



**SUTTER-YUBA BEHAVIORAL HEALTH QUALITY
ASSESSMENT AND PERFORMANCE
IMPROVEMENT PLAN**

FISCAL YEAR 2021-2022

ABSTRACT

This is the annual plan for quality monitoring and improvement for Sutter-Yuba Behavioral Health's service delivery system. This plan is a living document and adaptations will be made as needed. This annual plan builds upon previous years to add and modify activities to sustain continuous quality improvement and performance monitoring activities.

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A. Description of Quality Improvement

The role and function of the Quality Improvement Council (QIC), is to plan and evaluate the results of quality improvement activities, recommend policy changes, institute needed QI actions, ensure follow-up of QI processes, and ensure stakeholder input to the Sutter Yuba Behavioral Health (SYBH) Quality Assessment and Performance Improvement Program.

Structure of SYBH Quality Assessment and Performance Improvement Program (QAPI)

The QAPI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health, substance abuse and administrative services provided. The QAPI program includes active participation by the SYBH's practitioners and providers, SYBH quality improvement staff, as well as beneficiaries, family members, and other stakeholders, in the planning, design and execution of the QI program. SYBH will encourage providers to discuss the QI program with the beneficiaries to encourage recruitment as part of the selection process for participation in the QI program.

The Quality Improvement Council (QIC)

QIC provides oversight to ensure implementation of the QAPI Work Plan. QIC sets priorities, delegates authority to the various teams who then study processes, make recommendations for improvement and subsequently analyze effectiveness of any changes which may have occurred. All recommendations of these teams are reviewed by the QIC which will in turn make recommendations to the Behavioral Health Director. Specific responsibilities and activities of the QIC are identified under elements of QAPI Program and Utilization Management (UM) description.

Other QIC responsibilities are as follows:

- Provides oversight of all QI activities within mental health, substance use, and administrative services.
- Ensures that the results of various studies are publicized for employee and consumer review.
- Elicits and responds to employee and consumer identification of areas requiring improvement.
- Reviews data and information collected through surveys and data management and utilizes outcome measure results in the QAPI program.
- Makes recommendations to senior management, identifying needed resources for full implementation of continuous quality improvement.
- Monitors the problem resolution process.
- Monitors utilization management information with regards to SYBH's contract with State Department of Health Care Services.
- Conducts and reviews specialized quality improvement activities.

Quality Improvement Activities for FY 2021/2022 include objectives from the following categories:

1. Monitoring the service delivery capacity of the SYBH;
2. Monitoring the accessibility of services;
3. Monitoring beneficiary satisfaction;
4. Monitoring SYBH service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices;
5. Monitoring continuity and coordination of care with physical health care providers and other human services agencies;
6. Monitoring provider appeals;
7. Monitor cultural competence and linguistic standards.
8. Monitor mechanisms SYBH has implemented to assess the accessibility of services within its service delivery area, including goals for:
 - 1) Responsiveness for the Contractor's 24-hour toll-free telephone number.
 - 2) Timeliness for scheduling of routine appointments.
 - 3) Timeliness of services for urgent conditions.
 - 4) Access to after-hours care.

The QI activities shall include:

1. Collecting and analyzing data to measure against the goals, or priority areas of improvement that have been identified;
2. Identifying opportunities for improvement and deciding which opportunities to pursue;
3. Identifying relevant committees internal or external to SYBH to ensure appropriate exchange of information with the QIC;
4. Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;
5. Designing and implementing interventions for improving performance;
6. Measuring effectiveness of interventions;
7. Incorporating successful intervention into the SYBH's operations as appropriate;
8. Reviewing beneficiary grievances, appeals, expedited appeals, fair hearing, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9 § 18.10.440(a)(5);
9. Conduct two performance improvement projects; a clinical and a non-clinical.

Utilization Management

The Utilization Management (UM) Program is responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Cal. Code Regs., tit. 9, § 1810.440(b)(1)-(3).

Utilization Management activities will be conducted by SYBH authorization and quality assurance staff. Consistent with State DHCS regulations, licensed Mental Health staff are substantially involved in utilization management program planning and implementation.

A description of the authorization processes:

- Authorization decisions are made by licensed or “waivered/registered” mental health staff consistent with State regulations.
- Relevant clinical information will be obtained and used for authorization decisions. There will be a written description of the information that is collected to support authorization decision making.
- SYBH staff will use the statewide medical necessity criteria to make authorization decisions.
- Medical necessity must exist for specialty mental health treatment to be eligible for reimbursement under plan requirements. Medical Necessity criteria include:
 - A list of included and excluded diagnoses;
 - Associated impairment criteria;
 - Intervention criteria; and
 - The client must be expected to benefit from treatment.
- Mental Health Plan will clearly document and communicate the reasons for each denial.
- SYBH will send written notification to its beneficiaries and providers of the reason for denial.
- Clinical decisions shall be based upon the professional judgment of the provider and the clinical presentation of the client.
- Mental Health Plan authorization staff make payment authorization decisions.
- The clinical decision to provide or not to provide services to a client lies with the provider.
- Clinical features, specifically the level of clinical stability and the degree of functional impairment, are factors that determine the course of treatment.
- SYBH provides the statewide medical necessity criteria to its practitioners, providers, consumers, family members and others upon request.
- Authorization decisions are made in accordance with statewide timeliness standards for authorization of services for urgent conditions, as established by the Department of Health Care Services (DHCS).
- SYBH monitors the UM process to ensure it meets the established standards for authorization decision making and take action to improve performance if it does not meet the established standards.
- SYBH includes information about the beneficiary grievance and fair hearing processes in all denial notifications sent to the beneficiary.
- The UM program is reviewed annually by SYBH, including a review of the consistency of the authorization process.
- No Utilization Management activities will be delegated to other entities.

QI Work Plan Goals FY 2021/2022

This is a living document and may be changed as needed.

SYBH will continue monitoring efforts for previously identified issues, including tracking issues over time.

SYBH will consider objectives, scope, and planned QAPI activities for each year.

SYBH will review targeted areas of improvement or change in service delivery or program design.

1. Monitoring Service Delivery Capacity

Goal		Planned Activity	QI Staff	Review Date
Maintain and improve penetration rates of underserved population(s).	1.1	Monitor penetration rates of ethnic groups with low penetration and retention rates. <ul style="list-style-type: none"> • Compare these rates across ethnic groups, age, and gender • Compare these rates by ethnic groups to the total Medi-Cal population • Goals: decrease unknown penetration rates by 2 percent • Add more grouping for Asian populations and ethnicity options 	MHSA Staff Analyst, QA Staff Analyst, QIC, CCC	July 2022
Monitor SYBH's Capacity of service providers and set goals.	1.2	Annual report on changes in the number and geographic distribution of providers from the previous year. <ul style="list-style-type: none"> • Increase Network Provider by one in Sutter-Yuba County. 	QA Officer, QA staff, URC	July 2022

2. Monitoring Accessibility of Services

Goal		Planned Activity	QI Staff	Review Date
Ensure timely access for beneficiaries	2.1	<p>Monitor Timeliness:</p> <ul style="list-style-type: none"> • Average length of time from first request for service to first offered face to face triage/assessment service. • Average length of time from first request to first offered specialty mental health service. • Average length of time from first request for service to first offered medication appointment. <ul style="list-style-type: none"> • Goals: Reduce individual therapy length of time for individual therapy waitlist for Adult Services • Reduce the referral time for individual therapy • Elimination of a waiting list 	QIC/Adult Services	July 2022
Ensure timely access for beneficiaries	2.2	<p>Test the 24 hr./7 days per week toll free line/SYBH departments.</p> <ul style="list-style-type: none"> • 100% of test call will meet verbal and written requirements. • Report outcomes to QIC and CCC • Report outcomes to DHCS quarterly • Have a minimum of three test calls a quarter 	CCC, QIC, QI Staff Analyst	On-going
Reduce the number of clients receiving inpatient hospital services who are readmitted within 30 days.	2.3	<p>No more than 10% of clients receiving inpatient hospital services are readmitted with 30 days. Measure: Readmission Rate for:</p> <ul style="list-style-type: none"> • Adult PHF • Adult Managed Care Hospital • Youth Managed Care Hospitals <p>Data source: Inpatient PHF and TAR service logs</p>	URC, QI Staff Analyst, SYBH Staff	July 2022
Monitor consistency of authorization system	2.4	Conduct annual review of the consistency in the authorization system.	QA Staff, URC	July 2022

Goal		Planned Activity	QI Staff	Review Date
		<ul style="list-style-type: none"> TAR Logs and SARS 		
SYBH will approve or deny TARs within 14 calendar days of receipt of the TAR and in accordance with title 9 regulations.	2.5	<p>Monitor Utilization Management compliance with Statewide standards for approving or denying Out of County Inpatient Admissions within 14 calendar days of receipt of final TAR.</p> <ul style="list-style-type: none"> Continue to meet the benchmark of approving or denying out of county inpatient admissions within 14 calendar days of receipt of final TAR. 	QA Staff, URC	July 2022

3. Monitoring Beneficiary Satisfaction

Goal		Planned Activity	QI Staff	Review Date
Improve client and Parent/Caregiver satisfaction with outpatient services	3.1	<p>Administer the Client Perception Survey (CPS) as per direction of CiBHS under contract with DHCS to meet requirement and mandate.</p> <ul style="list-style-type: none"> Improve the number of surveys taken by 20 percent Conduct at least 5 youth surveys A minimum of 25 surveys 	QI Staff Analyst, QIC, CCC and SYBH Team	As administered
Improve client and Parent/Caregiver satisfaction with outpatient services	3.2	<p>Monitor % of Consumers who report that staff is sensitive to their ethnicity, language culture.</p> <ul style="list-style-type: none"> Goal: 80% Satisfaction Rate on the Client Perception Survey (CPS) Survey. 	QIC, CCC, QI Staff Analyst	As administered
Improve client and Parent/Caregiver satisfaction with outpatient services	3.3	<p>Percentage of those surveyed had access to written information in their primary language (*75% goal set per DHCS Protocol)</p> <ul style="list-style-type: none"> Goal: 80% received access in their written language on the Client Perception Survey (CPS) Survey. 	QIC, CCC, QI Staff Analyst	As administered
Improve client and Parent/Caregiver satisfaction with outpatient services	3.4	<p>Inform providers and staff of results of surveys</p> <ul style="list-style-type: none"> Staff receive within 30 days of data being received by QA 	QI Staff Analyst, QA Officer	As administered

Goal		Planned Activity	QI Staff	Review Date
Improve client and Parent/Caregiver satisfaction with outpatient services	3.5	<ul style="list-style-type: none"> 100% of Grievances, Appeals, and Expedited Appeals will be resolved within regulation timelines. Grievances: 90 calendar days Appeals: 30 calendar days Expedited Appeals: 72 hours	QIC, Deputy Director Clinical Services, QI Staff Analyst, Program Managers.	Reviewed quarterly
Improve client and Parent/Caregiver satisfaction with outpatient services	3.6	Conduct analysis of Grievances, Appeals, and Expedited appeals annually, looking for trends and implement system improvements as needed. <ul style="list-style-type: none"> Quarterly reports sent to staff with hard numbers of grievances 	QIC, QI Staff Analyst.	Annually November 2021 and June 2022
Analyze change of provider requests to determine if there are trends or areas needing quality improvement.	3.7	Evaluate requests to change persons providing services. <ul style="list-style-type: none"> Flag any provider that appears 3 times in a fiscal year 	QIC, QI Staff Analyst	Annually November 2021 and June 2022
To ensure the issuance of NOABDs are in accordance with State regulations and to allow beneficiaries the opportunity to practice their rights in response to a NOABDs.	3.8	QA will ensure NOABDs are issued in accordance with State regulations, and report results to QIC.	QA Officer, QIC	Annually November 2021 and June 2022

4. Monitoring the Mental Health Plan's Service Delivery System and Clinical Issues Affecting Beneficiaries

Goal		Planned Activity	QI Staff	Review Date
The Utilization Review Committee (URC) will monitor compliance of consumer charts.	4.1	100% of client treatment plans will have a staff signature.	QA Officer, QA Staff, URC	July 2022
Effectiveness of Care/Clinical Issues	4.2	Have 100% of staff and providers receive documentation training	QA Officer, QA Staff	On-going
SYBH will address meaningful clinical issues affecting beneficiaries	4.3	Review and monitor the progress of the performance improvement projects (one clinical and one non-clinical), evaluate	QA Officer, PIP Committee	On-going

Goal		Planned Activity	QI Staff	Review Date
system-wide.		results, recommend changes, and revise processes, as appropriate. <ul style="list-style-type: none"> Two active PIPs 		
Create and use meaningful outcome tracking tools to measure clients' and the system's effectiveness in achieving progress.	4.4	Download outcome data and share with staff. Implement changes as necessary. <ul style="list-style-type: none"> Revise reports as needed. Ensure outcome data is collected with consistency in the (EHR) SYBH Outcome Measures: <ul style="list-style-type: none"> CALOCUS LOCUS CANS PSC 35 MORs Goal: Dashboard finalized for outcome measure tracking 	QIC, Admin, Program Managers, Staff Analysts, EHR Staff	July 2022
SYBH will address meaningful clinical issues affecting beneficiaries system-wide.	4.5	Create a Practice Guideline and ensure that it meets the requirements of the SYBH contract, in compliance with 42 CFR 438.236 and CCR title 9, section 1810.326. <ul style="list-style-type: none"> Ensure Practice Guideline is disseminated to affected providers and, upon request, to beneficiaries and potential beneficiaries. 	QA Office, QA Staff, QIC, Admin, Program Mangers	July 2022

5. Monitoring Continuity and Coordination of Care with Physical Health Care Providers and Other Human Services

Goal		Planned Activity	QI Staff	Review Date
Ensure proper coordination and continuity of care	5.1	Ensure warm handoff to lower level of care, primary care and managed care providers including; (Harmony Health, Ampla, Peach Tree Clinic and Anthem Blue Cross and California Wellness. <ul style="list-style-type: none"> Monitoring: Number of referrals and successful connections. Monitoring: Number of continuity of care referrals. 	Health care access staff/Intervention Counselor/QA staff	July 2022

6. Provider Appeals

Goal		Planned Activity	QI Staff	Review Date
Monitor Provider Appeals.	6.1	Monitor provider appeals and provider appeal resolution process.	QA Officer, QA Staff, URC	July 2022

7. Cultural Competence and Linguistic Standards

Goal		Planned Activity	QI Staff	Review Date
To implement training programs to improve the cultural competence skills of staff and providers.	7.1	100% of behavioral health staff will receive one-hour cultural competency training per year.	CCC, Ethnic Outreach Staff, MHSA and QI Staff Analyst	July 2022
To implement training programs to improve the cultural competence skills of staff and providers.	7.2	Have 100% of staff receive annual training on client culture that includes a client's personal experience.	CCC, Ethnic Outreach Staff, MHSA and QI Staff Analyst	July 2022
Increase service delivery to the unserved/underserved consumers	7.3	<p>Conduct outreach and engagement to provide behavioral health education and access information.</p> <ul style="list-style-type: none"> Heart team engaging in homeless population. Increase homeless served. PEI outreach targeting the general population iCare Mobile engagement team for unengaged high utilizer population (Sarah) Full-service partnership mobile engagement DCR data - key event tracking 	PEI and Ethnic Outreach teams	On-going review at Cultural Competence Committee (CCC)