency will be able to proceed with this goal.
	Increase NOABD compliance rates • Develop formal training plan on NOABDs. • Conduct 2 sample audits to monitor compliance, include peer chart audits data to determine percentage of time NOABDs are being completed. • Review NOABD issuance rates and compliance monitoring results at 2 URC meetings	In FY 23/24 the agency implemented a formal NOABD training plan utilizing our online training platform, Relias. Every staff (those responsible for providing NOABD's), immediately upon initial hire and then again annually, will complete an online training created by Quality Assurance staff. Staff are trained on NOABD regulations and requirements including why NOABD's are an important process to protect the rights of Medi-Cal beneficiaries, review of all of the different types of NOABD's, how to know when to issue each type of NOABD as well as practical/logistical information specific to the agency about the process. In addition, in order to increase ease of use for staff and thus overall compliance rates, the agency has recently transitioned the process from one that was completed as a Microsoft Word document outside of the electronic health record to now being completed as part of the client's electronic health record. Due to the unforeseen constraints caused by the lack of technical assistance from DHCS around Financial Liability NOABD's and the very recent transition to utilizing the electronic health record only one sample audit was conducted during the review period to determine compliance. The results of that audit are attached; entitled "NOABD Tracking Audit FY 23.24 Q1 July_Sept 2023".

		The second sample audit will be conducted after all staff have completed the NOABD training which currently has a deadline of September 30, 2024. NOABD issuance rates and compliance monitoring results were reviewed at three URC meetings thus far during the FY 23/24; at the April, May and July 2024 meetings.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 9: Ensure consistency in the authorization system	Monitor and analyze all authorization types for trends of services offered and underutilization. ○ ICC ○ IHBS ○ TFC ○ TBS ○ SARS ○ TARS	Complete- URC was reformatted in April 2024 and now includes a more thorough process in which QA and programs gather data and present to the committee. This allows for identification and discussion of trends, over/under utilization, and authorizations. In progress: There is no current process in place for screening/serving TFC.
	Create benchmarks and standards for TARS to monitor against and share the findings at URC. • Conduct sample TARS audit to monitor quality and consistency. • Share results at two URC meetings.	In progress-Quarterly TAR numbers have been shared in at least two URC meetings during this time period. The quarterly reports indicate actual number of psychiatric hospitalizations reviewed and are based on TARS completed by month. The practice of TAR auditing has increased from 5 to 10%, with audit findings being presented to our subcontractor, Acentra. The results of the TAR audits (for the purpose of quality and consistency) have not yet branched in to the URC space as it was deemed appropriate to first share these findings/consult with our subcontractor before presenting to URC.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 10: Ensure compliance with concurrent	Learn how to run reports from the system being used by the contractor conducting concurrent review.	Complete: Five reports are now available in Acentra'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.

review standards		"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.).
	Utilize 2 Reports developed from Atrezzo • Analyze the results and share findings with URC	Complete: "Summary of Days" report has been utilized and shared in URC during this time period by reviewing out-of-house psychiatric inpatient approved vs denied days, acute vs admin days, average length of stay, extended days, while differentiating between youth vs adult beneficiaries. The "Census Report" has also been utilized in URC during this time period by sharing the extracted number of out-of-house patient admissions per month for the purpose of tracking and identifying trends. This report is also capable of identifying whether facility submissions were concurrent vs retrospective.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
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 the AB1299 HEDIS measures: • follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications • use of multiple concurrent psychotropic medications for children and adolescents • use of first-line psychosocial care for children and adolescents on antipsychotics	Implement a monitoring system for Children and Adolescents using the AB1299 HEDIS measures: • follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications • use of multiple concurrent psychotropic medications for children and adolescents • use of first-line psychosocial care for children and adolescents on antipsychotics Recommend goal to continue for monitoring purposes.

	Analyze and share results quarterly at the URC meeting	In progress: the data will be shared during the FY24/25 URC meetings.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 12: Monitor hospital readmission rates	Identify tracking issues with hospital readmission rates and Align benchmarks with State standards for the following: • Readmission rate within 7 days post-hospitalization • Readmission rate within 30 days post-hospitalization	In Progress: tracking issues were identified and Kingsview is working on correcting the issues in the dashboard. Once the issues are resolved the following data will be analyzed. • Readmission rate within 7 days post-hospitalization • Readmission rate within 30 days post-hospitalization ecommend goal to continue for monitoring purposes.
	Share readmission rates with URC routinely at least two time annually.	In Progress: Due to the tracking issues identified in the Dashboard the rates reviewed at URC, sharing the readmission rates is on hold until the issue in the Dashboard can be corrected.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 13: Compliance and oversight of psychiatric inpatient submissions	Monitor psychiatric impatient case statuses in order to identify issues that may delay timely claim submissions/payment. • Identify cases that contain submitted, rejected, or denied status and coordinate with facility and Acentra (Kepro) as appropriate for timely resolution. • Address Issued with treating facility or Acentra (Kepro) when not in compliance with Title 9 regulations or BHIN 22-017 to determine appropriate course of action.	Complete: The UR Specialist created a "Data Universe" to track and monitor psychiatric inpatient cases, both in-house and out-of-house. The Data Universe monitors case submissions by month, type of submission (concurrent vs retrospective), TAR status and authorization determination, as well as appeals. The UR Specialist reviews the Data Universe at minimum 1x/per month to follow-up on cases not resolved in a timely manner. These stagnant cases are promptly followed-up first within the case via the messaging feature; this allows observations to be communicated to the treating facility and Acentra clinical reviewer. If this method does not produce timely results, the next step taken by the UR Specialist is contacting the Acentra Help Desk, the treating facility, and lastly an Acentra team lead or manager for assistance.

		Acentra cases are currently being monitored at 10% of the total case submissions per month (an increase from the previous 5%). The auditing process involves a step-by-step walk through on the concurrent review process per BHIN 22-017 and Title 9 regulation. To-date, one case was overturned by the MHP and payment was recouped due to the patient not meeting medical necessity. Overall, findings are being shared on a monthly basis with Acentra's program manager to provide feedback. The SYBH QA UR Specialist is also a member of the Acentra's Stakeholder Advisory Committee and attends quarterly meetings with Acentra, CalMHSA, and other county members to obtain updates on actions taken by Acentra to improve their services, as well as to provide county feedback. Percentage of case denials associated with in-house and out-of-house facilities are shared with the URC committee to identify trends.
	Analyze compliance and share results with URC three times a year. • Achieve an overall compliance rate of at least 90% of unresolved cases. • Achieve an overall compliance rate of at least 90% of resolved cases.	In progress: Acentra's team of clinical reviewers have fallen behind with concurrent review and processing of TARS. The situation is being closely monitored by CalMHSA and DHCS; Acentra is meeting regularly with CalMHSA and DHCS to work through workforce issues and implement solutions. Acentra is providing the UR Specialist with updates on a monthly basis via a recurring virtual meeting. During FY 23/24, a total of 422 case submissions have been uploaded in to the Atrezzo portal for Sutter-Yuba Medi-Cal beneficiaries. Of those 422 submissions, 13 are currently unresolved, equaling 3.08%, meaning 96.92% of submitted cases during this time period are completed/resolved. This information has yet to be shared with the URC committee.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 14: Implement a system for utilization of services and monitoring and	Develop monitoring systems for the following: • IHBS utilization • Children using PES services or Hospitalization while in treatment with SYBH • Levelo of Care reporting and data analysis	Complete: IHBS utilization- Beginning April 2024, the revamped URC format now monitors IHBS data presented by SYBH's youth program. SYBH's youth program presents IHBS data on approved IHBS referrals to reflect monthly and total IHBS approvals. This assists the committee to identify changes/trends with this service type for Sutter-Yuba beneficiaries.

analyzing level of care and outcomes.		Partially complete: PES/hospitalization- Children/youth PES and hospitalization data is also monitored by the URC committee (encounters by month, total annual encounters) to identify trends while also comparing to previous FY during some meetings. SYBH pulls data on out-of-house admissions to identify hospital trends for Sutter-Yuba Medi-Cal beneficiaries (***this however data does not differentiate active vs inactive clients***). In progress: Level of care analysis- this data is monitored by the URC committee. Data collected is meant to track movement at service entry and throughout levels of care. Data includes: triage and intake (MH and SUDS), ICC/IHBS/TBS/CFT, utilization of PES/PHF/psychiatric inpatient, supplemental services (eating disorder, electroconvulsive treatment), residential (youth, adults, and SUDS). While data at service entry and referrals is being monitored, programs have yet to implement the practice of tracking movement through levels of care for existing/open clients. This has been discussed during URC and is a goal of the committee. Likewise, quantifying FSP level of care for tracking purposes/identifying trends is also a goal of the committee.
	Develop benchmarks for the following: • IHBS • PES and Hospitalizations for children • Locus and MORS	In progress: LOCUS/MORS. SYBH is striving to monitor these more routinely. Recommending this be a continued goal. Complete: IHBS/PES/hospitalization as detailed below.
	Review Trends and share with URC for the following: • Clients receiving IHBS • Children utilizing PES or Hospitalizations while in treatment with SYBH	Complete: IHBS and children utilizing PES or hospitalization are reviewed during URC to identify trends. For example, during the youth URC meeting on 5/1/24, it was noted that there were "not many (IHBS) referrals" sent to our contracted provider this fiscal year when presenting data. This meeting also noted in increase in referrals sent to SYBH's iHART (which reviews all youth seen at PES, those hospitalized and those released to caregivers with a safety plan). There was a documented increase in referrals, which reflects an increase from the previous year's numbers (which was in

		the 40s) to 109 by March of 2024. It was noted that the majority of child/youth clients going into the hospitals are *not* receiving services with SYBH. During the URC meeting on 12/13/23, Youth PES encounters and hospitalizations were reviewed by FY 22/23 and 23/24, with data broken out by month, to identify trends and fluctuations in service utilization.
	Explore the use of EHR to develop a system for reporting and data analysis of level of care.	In progress: During the last URC of FY 23/24, the URC committee discussed the upcoming implementation of NOABDs within Credible. This report will help to give a general idea of trends specific to NOABD types associated with identified programs. The Youth Program is working on utilizing Credible to present ICC data and meds-only patient data; however, it was discussed in May's URC meeting that the data being generated in Credible is likely inaccurate and is an area of improvement. The SYBH youth, adult, and SUDS programs collected data by hand during this reporting period due to the inaccuracies of our EHR. Integration of reports/dashboards to improve this workflow will be a continued goal.

Program Integrity

Program Integrity monitoring activities are designed to strengthen accountability and ensure compliance with federal and state statutory and regulatory requirements. The Program Integrity monitoring activities will help identify areas of improvement and needed technical assistance necessary to increase performance overtime.

Evaluation of FY23/24 Goals:

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 15: Conduct MH and SUDS Chart Audits	Conduct quarterly chart audits of services provided by both contractors and internal programs to score each programs overall rate of compliance with DHCS documentation rules and regulations.	In FY 23/24, twelve Specialty Mental Health Services chart audit were conducted; six for internal SYBH programs and six for contractors (Please see attached SMHS and Medication Management Chart Audits). During those audits, one internal program and one contracted program scored below the 80% compliance rate and/or had excessive services voided

	• Achieve an overall compliance rate of at least 80% on quarterly audits of contractors and internal program chart audits of SMHS and SUDS. • Issue and monitor Corrective Action Plans (CAPS to program leadership for charts that required services be voided/reimbursement recouped. • Provide Individual/Targeted trainings for any programs that score below the 80% overall compliance rate.	necessitating a Corrective Action Plan (CAP). The internal SYBH program CAP is still in the process of being developed by the program leadership whose staff provided those services. The CAP and evidence of training completed by the SMHS contractor is also enclosed. FY23-24 SUDS Chart Audits occurred each quarter for First Steps and Options for Change. Goals were met each quarter.
	Analyze and review compliance rates at quarterly QIC and SUDS QIC and SUDS QA meetings.	

Quality Improvement Projects

Performance Improvement Projects (PIP)

PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The PIPs have a direct beneficiary impact and will create improvement at a member, provider and/or MHP system level. A PIP is a focused effort to improve specific administrative or clinical performance in order to improve access to and quality of SMHS and SYBH will focus on both clinical area and non-clinical area PIPs as well as the CalAIM BHQIP PIPs.

FY23/24 Goals:

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 16: Implement Clinical PIP to improve the rate of Post-Psychiatric Hospitalization Follow-up within 7 days	Increase the rate of post-psychiatric follow-up services within 7 days • Implement follow-up call measures to increase attendance. • Plan additional interventions and implement as needed.	Completed: Follow up calls were implemented and there was an increase in the rate of post psychiatric follow-up services within 7 days There was an issue with the new EHR system pulling all the psychiatric sites into the data. Kingsview is working on the issue.
	Develop PIP write-up including baseline data.	No Started: the PIP write up was not completed due to the change in the PIP process. This goal will not continue during the next FY.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 17: Implement CalAIM BHQIP PIP: Follow-Up Care After Emergency Department Visit for Mental Illness (FUM)	Implement assertive outreach and check up via a minimum of two follow up calls to ensure client remains engaged and attends follow-up appointment. • Increase clients discharged from PES/Ed receiving a minimum of 2 follow upcalls to 80%. • Increase the number of clients discharged from PES/ED who receive follow up appointment within 7 days by 5%. • Increase number clients discharged from PES/Ed who received follow up appointment within 8-30 days by 5%.	Completed
	Create and implement an improved centralized referral tracking mechanism to enhance referral coordination from the ED. • Referral coordinator to monitor and follow up on referral in a timely manner.	Completed

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 18: Implement CalAIM BHQIP PIP: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Implement assertive outreach and checkup via a minimum of two follow up calls to ensure client remains engaged and attends follow-up appointment. • Increase clients discharged from ED visits for substance use receiving a minimum of 2 follow upcalls to 80%. • Increase the number of clients discharged from ED for substance use who receive follow up appointment within 7 days by 5%.	Completed

	• Increase number clients discharged from ED for substance use who receive who received follow up appointment within 8-30 days by 5%.	
	Create and implement an improved centralized referral tracking mechanism to enhance referral coordination from the ED. • Referral coordinator to monitor and follow up on referral in a timely manner.	Completed

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 19: Implement CalAIM BHQIP PIP: Pharmacotherapy for Opioid Use Disorder (POD)	Increase screening for co-occurring mental health, medical and other substance use needs to 80%. • Develop a screening tool for SDOH needs and co-occurring mental health and substance use disorder needs.	Completed
	Increase screened clients who receive a referral to address those needs to 80% • Develop a tracking mechanism to enhance referral coordination to and from SDOH resources. • Referral coordinator to monitor and follow up on referrals in a timely manner.	Completed

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 20: Implement Non-clinical PIP to improve communication with	Conduct a root cause analysis: • Complete 1 pre-survey to look further into issues identified by the consumer focus group • Develop PIP write-up including baseline	Not Started: due to staffing shortages this goal has not been started. Due to the changes in the PIP process this goal will not continue.

families regarding hospital transfer and step-down services Develop action plan and interventions to increase satisfaction with positive outcomes of services/functioning for youth and adults.	data	
	Plan interventions • Conduct follow-up surveys to evaluate improvement efforts.	Not Started: due to staffing shortages this goal has not been started. Due to the changes in the PIP process this goal will not continue.

CalAIM Behavioral Health Quality Improvement Projects

The CalAIM Behavioral Health Quality Improvement Program comprises of three major initiatives: Payment Reform, Behavioral Health Policy Changes, and Data Exchange. The purpose of these initiatives is to improve quality of care by streamlining the Medi-Cal behavioral health delivery system improving administrative efficiency, creating consistency, and improving data exchange. Monitoring SYBH's CalAIM Behavioral Health Quality Improvement Program will allow us to reach targeted benchmarks to achieve full implementation of CalAIM and ultimately improve access, coordination, and care quality for Medi-Cal beneficiaries.

FY23/24 Goals:

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 21: Implement and monitor CalAIM Payment Reform changes	Update claiming rates and system: • Update system with new codes • Align benchmarks with State standards	The EHR system was updated with new codes. This is a continual effort as DHCS provides more guidance as CalAIM implementation continues. All coding specifications such as changing to unite versus minutes and rate setting standards have been aligned with DHCS guidance or requirements.

	Provide staff trainings on claiming rates and systems: • Implement CPT staff trainings • Implement IGT staff training	Coding in the EHR happens in the background as set up by our EHR servicer, Kings View. Staff were trained in Spring and Summer of 2023 how to select services with their intro training to the new EHR, Credible. Fiscal staff have attended applicable trainings by DHCS to ensure IGT processes are developed appropriately.
	Review payment reform implementation routinely • Share payment reform implementation analysis with BH leadership and QIC quarterly, to include approval rates, denial rates and reimbursement revenues in analysis.	Since this goal was created, there was a determination that this oversight would take place within fiscal leadership. Fiscal has created processes to monitor and evaluate claiming, rate setting, and fiscal modeling for our agency. QA provided a general training on IGTs in October 2023 for applicable staff. QA will not be the owner of this moving forward but will remain peripherally aware and attend meetings where analysis is shared.

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 22: Implement, monitor, and provide continuous training on CalAIM Behavioral Health Policy changes	Develop, update, and implement behavioral health policies and procedures to align with CalAIM changes, including all aforementioned categories as reference in the goal description. • Update EHR documentation to alignw tih documentation reform.	The documentation guide was updated to reflect all CalAIM changes.
	Develop and implement new and ongoing training plan on all behavioral health policy changes, including but not limited to use of the screening and transition tools, ASAM, documentation. • Implement training for staff and subcontractors on CalAIM behavioral health policy changes. • 1 pre and post test score analyses for all CalAIM behavioral health policies and procedures to be shared annually with QIC.	The documentation training has integrated all CalAIM changes. This takes place monthly for new and existing staff to attend. Other mandatory trainings related to CalAIM are on-going through our QA Academy series are as follows: Screening tool training Transition of Care tool training Continuity of Care Access Criteria ASAM No Wrong Door Treatment During Assessment

FY 23/24 Goal	Planned Intervention and Measurement	FY 23/24 Evaluation
Goal 23: Improve data exchange capabilities	Onboard to an HIE and develop project plan to implement data exchange. • Align benchmarks with State standards • Track and meet benchmarks for progress on HIE onboarding and successful data sharing transactions. • Annually analyze benchmarks and share results with QIC.	SYBH has been utilizing an HIE, Sac Valley MedShare, to implement the requirements as set by DHCS. These data benchmarks are still in progress as configurations are being worked on with the new EHR. Our go live for production and transmission is close as we are working through the final opt-out and consent workflows to turn on the functionality to routinely transmit data.
	Enable an active Fast healthcare Interoperability Resources (FHIR) application programming interface (API) to be compliant with CMS-mandated interoperability rules. • Align benchmarks with State standard • Track and meet benchmarks for progress on implementation of the FHIR API. • Annually analyze benchmarks and share results with QIC.	This is in progress and Kings View works on the configurations. Currently the system has the proper settings to comply with FHIR and API interoperability rules.
	Map data elements to the United States Core Data for Interoperability (USCDI) standard set. • Align benchmarks with State standards • Track and meet benchmarks for progress on mapping data elements to the USCDI • Annually analyze benchmarks and share results with QIC.	This item has been met as the elements have been mapped by Kings View.

Figures and Tables

Table 1: Grievance and Appeal Timeliness FY2024

Grievance Timeliness	Logged (1 business day)	Acknowledgment Letter (5 business days)	Resolution letter (90 days)	Maximum duration beyond due date	Total Grievances	Pending Grievances
Q1	85.7%	85.7%	85.7%	6	7	3
Q2	100%	100%	100%	0	3	1
Q3	100%	100%	100%	0	5	3
Q4	100%	100%	100%	0	8	3
Total	**95.65%**	**95.65%**	**95.65%**	**6**	**23**	**3**
Appeal Timeliness	Logged (1 business day)	Acknowledgment Letter (5 business days)	Resolution Letter (30 business days)	Maximum duration beyond due date	Total Appeals	Pending Appeals
Q1	N/A	N/A	N/A	N/A	0	0
Q2	N/A	N/A	N/A	N/A	0	0
Q3	100%	100%	100%	0	1	0
Q4	100%	100%	100%	0	1	0
Total	**100%**	**100%**	**100%**	**0**	**2**	**0**

Table 2: Grievance and Appeal categories FY2024

Grievance Categories	Q1	Q2	Q3	Q4	**Total**
Related to Customer Service	1		1	3	**5**
Related to Case Management					
Access to Care		1		1	**2**
Quality of Care	2	1	2	2	**7**
County Communication				1	
Payment/Billing Issues	3			1	**4**
Suspected Fraud					
Abuse, Neglect or Exploitation					
Lake of Timely Response					
Denial of Expedited Appeal					
Filed for other reasons	2	1	2		**5**
Appeal Categories	Q1	Q2	Q3	Q4	**Total**
Denial or Limited Authorization of Services	0	0	0	0	**0**
Reduction, Suspension, or Termination of a Previously Authorized Services	0	0	1	1	**2**
Payment Denial	0	0	0	0	**0**
Service Timeliness	0	0	0	0	**0**
Untimely Response to Appeal or Grievance	0	0	0	0	**0**
Denial of Beneficiary Request to Dispute Financial Liability	0	0	0	0	**0**

Figure 3: Consumer Perception Survey Family Data 2023

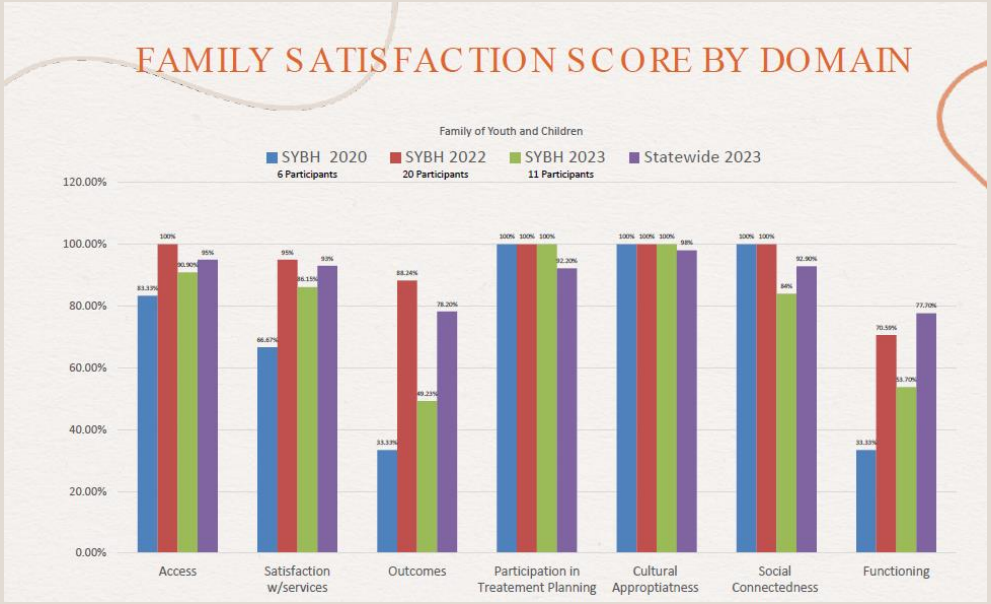


Figure 4: Consumer Perception Survey Youth Data 2023

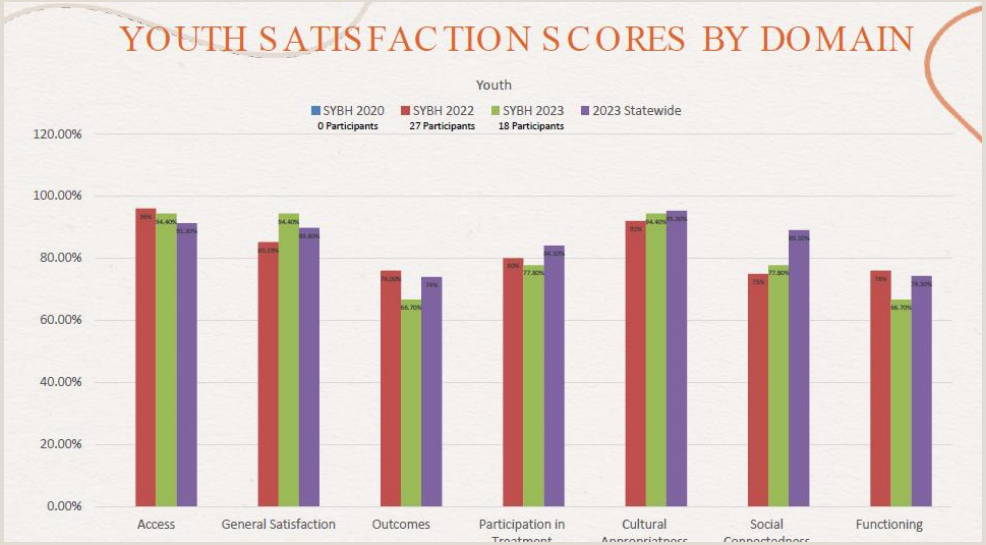


Figure 5: Consumer Perception Survey Adult Data 2023

Figure 6: Consumer Perception Survey Older Adult Data 2023

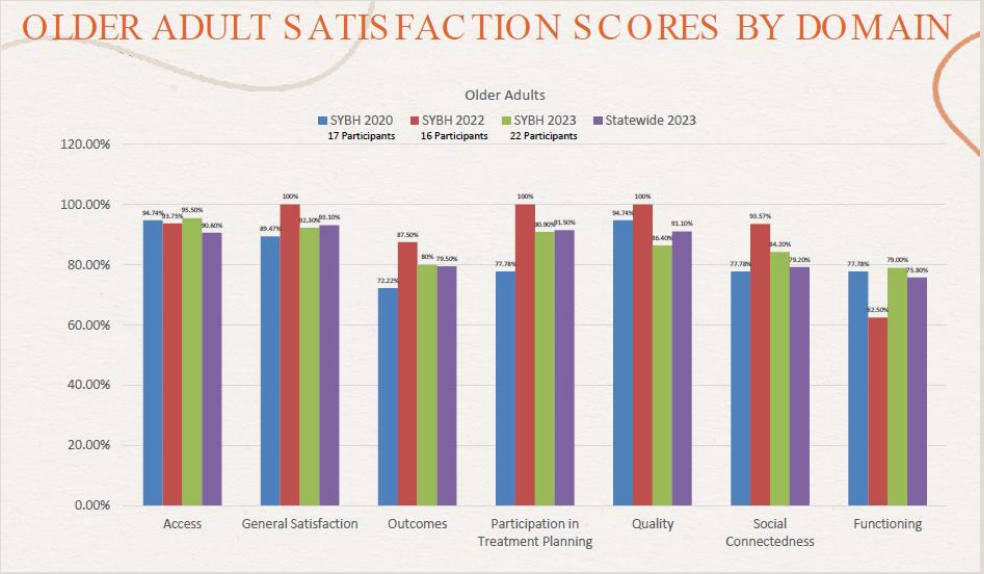
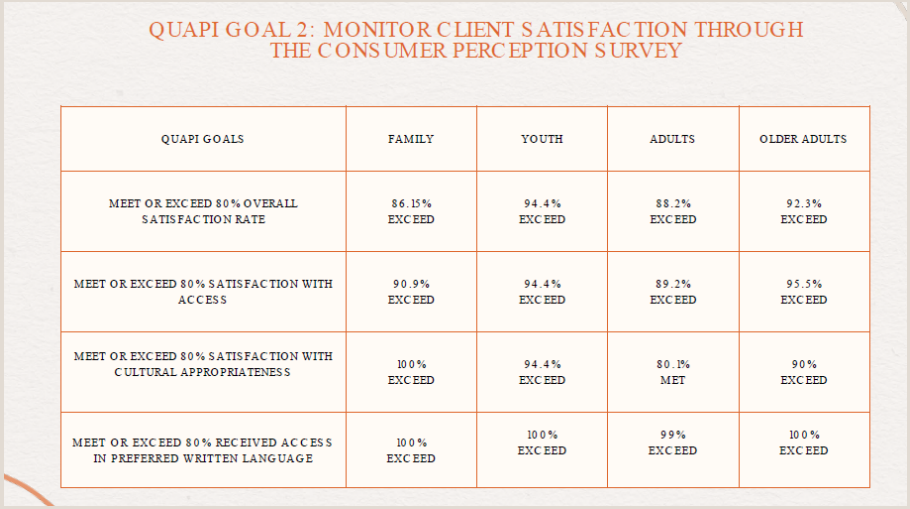


Table 7: Consumer Perception Survey QAPI Goal Review 2023



QUAPI GOAL 2: MONITOR CLIENT SATISFACTION THROUGH THE CONSUMER PERCEPTION SURVEY

QUAPI GOALS	FAMILY	YOUTH	ADULTS	OLDER ADULTS
MEET OR EXCEED 80% OVERALL SATISFACTION RATE	86.15% EXCEED	94.4% EXCEED	88.2% EXCEED	92.3% EXCEED
MEET OR EXCEED 80% SATISFACTION WITH ACCESS	90.9% EXCEED	94.4% EXCEED	89.2% EXCEED	95.5% EXCEED
MEET OR EXCEED 80% SATISFACTION WITH CULTURAL APPROPRIATENESS	100% EXCEED	94.4% EXCEED	80.1% MET	90% EXCEED
MEET OR EXCEED 80% RECEIVED ACCESS IN PREFERRED WRITTEN LANGUAGE	100% EXCEED	100% EXCEED	99% EXCEED	100% EXCEED

Figure 8: Provider Change Request Analysis FY2024

Provider Change Requests	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Adult Psychiatry	9	8	8	12	**37**
Youth Psychiatry	0	0	0	0	**0**
Adult Clinician	0	0	0	0	**0**
Youth Clinician	0	0	0	1	**1**
Total	**9**	**8**	**8**	**13**	**38**
Requests for Second Opinion	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Total	**0**	**0**	**0**	**0**	**0**

Figure 9: Provider Change Percentages FY2024

Percentage of Change Requests/Second Opinion Requests	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Dr. Bains	33%	20%	28%	15%	**27%**
Dr. Chezian	22%	20%	N/A	N/A	**13%**
Dr. Cots	33%	20%	14%	23%	**21%**
Sheela Zachariah	11%	20%	14%	15%	**13%**
Elly Willerup	0	20%	0	15%	**8%**
Dr. Hariri	N/A	N/A	28%	N/A	**8%**
Dr. Singh	0	0	14%	0	**2%**
Dr. Mason	0	0	0	15%	**5%**
Ariana Palacios	0	0	0	**7%%**	**2%**

Figure 10 Change in Provider Requests by reason FY2024

Reason for Change in Provider Request	Dr. Singh	Dr. Bains	Dr. Chezian	Dr. Cots	Sheela	**E**lly	Dr. Hariri	Dr. Mason	Arriana Palacios	**Total**
I do not feel my needs are being addressed/or I am being listened to	1	9	2	6	3	1	1	2	1	**26**
A family member/friend is being treated by the same physician/therapist										
I am concerned about the medications prescribed	1	3	1	3	3			1		**12**
I feel I would be more comfortable with a male/female therapist				4		1				**5**
I feel that my cultural and/or language needs are not being addressed			2							**2**
Other: She is very short with me and gives me anxiety			1							**1**
Other: Provider cancels too many appointments		1								**1**
Other: Does not want Telehealth							1			**1**
Other: Forgets chart				1						**1**
Other: Feels provider is abusive		1								**1**
Other: Feels provider just does not care		1								**1**
Other: Provider is leaving						1				**1**

Table 11: Test Call Compliance Results FY2024

FY 23-24 Test Calls	Number of calls completed	Verbal Requirements met	Written Requirements met
Q1	5	100%	100%
Q2	7	85.7%	71.4%
Q3	6	100%	100%
Q4	11	100%	66.67%
Totals	**29**	**96.55%**	**82.75%**

Table 12: Test Call Verbal Requirements Compliance FY2024

FY 23-24 Test Calls	How to access SMH	Info. about services to treat urgent condition	How to use the problem resolution and fair hearing process.
Q1	100% - 3	100% -1	100% -1
Q2	85.71% - 7	0	0
Q3	100% - 2	100% - 2	100% - 2
Q4	100%-8	100%-1	100%-2
Totals	**91.66%**	**100%**	**100%**

Table 13 Test Call Written Requirements Compliance FY2024

FY 23-24 Test Calls	Name of Beneficiary	Date of the Request	Initial Disposition
Q1	100%	100%	100%
Q2	71.43%	71.43%	71.43%
Q3	100%	100%	100%
Q4	66.67%	66.67%	66.67%
Totals	**82.75%**	**82.75%**	**82.75%**

Table 14: Language Capabilities FY2024

FY 23-24 Test Calls	English	Spanish	Punjabi	Hmong	Korean
Total Calls	21	4	3	1	1
Verbal Requirements	100%	100%	66.66%	0	100%
Written Requirements	95.23%	50.00%	33.33%	0	100%

Table 15: Timeliness for Non-Psychiatric SMHS Analysis FY 2024

FY 23-24	Count of First Service Request	Count of first offered appointments	Count of First Offered Appointments that met the 10-day standard	Percent of first offered appointments that met the 10-day standard	Count of First delivered services	Percentage of delivered services that met the 10-day standard.	Count of Urgent Requests	Percentage of Urgent requests that meet 48-hour standard
Q1	235	211	202	95%	150	87%	8	75%
Q2	114	94	90	96%	103	91%	5	100%
Q3	117	87	86	99%	112	95%	2	100%
Q4	150	135	115	85%	125	89%	3	100%
Totals	**616**	**527**	**493**	**93%**	**490**	**90%**	**18**	**88%**

Table 16: Timeliness for Psychiatric SMHS Analysis FY 2024

FY 23-24	Count of First Service Request	Count of first offered appointments	Count of First Offered Appointments that met the 15-day standard	Percent of first offered appointments that met the 15-day standard	Count of First delivered services	Percentage of delivered services that met the 15-day standard.	Count of Urgent Requests	Percentage of Urgent requests that meet 48-hour standard
Q1	74	74	43	58%	50	86%	1	100%
Q2	59	59	37	63%	17	100%	3	100%
Q3	103	102	60	59%	57	96%	2	100%
Q4	90	90	85	94%	47	100%	1	0
Totals	**326**	**325**	**225**	**69%**	**171**	**94%**	**7**	**85%**

Table 17: Network Adequacy Analysis July 2024

Network Adequacy

Provider-To-Member Ratio Standards				
Measurement Category	**Ratio Standards**	**SYBH FTE Anticipated Need**	**SYBH July 2024 FTE's**	**Deficiancy**
Psychiatry-Adults	1:457	3.73	4.8/5.65	N/A
Psychiatry-Children/Youth	1:267	2.5	2.8/1.95	N/A-0.55
Mental Health Services-Adults	1:85	29.9	17.15	12.75
Mental Health Services - Children/Youth	1:49	50.9	46.3	4.6

Figure 18: Follow-up after Hospitalization and Readmission Rates 2024 (this data is incomplete and does not reflect every hospitalization)

Figure 19: NOABD Trends FY2024

NOABD Type	Trend Meaning
NOABD Denial Notice	Increase: Change in determination criteria, reduced need for service type in poulation, change in workflow, training issues, influx of referral source, increase in stepping clients down into a lower level of care. Stagnant: Consitency so long as conditions such as requirements aren't changing. Lack of proper use I stagnant at low rate. Decrease: Change in determination criteria, change in workflow, training issues, inefffectively stepping clients down.
NOABD Payment Denial Notice	Increase: Training issues related to billing workflows, change in benefits, influx of improper documentation practices. Stagnant: Maintaining solong as all other conditions remain. Lack of proper use I stagnant at low rate. Decrease: Good sign of documentation and billing practices, but could also mean improper oversight.
NOABD Delivery System Notice	Increase: Change in determination criteria or practices, training issues, increase in requests. Stagnant: Maintaining unless other conditions change. Lack of proper use I stagnant at low rate. Decrease: Change in determination criteria or practices, training issues, decrease in requests.
NOABD Modification Notice	Increase: Change in determination criteria, reduced need for service type in poulation, change in workflow, training issues, increase in stepping clients down into a lower level of care. Stagnant: Consitency so long as conditions such as requirements aren't changing. Lack of proper use I stagnant at low rate. Decrease: Change in determination criteria, change in workflow, training issues, inefffectively stepping clients down.
NOABD Termination Notice	Increase: Change in determination criteria, training issue, increased no-shows. Stagnant: Consitency so long as conditions such as requirements aren't changing. Lack of proper use I stagnant at low rate. Decrease: Change in determination criteria, training issue, decrease in no-shows.
NOABD Timely Access Notice	Increase: Staffing issues, training issues, workflow inefficiencies. Stagnant: Consistency so long as conditions such as requirements aren't changing. Lack of proper use if stagnant at low rate. Persistent primary issue causing increased access time. Decrease: Adequate staffing, efficient workflow, training issue.
NOABD Financial Liability Notice	Increase: Training issue, increase in clients with financial liability/SOC. Stagnant: Consistency so long as conditions such as requirements aren't changing. Lack of proper use if stagnant at low rate. Persistent primary issue causing increased financial liability. Decrease: Training issue.
NOABD Authorization Delay Notice	Increase: Lag in workflow, staffing issues, training issues. Stagnant: Consistency so long as conditions such as requirements aren't changing. Lack of proper use if stagnant at low rate. Persistent primary issue causing increased auth delay. Decrease: Efficient workflows, training issues, adequate staffing.
NOABD Grievance and Appeal Timely Resolution Notice	Increase: Inefficient workflow, training issues, influx in grievances in a particular area. Stagnant: Consistency so long as conditions such as requirements aren't changing. Lack of proper use if stagnant at low rate. Persistent primary issue causing increased timely resolution. Decrease: Efficient workflow, training issue.

Figure 20: Level of Care Analysis for MH Adult OP Access FY 2024

MH Adult OP Access Stats:

MH Adult	January	February	March
Screenings	95	63	67
Triage/Intake	?/44	?/34	?/34
Referred to MCP	9	10	15
Intake LOC	Discussion	Discussion	Discussion

Figure 21: Level of Care Analysis for SUDS OP Access FY 2024

SUDS Adult OP Access Stats

SUDS Adult January-March 2024	Triages	Intake Referrals
OFC	68	44
Yuba County Drug Courts	4	4
First Steps	24	16
Intake LOC	Discussion	Discussion

Figure 22: SYBH PES Encounters FY2024

Months 2024	Youth	Adult	Monthly Total
January	39	149	188
February	57	116	173
March	49	131	180
			_____
			Annual Total
			541

Figure 23: SYBH Out-of-House Psychiatric Inpatient admissions FY 2024

Month	Total admits	Youth	Adults
Jan-24	32	14	18
Feb-24	24	15	9
Mar-24	31	20	11

Figure 24: SYBH PHF Admissions FY 2024

Month	Total admits
Jan-24	21
Feb-24	16
Mar-24	22

Figure 25: SUDS Adult Level of Care for On-going Members Analysis FY2024

Program Completion vs. Failed rate

SUDS Adult January-March 2024	Completion	Failed Rate
OFC	Verbal report from Rob	Verbal Report from Rob
Yuba County Drug Courts	ND	ND
First Steps	3	6

Figure 26: SYBH Out-of-House Psychiatric Inpatient Extended Days January 2024

					Acute		Administrative		Age group	
Case ID	Facility	LOS	Admit Date	Discharge Date	Approved	Denied	Approved	Denied	Youth	Adult
X	BHC HERITAGE OAKS HOSPITAL INC.	16	1/2/2024	1/18/2024	16	0	0	0		X
X	BHC SIERRA VISTA HOSPITAL INC.	18	1/29/2024	2/16/2024	18	0	0	0		X
X	SANTA ROSA BEHAVIORAL HEALTHCARE HOSPITAL - FORMERLY AURORA	15	1/16/2024	1/31/2024	15	0	0	0		X
X	SANTA ROSA BEHAVIORAL HEALTHCARE HOSPITAL - FORMERLY AURORA	20	1/23/2024	2/12/2024	20	0	0	0	X	
X	ADVENTIST HEALTH VALLEJO	18	1/12/2024	1/30/2024	18	0	0	0		X
X	BHC SIERRA VISTA HOSPITAL INC.	22	1/26/2024	2/17/2024	22	0	0	0		X

Figure 27: SYBH Eating Disorder Data FY 2024

Month	Total admits	Level of Care	LOS (days)	Complete program?	Days Denied	Days Approved	Youth	Adult	MCP
Jan-24	1	RTC	59	Yes	0	59		X	Partnership
Feb-24	0	n/a	n/a	n/a	n/a	n/a			
Mar-24	1	Partial Hospitalization	Ongoing	TBD	TBD	TBD		X	Partnership

Figure 28: Adult Clients in Residential Placement January 024-February 2024

Adult Clients in Residential Placement:	1/2024	2/2024
Crestwood Behav. Eureka SNF	0	0
Crestwood Behav. Modesto SNF	4	4
Crestwood Behav. Stockton SNF	4	4
Crestwood Behav. Redding SNF	4	4
Crestwood Behav. Sacramento MHRC	1	0
Crestwood Behav. San Jose	0	0
Country Villa-Merced Beh.Hlth	0	0
Ever Well	1	1
Garfield Neurobehavioral Center	1	1
Metropolitan State Hospital	0	0
Ridgeview	0	0
7th Avenue	2	2
Villa Fairmont	0	0
Vista Pacifica	6	7
Sequoia MHRC	2	1
Cedar Grove MHRC	5	5
Rosewood (tracking started 3/1/24)		
Golden Beginnings (started 3/1/24)		
Willow Glen	10	9
TOTAL ADULTS IN RESIDENTIAL TX FACILITIES:	40	38

Figure 29: SYBH Psychiatric Inpatient FY2024 Quarter 1 TAR Data

Combined youth & adult data

Month	Actual Number of Hospitalizations Reviewed (Based on completed TARs for the month)
January	25
February	35
March	17

Figure 30: SYBH SUDS Residential Placement Stats January 2024-March 2024

January 2024-March 2024

Residential Placement	Number of Referrals
Progress House	8
Granite Wellness	3
Pathways	3

All referrals accepted with a 30 day average stay.