Quality Assurance and Performance Improvement Plan Evaluation

Fiscal Year 2024-2025

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

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Mission

The Sutter County Health and Human Services Department promotes health, safety, economic stability, and quality of life for our community.

Vision

Healthy people in thriving communities.

Navigating this Plan

The Fiscal Year 2024-2025 Quality Assurance and Performance Improvement (QAPI) Plan consists of three primary categories: **Quality Monitoring**, **Program Integrity**, and **Quality Improvement Projects**. Each category encompasses specific topics and goals.

- The **Quality Monitoring** section outlines our routine monitoring activities.
- The **Program Integrity** section focuses on ensuring compliance and safeguarding the integrity of our operations.
- The **Quality Improvement Projects (QIPs)** section is dedicated to formal Performance Improvement Projects (PIPs) and other improvement initiatives that SYBH aims to pursue.

Within each category, goals are organized by function. Each goal includes associated interventions and performance measures. The interventions provide a roadmap for achieving the goal, while the measures are specific, quantifiable indicators—both qualitative and quantitative—that allow us to track progress and success.

Structure of SYBH Quality Ass*urance* and Performance Improvement (QAPI) Program

The QAPI Program outlines the structures and processes used to monitor and evaluate the quality of mental health, substance use, and administrative services provided. It involves active participation from SYBH practitioners and providers, quality improvement staff, as well as beneficiaries, family members, and other stakeholders in the planning, design, and execution of the program. SYBH actively engages stakeholders to identify gaps, analyze data, and gather input for the planning and implementation of quality improvement initiatives.

About the Quality Improvement Committee (QIC)

The Quality Improvement Committee (QIC) is responsible for planning and evaluating the outcomes of quality improvement activities, recommending policy changes, instituting necessary QI actions, ensuring follow-up on QI processes, and providing stakeholder input to the Sutter Yuba Behavioral Health (SYBH) Quality Assurance and Performance Improvement Program.

Quality Improvement Committee (QIC) Members

- Rick Bingham, LMFT – Director, Sutter-Yuba Behavioral Health
- Dr. Hardeep Singh, MD – Medical Director
- Betsy Gowan, PhD – Branch Director, Adult Services
- Josh Thomas, LCSW – Branch Director, Children's Services
- Susan Redford, LMFT – Branch Director, Acute Psychiatric Services
- Phillip Hernandez – Deputy Branch Director, Adult Services
- Steven Leahy – Assistant Director Health & Human Services, Administration and Finance
- Melissa Clavel, MPA – Quality Assurance Officer
- April Tate, LMFT – Program Manager, Adult Services
- Stacy Lee – Program Manager, SUDS
- Janet Amaya, LCSW – Clinical Services Program Manager, Youth and Family Services (CSOC/TAY)
- Darrin Whittaker, LMFT – Clinical Services Program Manager, Youth and Family Services
- Gina Duran, LCSW – Program Manager, Psychiatric Emergency Services
- Adam Reeb, LMFT – Program Manager, Psychiatric Health Facility
- Amanda Martin, MBA – Administrative Services Officer
- Consuelo Ayala – Office Services Supervisor
- Tina Wilson-Baker – Medical Records Supervisor
- Roxana Castellon – Staff Services Manager, Quality Assurance
- Tammy Andersen – Staff Analyst, Quality Assurance
- Rusti Bradford, LMFT – Utilization Review Specialist, Quality Assurance
- Kristine Hughes, LMFT – Mental Health Therapist III, Quality Assurance
- Xay Chue, LCSW – Mental Health Therapist III – SUDS, Quality Assurance
- Jesse Hallford – Staff Services Manager, Adult Services
- Amy Heir – Staff Analyst, Children’s Services
- Jaime Gascon – Secretary, Quality Assurance
- Sarah Feingold – Director of Behavioral Health Programs, Youth for Change
- Brooke Chambers – Director of Quality, Youth for Change
- Misty Utter, LMFT – Mental Health Therapist III/ Supervisor, Youth Urgent Services
- Adrian Rodriguez, LCSW – Mental Health Therapist III/Supervisor, Latino Outreach Center
- Tonya Beebe – Program Manager, Community Services - Adult Services
- Dustina Cordero, LCSW – Program Manager, Clinical Services Forensics and LPS Services
- Isac Matei, LMFT – Supervisor, Clinical Services Forensics
- Kelani Johnson – Prevention Services Coordinator
- Dr. Jacinta Brown-Wade, PhD, LMFT – Mental Health Therapist III/Supervisor, Youth and Family Services
- Estela Ramos, LCSW – Mental Health Therapist III/Supervisor, Youth and Family Services
- Donna Brown, LMFT – Psychiatric Emergency Supervisor, PES

The Quality Improvement Committee (QIC) Role

The Quality Improvement Committee (QIC) provides oversight to ensure the effective implementation of the QAPI Work Plan. The QIC sets priorities and delegates authority to various staff members, who study processes, implement improvement interventions, and analyze the effectiveness of any resulting changes. The QIC's responsibilities include:

- Overseeing all quality improvement activities within mental health, substance use, and administrative service functions.
- Ensuring that the results of studies are communicated for employee and consumer review.
- Soliciting and responding to employee and consumer feedback regarding areas that need improvement.
- Reviewing data collected through surveys and data management systems and using outcome measures to inform the QAPI program.
- Making recommendations to senior management, identifying the resources required for the full implementation of continuous quality improvement.
- Monitoring the problem resolution process.
- Overseeing utilization management information related to SYBH’s contract with the State Department of Health Care Services.
- Conducting and reviewing specialized quality improvement activities.

Quality Monitoring

Client Satisfaction Monitoring Overview

Client satisfaction monitoring includes various activities designed to help SYBH leadership assess consumer satisfaction with key components such as services, treatment, customer service, and access. The client satisfaction monitoring system will involve regular reviews of client problem resolutions, Consumer Perception Survey results, and Change of Provider Requests. Additionally, the quality program establishes a framework that utilizes benchmarks and targets to ensure client satisfaction is met and the monitoring system remains effective.

Client Satisfaction Monitoring Goals for Fiscal Year 2024-2025

Goal 1: Achieve 100% compliance with established timeliness standards for all complaints received through the problem-resolution process by the end of FY 2024-2025, with quarterly reviews of progress and monthly reporting to the QIC.	
Measurement	• **Annual Report**: Provide an annual report to the QIC and SUDS QIC by June 30, 2025, that includes the percentage of grievances, appeals, and State Fair Hearings resolved within the respective timeliness standards. The report will also highlight any notable trends related to timeliness compliance. • **Quarterly Reviews**: Conduct four quarterly reviews (October 2024, January 2025, April 2025, and July 2025) of all grievance/appeal cases, including the percentage of each category resolved within the timeliness standards. Each review will include an analysis of any notable trends in the data. • **Individual Case Reviews**: Review individual cases in program QIC meetings and SUDS QA as necessary, tracking the percentage of cases meeting timeliness standards. Reviews will be documented, and adjustments will be made as needed based on trends observed.
Intervention	• **Analyze Grievances**: Analyze grievances on a quarterly basis (October 2024, January 2025, April 2025, and July 2025) to identify trends in the types of grievances being filed. Develop targeted interventions as needed, with a clear action plan to address recurring issues by July 2025. • **Quarterly Monitoring**: The QA Staff Analyst will monitor cases at risk of non-compliance on a quarterly basis (October, January, April, and July). Specific focus will be given to cases nearing timeliness violations to ensure corrective actions are implemented immediately. • **Annual Report**: By July 30, 2025, the QA Staff Analyst will prepare and submit an annual report to the QIC and SUDS QIC. This report will include an analysis of notable trends in grievances, appeals, and State Fair Hearings, as well as any interventions that were implemented to address recurring issues.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, Quality Improvement Committee (QIC), SUDS QIC, Business Office
Evaluation	**Completed:** Grievance, appeal, and State Fair Hearing timeliness compliance was monitored throughout FY 2024–2025 through quarterly reviews, case-level monitoring, and reporting to the Quality Improvement Committee (QIC) and SUDS QIC. Quarterly data presentations included timeliness performance rates, trend analysis, and identification of cases at risk of exceeding required timelines.

	An annual grievance and appeal timeliness report was completed and submitted, including summary findings, performance outcomes, and analysis of notable trends. Results were reviewed with program leadership and shared through QIC processes. Training and technical assistance were provided to staff to strengthen compliance and improve consistency in documentation and tracking. Processes were also reviewed and updated to ensure alignment with DHCS requirements, including applicable Behavioral Health Information Notices (BHINs) issued during the fiscal year. Annual analysis found that there were only minor errors in the timeliness standards and no trends. The issues were addressed with the subcontractors/individuals responsible through education and training. **Ongoing:** Monitoring and reporting activities will continue into FY 2025–2026 to sustain compliance, address emerging risks, and support continuous quality improvement.

Goal 2: Administer the Consumer Perception Survey annually to assess client satisfaction with services, treatment, customer service, and access. The surveys will target a representative sample of beneficiaries to ensure comprehensive feedback.	
Measurement	• Annually share the results of the Consumer Perception Survey with staff and post them on the Sutter County website. • Achieve or exceed 80% satisfaction scores for both youth and adult outcomes and youth and adult functioning. • Results will be gathered from the semi-annual surveys, ensuring that satisfaction and functioning scores are consistently tracked and reported. • Monitoring these scores will ensure the services meet the needs of both youth and adult clients, promoting continuous improvement. • Survey results will be shared by June 30, 2025, and progress toward the 80% target will be evaluated annually.
Intervention	• Develop a targeted action plan and interventions aimed at improving satisfaction and outcomes/functioning for both youth and adults based on survey findings. • Collect and analyze survey data as soon as it is released by the State-contracted entity overseeing the CPS surveys, focusing on areas where satisfaction and outcomes are below target. • Based on data analysis, create interventions to address areas needing improvement, aiming for a minimum 80% satisfaction and functioning scores for both youth and adult populations. • Developing actionable interventions ensures that SYBH can enhance service delivery and client satisfaction, directly impacting program effectiveness. • Finalize and implement the action plan by July 31, 2025, and distribute the findings to leadership and staff within 30 days of receiving the survey results.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, QIC, SUDS QIC, SUDS QA
Evaluation	**Completed/Ongoing:** Consumer Perception Survey (CPS) results were reviewed and analyzed upon release from the State-contracted survey administrator and shared with program leadership, the Quality Improvement Committee (QIC), and SUDS QIC. Survey

	findings were used to assess client satisfaction, customer service, access to services, and treatment outcomes for both youth and adult populations. Results were reviewed against established performance targets, and trends and opportunities for improvement were discussed through QIC processes. Based on CPS findings, action planning and quality improvement activities were initiated to support continued improvement in satisfaction and access measures. Survey results and monitoring activities will continue into FY 2025–2026, including implementation and tracking of targeted improvement strategies through QIC oversight. SYBH will continue to analyze the Functioning and Outcome CPS results in the QIC and develop interventions as appropriate to increase scores in this area.

Goal 3: Track and review all Change of Provider Requests to assess consumer satisfaction with their assigned provider and identify potential areas for improvement.	
Measurement	• Identify providers who account for 30% or more of total Change of Provider Requests and perform trend analysis on those representing 40% or more of all requests. • Track and analyze the reasons for requests related to the identified providers, aiming to determine actionable patterns and areas for improvement. • The Quality Assurance (QA) team will collect data quarterly to identify the top providers contributing to the requests and analyze the reasons for changes. • Identifying and analyzing trends in provider-related requests helps to address specific issues in the provider-client relationship, leading to potential service improvements. • Complete trend analysis by June 30, 2025, and share the annual results with QIC by the end of July 2025.
Intervention	• Conduct quarterly analyses of Change of Provider Requests to identify concerns or trends related to provider changes. • Develop and implement interventions based on the identified trends, with the goal of addressing the top issues contributing to the requests and reducing the number of requests by 10% by the end of FY 2024-2025. • The QA team will analyze the data each quarter, collaborate with the SUDS QIC and other stakeholders to develop targeted interventions, and track the progress of these interventions. • Addressing trends and concerns through targeted interventions will help improve consumer satisfaction and reduce unnecessary provider changes. • Share the quarterly analysis and developed interventions with QIC within 30 days after each quarterly review, with the first review due by October 31, 2024, and continuing on a quarterly basis through June 30, 2025.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, QIC, SUDS QA
Evaluation	**Completed/Ongoing:** Change of Provider Requests were tracked and reviewed on a quarterly basis to assess trends related to consumer satisfaction, access, and provider-client relationship factors. Quarterly monitoring did not identify any significant or recurring trends requiring corrective action during FY 2024–2025. Findings were reviewed and discussed through the Quality Improvement Committee (QIC) process.

	Ongoing monitoring will continue into FY 2025–2026 to ensure timely identification of emerging concerns, support continuous quality improvement efforts, and maintain consumer access to appropriate provider services.

Access and Timeliness Monitoring Overview

The Access and Timeliness Monitoring system is designed to help SYBH leadership identify, and address barriers individuals may encounter when seeking care. This system provides a comprehensive picture of our ability to meet the behavioral health needs and demands of our community. The monitoring activities will include:

- **24/7 Access Line Monitoring:** Ensure continuous access to care through the availability and responsiveness of our 24/7 access line.
- **Cultural Competence:** Regularly assess and enhance cultural competence, including mandatory staff training, to ensure services are accessible and sensitive to the diverse needs of our community.
- **Timeliness of Service Access:** Track and evaluate how promptly services are provided in relation to established targets, aiming to ensure timely access for all individuals.
- **Provider Network Monitoring:** Continuously assess the adequacy of our provider network, ensuring sufficient capacity to meet the behavioral health needs of our community.

Together, these activities help assess our capacity to provide timely, culturally appropriate, and accessible behavioral health services to the people we serve.

Access and Timeliness Monitoring Goals for Fiscal Year 2024-2025

Goal 1: Increase the compliance rate of test calls to the 24/7 access line, ensuring that the line meets established responsiveness standards.	
Measurement	• Conduct a minimum of 12 test calls per quarter, ensuring testing occurs for the following types of calls: SMHS (Specialized Mental Health Services), Urgent, Problem Resolution Process • Ensure 100% compliance with the verbal requirements for test calls, increasing from 92% to 100% by the end of FY 2024-2025. • Ensure 100% compliance with written requirements for test calls, increasing from 60% to 100% by June 30, 2025. • Ensure that at least one test call annually is made in Hmong and Punjabi, and one test call per quarter is made in the Threshold language Spanish. • Review and analyze the results of the 12 test calls each quarter, focusing on improving verbal and written compliance, and ensuring that language diversity requirements are met. • Improving compliance with verbal and written requirements, along with language accessibility, ensures that the access line is fully responsive and meets community needs. • Submit 4 quarterly reports to PES leadership. • Share annual outcomes and analysis with QIC by June 30, 2025.
Intervention	• Report test call outcomes that do not meet verbal or written requirements monthly to PES leadership. • Share test call results with QIC for ongoing review and improvement. • Review and update Access Policies and Procedures (P&P) as necessary to ensure alignment with current standards and best practices. • Determine and implement an appropriate workflow for logging access calls and ensuring follow-up by screening/intake staff.

	• Develop and deliver annual training on access calls to ensure that PES staff are fully trained on call protocols and expectations.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, QIC, PES Leadership
Evaluation	**Completed/Ongoing:** Test calls to the 24/7 Access Line were conducted and reviewed on a quarterly basis to assess compliance with established verbal and written responsiveness standards, including language accessibility requirements. Results were reviewed with the Quality Improvement Committee (QIC) and shared with PES leadership. During FY 2024–2025, compliance targets were met during multiple reporting periods, and monitoring activities supported identification of improvement opportunities to strengthen access line responsiveness. Based on findings, feedback was provided to leadership and targeted staff retraining was completed to reinforce call handling expectations and documentation requirements. An improvement opportunity was also identified to expand the pool of test callers to support broader and more representative monitoring. Ongoing monitoring continued throughout the fiscal year to ensure sustained performance and continued quality improvement. Monitoring and improvement efforts will continue into FY 2025–2026 to support consistent compliance and maintain timely access to services.

Goal 2: Monitor and assess the timeliness of access to services for all individuals seeking care to ensure that all timeliness measures (e.g., initial contact, intake, and service provision) are met in accordance with regulatory requirements and SYBH standards.	
Measurement	• 80% of Mental Health (MH) and Substance Use Disorder Services (SUDS) clients are offered or receive billable services within 10 calendar days from the request to the first appointment. • 80% of new clients requesting Psychiatry Services will receive services within 15 calendar days from the request or assessment to the first psychiatric appointment. • 80% of new clients will begin Opioid Treatment Program services within 3 business days of request. • 80% of urgent requests for non-psychiatry and psychiatry services will be offered an appointment within 48 hours of the request.
Intervention	• Implement changes to improve data collection, monitor timeliness, and develop workflows to streamline urgent request handling. • Revise the Access to Service form to enhance data collection capabilities. • Conduct at least 4 meetings focused on timeliness monitoring and the quality of timeliness data. • Develop and finalize one tool that clearly defines urgent requests for the following service areas: 1. Adult Services 2. Youth Services 3. Psychiatric Services • Create one workflow document for urgent requests for each of the following services: Adult Services, Youth Services, Psychiatric Services. • Develop one training that includes detailed instructions on the new Access to Service forms and the handling of urgent requests.

Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, QIC (Quality Improvement Committee), Program Managers
Evaluation	**Completed/Ongoing:** Timeliness of access to services was monitored throughout FY 2024–2025, including initial contact, intake, and service provision, in alignment with applicable regulatory requirements and SYBH performance standards. During the fiscal year, work was completed to strengthen timeliness monitoring processes through collaboration with the EMR vendor, development of improved Access to Service forms, and enhancement of reporting capabilities to support consistent data collection across programs. Updated workflows and standardized documentation tools were implemented to improve tracking of routine and urgent requests for services. Staff training and technical assistance were provided to support consistent use of the updated processes. Progress and monitoring activities were reviewed through the Quality Improvement Committee (QIC) and with program leadership to support ongoing performance improvement. Monitoring and reporting efforts will continue into FY 2025–2026 to support sustained compliance, improved access, and continuous quality improvement.

Goal 3: Monitor the provider network adequacy to ensure it meets the community's behavioral health needs and service demands.	
Measurement	• Conduct one analysis of anticipated provider network needs and share findings with QIC by July 31, 2025. • Participate in monthly 274 submissions, ensuring accurate and timely reporting of provider network data.
Intervention	• Monitor the number of providers monthly to ensure network adequacy, with data reviewed and adjustments made as needed. • Utilize annual Meds anticipated needs data to determine the required number of providers, ensuring that the network can meet demand throughout the year. • Review network capacity quarterly to adjust for any fluctuations in provider availability and anticipated needs.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, QA Secretary, QIC (Quality Improvement Committee)
Evaluation	**Completed:** Provider network adequacy was monitored throughout FY 2024–2025 to ensure alignment with community behavioral health needs and service demands. Network data was reviewed on an ongoing basis, including completion of required monthly reporting submissions and analysis of anticipated provider network needs. Findings were reviewed with the Quality Improvement Committee (QIC) and used to support oversight of network capacity and availability. During the fiscal year, significant progress was also made in strengthening network adequacy monitoring through collaboration with the EMR vendor to enhance provider reporting functionality and improve the reliability of network data. Ongoing monitoring supported

	identification of provider capacity trends and ensured the provider network remained responsive to service needs. Monitoring activities will continue into FY 2025–2026 to support sustained compliance and continuous quality improvement.

Goal 4: Ensure a culturally competent workforce to improve service delivery and meet the diverse needs of the community.	
Measurement	• Increase attendance and participation in the DEIC and Affinity groups by 20% by June 30, 2025. • Collect real-time data to identify client needs and measure service gaps on a quarterly basis, with a target of 90% of client interactions documented. • Train 100% of staff in working with interpreters by December 31, 2025, and track completion through training records.
Intervention	• Collaborate with Program Managers and Subcontractors to recruit 100% participation from all programs for DEIC and Affinity groups by December 31, 2025. • Allocate budget for client and family incentives in the DEIC, ensuring that at least 75% of participating clients and families receive incentives by June 30, 2025. • Develop a "Working with Interpreters" training and roll it out to all staff by September 30, 2025. • Create pre- and post-tests for "Working with Interpreters" training and ensure 90% of staff complete them by December 31, 2025. • Partner with Kingsview to develop penetration rates report and deliver it by June 30, 2025. • Design and distribute an annual cultural competency survey for staff, clients, and families, with a target response rate of 80% by June 30, 2025. • Conduct an annual review of Real Data at the DEIC meeting and share the findings with leadership by December 31, 2025.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, QIC, DEIC, Hmong Outreach Supervisor, Latino Outreach Center Supervisor, SUDS QA
Evaluation	**Completed/Ongoing:** Activities to strengthen cultural competency and support a culturally responsive workforce were implemented throughout FY 2024–2025. Participation in DEIC and Affinity Group activities was monitored, and Real Data was reviewed to assess engagement, identify service gaps, and guide quality improvement efforts. Staff training related to interpreter access and culturally and linguistically appropriate service delivery was completed and tracked, and findings were incorporated into program reporting and oversight activities. A cultural competency survey process and staff engagement activities were developed and will be administered and results shared with leadership in the future. Work to strengthen monitoring of penetration rates and reporting capabilities is ongoing in collaboration with the EMR vendor to improve data reliability and support continued evaluation of outreach effectiveness. Continued monitoring of cultural competency activities, staff training, and workforce engagement will continue into FY 2025–2026 to ensure services remain responsive to the diverse needs of the community.

Utilization and Care Quality Monitoring Overview

Utilization and care quality monitoring activities focus on key indicators related to authorizations for both routine and hospitalization services. These activities aim to ensure appropriate use of services and identify potential issues impacting care quality. Specifically, we monitor trends in over- and under-utilization, leveraging data from our authorization system to spot inconsistencies or patterns that could indicate quality concerns.

Additionally, we incorporate HEDIS (Healthcare Effectiveness Data and Information Set) measures, focusing on medication adherence and readmission rates, to evaluate and improve care quality. This dual approach enables us to assess both the efficiency of service utilization, and the effectiveness of the care provided, ensuring that we meet industry standards and continuously improve service delivery for our clients.

Utilization and Care Quality Monitoring Goals for Fiscal Year 2024-2025

Goal 1: Ensure that all Notices of Action and Beneficiary Determination (NOABD) are issued in compliance with established timelines and regulatory requirements.	
Measurement	• Develop and deliver one formal training for business office staff on financial liability NOABD issuance by June 30, 2025. • Conduct one Utilization Review Committee (URC) meeting to review NOABD issuance rates and compliance monitoring results by March 31, 2025. • Monitor and track NOABD issuance compliance rates monthly, aiming for 100% compliance with regulatory timelines. • Provide quarterly reports to the Quality Improvement Committee (QIC) on compliance progress, with data on trends and improvement areas.
Intervention	• Conduct a process review of financial liability NOABD issuance by June 30, 2025, to identify inefficiencies and compliance issues. • Identify process and knowledge gaps related to financial liability NOABD issuance by June 30, 2025, and develop corrective actions to address these gaps. • Develop and deliver formal training for all relevant staff on financial liability NOABD issuance by August 31, 2025, to ensure knowledge is up to date. • Conduct sample audits of financial liability NOABD issuance monthly, aiming for a 95% compliance rate by December 31, 2025 • Analyze audit data quarterly and share findings with relevant stakeholders to ensure continuous improvement and adherence to timelines.
Due Date	December 31, 2025
Responsible Parties	QA Staff Analyst, QA Staff Mental Health Therapist III, QIC, Business Office Leadership and Staff, SUDS QIC, SUDS QA
Evaluation	**Ongoing/Partially Completed:** Authorization process outcomes were reviewed and monitored throughout FY 2024–2025 through regular Utilization Review Committee (URC) meetings and ongoing data analysis. Authorization results and identified discrepancies were reviewed, documented, and addressed through URC oversight, with progress tracking incorporated into quality improvement discussions. Quarterly monitoring activities supported identification of trends related to utilization, timeliness, and consistency across authorization types. Findings informed ongoing efforts to strengthen standardization of authorization processes, including review of benchmarking needs, audit considerations, and opportunities for targeted process improvements. Continued monitoring and quality improvement activities will carry forward into FY 2025–2026 to support timely authorizations, improved consistency, and alignment with service needs.

Goal 2: Improve and standardize the authorization process for all services to eliminate discrepancies, ensure timely approvals, and optimize resource allocation.	
Measurement	• Hold at least 2 meetings per year where authorization results are reviewed and discussed with the Utilization Review Committee (URC). • Ensure 100% of discrepancies in authorization results are documented and addressed in the meetings. • Track and report progress on the implementation of improvements identified during meetings, aiming for at least 80% implementation of action items discussed.
Intervention	• Monitor and analyze all authorization types (ICC, IHBS, TFC, TBS, SARS, TARS) for trends of services offered and underutilization on a quarterly basis. • Create benchmarks and standards for TARS by March 31, 2025, and use these • benchmarks to monitor against, sharing findings at the next available URC meeting. • Conduct a quarterly sample audit of TARS to assess quality and consistency, targeting at least 90% accuracy in the identified sample. • Review and analyze screenings for Therapeutic Foster Care (TFC) and develop specific goals by December 31, 2025, implementing them in the following quarter, and ensuring progress is tracked.
Due Date	June 30, 2025
Responsible Parties	QA Utilization Review Specialist, QA Mental Health Therapist III, QA Staff Analyst, URC (Utilization Review Committee)
Evaluation	**Ongoing/Partially Completed:** Authorization process outcomes were reviewed and monitored throughout FY 2024–2025 through regular Utilization Review Committee (URC) meetings and ongoing data analysis. Authorization results and identified discrepancies were reviewed, documented, and addressed through URC oversight, with progress tracking incorporated into quality improvement discussions. Quarterly monitoring activities supported identification of trends related to utilization, timeliness, and consistency across authorization types. Findings informed ongoing efforts to strengthen standardization of authorization processes, including review of benchmarking needs, audit considerations, and opportunities for targeted process improvements. Continued monitoring and quality improvement activities will carry forward into FY 2025–2026 to support timely authorizations, improved consistency, and alignment with service needs.

Goal 3: Ensure that all concurrent reviews for services are conducted in compliance with established standards, including timely reviews and accurate documentation.	
Measurement	• Develop two detailed reports from Atrezzo system, outlining concurrent review compliance data (one quarterly report and one annual summary report). • Share results at least once with the URC (Utilization Review Committee) ensuring review of compliance and trends.
Intervention	• Familiarize with how to run reports from the system used by the contractor conducting concurrent reviews by March 30, 2025. • Analyze the concurrent review data from the system and share findings with URC in at least 1 meeting by June 30, 2025.
Due Date	June 30, 2025
Responsible	QA Staff Analyst, URC (Utilization Review Committee), Utilization Review Specialist

Parties	
Evaluation	**Ongoing/Partially Completed:** Concurrent review activities were monitored throughout FY 2024–2025 to support compliance with established timeliness and documentation standards. Concurrent review findings and monitoring activities were reviewed through Utilization Review Committee (URC) processes to support oversight and identify trends and opportunities for improvement. Efforts were initiated to strengthen reporting capabilities within the Atrezzo system to support more consistent monitoring and analysis of concurrent review performance. Monitoring and reporting improvements will continue into FY 2025–2026 to enhance accuracy, consistency, and compliance with concurrent review requirements.

Goal 4: Implement a system for monitoring and documenting the review of indicators from the California Child Welfare Indicators Project (CCWIP).

Measurement	• Analyze results from monitoring indicators and share findings at each quarterly URC meeting. • Ensure that 100% of relevant results are included in the analysis, with clear trends, recommendations, and action items. • Present findings by the end of each quarter, ensuring the data is shared with URC members at least one week prior to each meeting for review. • Track the implementation of action items resulting from the analysis, ensuring that 90% of recommended actions are addressed by the next quarterly review.
Intervention	• Implement a monitoring system for Children and Adolescents based on AB1299 HEDIS measures: 1. Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medications, with at least 90% of eligible children receiving appropriate follow-up care within the recommended timeframe. 2. Use of multiple concurrent psychotropic medications for children and adolescents, with a goal of reducing instances of unnecessary polypharmacy by 10% annually. 3. Metabolic monitoring for children and adolescents on antipsychotics, ensuring 95% of eligible children receive metabolic monitoring as per established guidelines within 12 weeks of starting antipsychotic medications. 4. Use of first-line psychosocial care for children and adolescents on antipsychotics, aiming for 80% of children to receive appropriate psychosocial interventions before or concurrently with antipsychotic prescriptions. • Conduct quarterly reviews of each measure, with results analyzed and action items developed to improve performance. • Train staff on AB1299 HEDIS measures and ensure that 100% of relevant

	staff are trained by June 30, 2025, on these guidelines to ensure compliance. • Ensure that monthly audits are conducted to track compliance rates and share results with leadership.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, URC, Medical Director, Youth Services Program Managers, Youth Services Staff Analyst
Evaluation	**Ongoing:** Monitoring activities related to California Child Welfare Indicators Project (CCWIP) AB1299 HEDIS measures were incorporated into FY 2024–2025 quality monitoring efforts, with a focus on strengthening the County's ability to track follow-up care, psychotropic medication monitoring, and related children and adolescent performance indicators. Quarterly review processes and indicator tracking efforts were supported through utilization review and quality oversight activities. Progress toward fully implementing a standardized monitoring and reporting framework was impacted by limitations in available HEDIS reporting tools and access to required dashboards and data elements within the EMR system. During the fiscal year, efforts were initiated to strengthen reporting capabilities and improve access to performance data to support ongoing analysis, trend identification, and quality improvement planning. Monitoring and reporting efforts will continue into FY 2025–2026 as reporting capabilities and data access are further enhanced.

Goal 5: Monitor hospital readmission rates for both mental health and substance use disorder services to identify trends and areas for improvement.	
Measurement	• Track the readmission rate within 7 days post-hospitalization for mental health and substance use disorder services, aiming to achieve a reduction of 10% by June 30, 2025. • Track the readmission rate within 30 days post-hospitalization for mental health and substance use disorder services, aiming for a 10% reduction by June 30, 2025. • Share readmission rates with the Utilization Review Committee (URC) at least twice a year including data analysis and trends. • Develop and implement a plan to address data inaccuracies, ensuring any discrepancies in readmission tracking are resolved and corrected by the end of Q3 2025.
Intervention	• Identify tracking issues related to readmission rates by conducting a comprehensive review of data collection processes and resolving discrepancies by Q2 2025. • Align benchmarks with State standards for hospital readmission rates, ensuring that the benchmarks are based on the most recent available data and incorporate any relevant state guidelines by March 31, 2025. • Share readmission rates with the Utilization Review Committee (URC) routinely at least twice per year (e.g., semi-annually), providing trend analyses and discussing improvement strategies by June 30, 2025.
Due Date	June 30, 2025

Responsible Parties	QA Staff Analyst, QIC, Inpatient Leadership
Evaluation	**Ongoing:** Hospital readmission monitoring activities were initiated during FY 2024–2025 to support identification of trends and improvement opportunities for both mental health and substance use disorder services. Work during the fiscal year focused primarily on establishing a reliable process for obtaining and validating readmission data within the EMR system to support accurate reporting for 7-day and 30-day readmission measures. Progress and findings were reviewed through Utilization Review Committee (URC) processes as available, and efforts were directed toward improving data collection, ensuring consistency in tracking methodology, and aligning monitoring practices with applicable standards and benchmarks. Collaboration with the EMR vendor is ongoing to enhance reporting capabilities and strengthen the County's ability to monitor readmission rates consistently over time. Monitoring and system development efforts will continue into FY 2025–2026 to support improved access to actionable data and continued quality improvement.

Goal 6: Ensure compliance with psychiatric inpatient submission standards, including the accuracy, completeness, and timeliness of submitted documentation.	
Measurement	• Achieve an overall compliance rate of at least 90% for unresolved cases by June 30, 2025. • Achieve an overall compliance rate of at least 90% for resolved cases by June 30, 2025. • Analyze compliance data biannually (twice per year) and share the findings with the Utilization Review Committee (URC). • Track and report compliance trends and improvements each quarter to ensure progress toward the 90% target.
Intervention	• Monitor psychiatric inpatient case statuses at least monthly to identify any issues that may delay timely claim submission or payment and take corrective action as needed. • Identify cases with submitted, rejected, or denied status and coordinate with the facility and Acentra (Kepro) as appropriate for timely resolution. • Address non-compliance with Title 9 regulation or BHIN 22-017 immediately upon discovery by coordinating with the treating facility or Acentra (Kepro) to determine the appropriate course of action. • Provide quarterly reports on the status of identified issues and resolutions to ensure timely action and improvement.
Due Date	June 30, 2025
Responsible Parties	Utilization Review Specialist, URC Committee
Evaluation	**Completed:** Compliance with psychiatric inpatient submission standards was monitored throughout FY 2024–2025 to assess accuracy, completeness, and timeliness of submitted documentation. Compliance data for both resolved and unresolved cases was reviewed on a biannual basis and shared through Utilization Review Committee (URC) oversight processes.

	Monitoring activities supported identification of trends, recurring issues, and opportunities for improvement related to inpatient submissions, denials, and delays. Corrective actions were implemented as needed, including follow-up with appropriate staff and coordination with external entities when applicable to support timely resolution. Quarterly reporting and ongoing monitoring supported continued progress toward established compliance targets and strengthened adherence to regulatory and documentation standards. Monitoring will continue into FY 2025–2026 to ensure sustained compliance and continuous quality improvement.

Goal 7: Develop and implement a comprehensive system to track and monitor service utilization, levels of care, and related outcomes to ensure appropriate care delivery.	
Measurement	• Develop a monitoring system to track children utilizing PES services or hospitalization, including youth not connected to ongoing services by June 30, 2025. • Implement a system for level of care reporting and data analysis, with a goal of having the system fully functional and reporting outcomes for at least 95% of children receiving services by December 31, 2025. • Review and analyze trends for children utilizing PES services or hospitalizations while engaged in treatment with SYBH, with a report on findings shared with leadership quarterly.
Intervention	• Develop benchmarks for the utilization of PES services and/or hospitalization by December 31, 2025, with clear guidelines for comparison and analysis. • Create benchmarks for LOCUS and MORS assessments by March 31, 2025, ensuring they align with clinical best practices and service utilization standards. • Collaborate with EHR team to explore and implement a system for reporting and analyzing level of care (LOC) data by June 30, 2025, ensuring all data points are captured accurately and accessible for continuous monitoring.
Due Date	June 30, 2025
Responsible Parties	Utilization Review Specialist, URC Committee
Evaluation	**Ongoing:** Development of a comprehensive system to monitor service utilization, levels of care, and related outcomes for children receiving PES services and/or experiencing hospitalization remained in progress throughout FY 2024–2025. Progress during the fiscal year was impacted by limitations in existing EMR reporting functionality and access to required data elements needed to support standardized monitoring and outcome reporting. Work focused on strengthening data collection processes, defining monitoring workflows, and collaborating with system stakeholders to enhance EMR reporting capabilities. Available monitoring activities and findings were reviewed through Utilization Review Committee (URC) oversight and shared with leadership to support program planning and quality improvement.

	System development and reporting enhancements will continue into FY 2025–2026 to support consistent utilization monitoring, improved data reliability, and continuous quality improvement.

Program Integrity Monitoring Overview

Program Integrity monitoring activities are designed to enhance accountability and ensure compliance with federal and state statutory and regulatory requirements. These activities aim to systematically identify areas for improvement, ensure consistent adherence to regulations, and highlight the need for targeted technical assistance. By tracking performance metrics, the monitoring process will facilitate continuous improvement and help optimize service delivery, ensuring ongoing compliance and better outcomes over time.

Program Integrity Monitoring Goals for Fiscal Year 2024-2025

Goal 1: Conduct comprehensive audits of Mental Health (MH) and Substance Use Disorder Services (SUDS) charts to ensure compliance with federal, state, and local regulations.	
Measurement	• Achieve an overall compliance rate of at least 80% on quarterly audits for both contractors and internal program charts of SMHS and SUDS. • Analyze and review the compliance rates at quarterly QIC, SUDS QIC, and SUDS QA meetings and share findings by the end of each quarter to identify trends and areas of improvement.
Intervention	• Conduct quarterly chart audits for both contractors and internal programs to assess overall compliance with DHCS (Department of Health Care Services) documentation rules and regulations. • Issue and monitor Corrective Action Plans (CAPs) to program leadership for any charts requiring service voiding or reimbursement recoupment. • Monitor CAP implementation throughout the quarter. • Provide individualized/targeted training for any program scoring below the 80% compliance threshold, with training completed within 30 days of audit results.
Due Date	June 30, 2025
Responsible Parties	QA Therapist, QIC, Youth Services Leadership, Adult Services Leadership, Contracted Provider Leadership, SUDS QA, SUDS QIC
Evaluation	**Completed/Partially Completed:** Chart audits for both Mental Health (MH) and Substance Use Disorder Services (SUDS) were conducted during FY 2024–2025 to assess compliance with federal, state, and local documentation requirements. While the QAPI goal of completing quarterly chart audits was not fully met, SYBH completed chart review activities in alignment with the agency standard of conducting audits at least annually. Audit results were reviewed and analyzed, and findings were shared through QIC, SUDS QIC, and applicable QA/UR oversight processes. Trends and areas for improvement were identified, and corrective actions were implemented as needed. Corrective Action Plans (CAPs) were issued when appropriate and monitored to support timely resolution of identified deficiencies. Targeted training and technical assistance were

	provided to programs and staff to strengthen documentation practices and support compliance with established performance standards. Monitoring and audit activities will continue into FY 2025–2026 to support continuous quality improvement, strengthen documentation compliance, and ensure program integrity across service areas.

Quality Improvement Projects

Performance Improvement Projects (PIP) Overview

Performance Improvement Projects (PIPs) are designed to achieve measurable, sustainable improvements in health outcomes and enrollee satisfaction. These projects have a direct impact on beneficiaries and work towards improving services at the individual member, provider, and/or Mental Health Plan (MHP) system levels.

Each PIP is a structured initiative aimed at enhancing specific administrative or clinical processes to improve access to, and the quality of, Specialty Mental Health Services (SMHS). The focus of SMHS will be both on clinical and non-clinical areas. By targeting these areas, PIPs aim to reduce barriers to care, enhance service delivery, and improve overall service quality.

Performance Improvement Projects (PIP) Goals for Fiscal Year 2024-2025

Non-Clinical PIP Goal: Improve the timeliness of access to urgent non-psychiatry and psychiatry services for adults (ages 21+) and children and youth (ages 0-20) by ensuring that 90% of appointments are offered within 48 hours from first contact with any referral source, by June 30, 2025.

Measurement	• **Target:** At least 80% of clients requesting urgent non-psychiatry SMHS services will be offered an appointment within 48 hours of first contact by June 30, 2025.
Intervention	• Develop a tool to define urgent requests for non-psychiatry and psychiatry services by June 30, 2025. • Develop a workflow for confirming the urgency of requests, scheduling, and documenting urgent appointments by June 30, 2025. • Create and implement training on determining, documenting, and scheduling urgent requests for staff by June 30, 2025. • Review urgent timeliness data at QIC meetings quarterly starting from July 2025.
Due Date	June 30, 2025
Responsible Parties	Children and Family Program Manager, Youth Urgent Services Supervisor, Reception Supervisor, Reception Staff QIC, QA Staff Analyst
Evaluation	**Completed/Ongoing:** Timeliness of access to urgent non-psychiatric and psychiatric services was monitored throughout FY 2024–2025 to assess compliance with established access standards. Data related to urgent requests was reviewed to evaluate whether appointments were offered within required timeframes. Tools and workflows were developed to support standardized identification, documentation, and scheduling of urgent requests, and staff training was provided to promote consistent implementation. Monitoring results identified periods of variability in performance; however, improvement activities were implemented to address barriers and strengthen timely access processes. Findings were reviewed through QIC oversight and used to guide continued process

	improvement efforts. Ongoing monitoring and improvement activities will continue into FY 2025–2026 to support sustained progress and timely access to care.

Clinical PIP Goal: Increase the percentage of patients who receive a follow-up appointment with a mental health provider within 30 days after an Emergency Department (ED) visit for mental illness.	
Measurement	• Achieve a 80% follow-up rate for individuals who visit the Emergency Department (ED) for mental illness, ensuring they are seen by a mental health provider within 30 days of the visit. • Track and report follow-up rates quarterly at URC meeting, documenting the number of ED visits for mental illness and the number of patients receiving a follow-up within 30 days. • Establish a baseline follow-up rate at the start of the initiative and compare progress quarterly. The goal is to increase the current rate to 80% by June 30, 2025.
Intervention	Collaboration with ED Teams: • Work with Emergency Department staff to establish a direct communication link to identify patients with mental health needs and ensure proper referral to follow-up care. • Develop an efficient communication system between ED staff and mental health providers to ensure timely follow-up scheduling. Utilize Technology for Appointment Scheduling: • Leverage the electronic health record (EHR) system to flag ED visits for mental illness and prompt automatic appointment scheduling or reminders for follow-up appointments within the required timeframe. • Implement electronic appointment reminders (e.g., text messages, phone calls) for patients to reduce no-show rates. HSAG Submission Requirements • Submit PIP Submission form (Steps 1-6) by July 1, 2025. • Submit PIP Submission form (Steps 1-8) annually thereafter starting July 1, 2026.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, PES Leadership and staff, QA Staff Services Manager, Reception Leadership and staff
Evaluation	**Ongoing:** Follow-up appointment rates for individuals presenting to the Emergency Department (ED) for mental illness were monitored throughout FY 2024–2025 to assess timeliness of connection to outpatient mental health services. Baseline data was established, and quarterly tracking efforts were initiated to support monitoring toward the 30-day follow-up target. A multidisciplinary workgroup was established to support implementation of this Performance Improvement Project (PIP), including coordination with PES leadership, ED partners, and internal stakeholders. Work during the fiscal year focused on strengthening referral and follow-up workflows and improving the County's ability to capture ED visit data across facilities. Collaboration with the EMR vendor and Health Information Exchange (HIE) partners is ongoing

	to enhance data integration and reporting capabilities, including the ability to identify ED visits from multiple hospitals within the EMR. Monitoring and improvement activities will continue into FY 2025–2026 to strengthen data reliability, expand reporting capacity, and support improved follow-up care after ED visits.

Quality Performance Measures Overview

Quality Performance Measures (QPMs) are designed to drive continuous improvements in healthcare delivery, focusing on achieving specific, measurable outcomes that enhance patient care and overall system performance. These measures play a critical role in tracking and evaluating the effectiveness of care across various domains, including mental health, chronic disease management, and preventive services. By aligning with evidence-based practices, QPMs aim to improve service quality, access, and patient satisfaction at the individual, provider, and system levels. Through the systematic monitoring and analysis of key performance indicators, we can identify opportunities for improvement, enhance care coordination, and ensure the delivery of high-quality services to all beneficiaries.

Quality Performance Measures Goals for Fiscal Year 2024-2025

Goal 1: Increase the percentage of patients who receive a follow-up appointment with a mental health provider within 30 days after hospitalization discharge for mental illness.	
Measurement	• Achieve a 5% improvement from baseline follow-up rates for individuals hospitalized for mental illness, ensuring they are seen by a mental health provider within 30 days of discharge. • Track and report follow-up rates quarterly at URC meetings, documenting the number of hospitalization visits for mental illness and the number of patients receiving a follow-up within 30 days. • Establish a baseline follow-up rate at the start of the initiative and compare progress quarterly. The goal is to increase the current rate by 5% by June 30, 2025.
Intervention	Utilize Technology for Appointment Scheduling: • Leverage the electronic health record (EHR) system to flag post-hospitalization visits for mental illness and prompt automatic appointment scheduling or reminders for follow-up appointments within the required timeframe. • Implement electronic appointment reminders (e.g., text messages, phone calls) for patients to reduce no-show rates. HSAG/DHCS Submission Requirements • Submit annually.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, PHF Leadership and staff, QA Staff Services Manager
Evaluation	**Ongoing:** Follow-up appointment rates within 30 days of hospitalization for mental illness were monitored throughout FY 2024–2025 to assess continuity of care following discharge. Baseline data was established, and quarterly tracking efforts were initiated through URC processes to support measurement of follow-up performance and identification of trends and improvement opportunities.

	A multidisciplinary workgroup supported implementation activities, including review of follow-up workflows, coordination with program leadership, and identification of strategies to strengthen timely linkage to outpatient mental health services. Work during the fiscal year focused on improving data capture and reporting capabilities within the EMR system, including collaboration with the EMR vendor and Health Information Exchange (HIE) partners to strengthen visibility of hospitalization events and follow-up appointment tracking. Monitoring and improvement efforts will continue into FY 2025–2026 to enhance reporting accuracy, strengthen scheduling and follow-up processes, and support continued progress toward established performance targets.

Goal 2: Improve the percentage of patients with major depressive disorder who are effectively managed with antidepressant medication during the acute and continuation phases of treatment.	
Measurement	• Achieve 5% improvement in the percentage of patients with major depressive disorder (MDD) who are effectively treated with antidepressants in the acute and continuation phases (tracked by medication adherence, prescribed dosage, and treatment duration). • Quarterly tracking and reporting of adherence and treatment effectiveness at URC meetings.
Intervention	• Utilize electronic health records (EHR) to track prescriptions, medication adherence, and timely follow-up appointments. • Assign care coordinators to support patients throughout their antidepressant treatment and follow-up appointments. • Offer educational sessions and materials to ensure patients understand their medication regimen and the importance of adherence. • Provide follow-up appointments via telehealth and virtual check-ins for medication adherence.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, Adult Outpatient Leadership, Youth Outpatient Leadership, QA Staff Services Manager, Medical Director
Evaluation	**Ongoing:** Antidepressant medication management for individuals with major depressive disorder was identified as a priority quality monitoring area during FY 2024–2025 to support improved continuity of care during both the acute and continuation phases of treatment. During the fiscal year, efforts primarily focused on defining required data elements, establishing baseline measurement methodology, and collaborating with the EMR vendor to determine feasibility and reporting specifications needed to support accurate performance tracking. Due to limitations in existing EMR reporting functionality, full implementation of routine monitoring and quarterly reporting was dependent on development of enhanced reporting tools. Reporting capability has since been strengthened to support establishment of baseline performance and ongoing monitoring moving forward. Monitoring and reporting will continue into FY 2025–2026 to support continuous quality improvement and progress toward established performance targets.

Goal 3: Increase the percentage of individuals with schizophrenia who adhere to their prescribed antipsychotic medication regimen.	
Measurement	• Achieve a 5% improvement in the medication adherence rate for individuals with schizophrenia who are prescribed antipsychotic medications. • Monthly tracking and quarterly reporting of adherence data at URC meetings.
Intervention	• Leverage EHR systems to monitor prescriptions, refills, and adherence trends. • Provide ongoing education to clients on the importance of adherence to antipsychotic medications to reduce the risk of relapse and manage symptoms effectively. • Establish a protocol for regular follow-ups with patients to discuss medication adherence, address concerns, and ensure refills are being processed.
Due Date	June 30, 2025
Responsible Parties	QA Staff Analyst, Adult Outpatient Leadership, Youth Outpatient Leadership, QA Staff Services Manager, Medical Director
Evaluation	**Ongoing:** Antipsychotic medication adherence for individuals with schizophrenia was identified as a priority quality monitoring area during FY 2024–2025 to support continuity of care, reduce relapse risk, and improve treatment outcomes. During the fiscal year, efforts primarily focused on defining required data elements, establishing baseline measurement methodology, and collaborating with the EMR vendor to determine feasibility and reporting specifications needed to support accurate performance tracking. Due to limitations in existing EMR reporting functionality, routine performance monitoring and quarterly reporting were dependent on development of enhanced reporting tools. Reporting capability has since been strengthened to support establishment of baseline performance and ongoing monitoring moving forward. Monitoring and reporting will continue into FY 2025–2026 to support continuous quality improvement and progress toward established performance targets.