SYBH Quality Assessment and Performance Improvement Evaluation

Fiscal Year 21-22

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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

Evaluation of FY21/22:

21/22 Goal	Planned Activity	21/22 Evaluation
Improve client and Parent/Caregiver satisfaction with outpatient services.	3.5) 100% of Grievances, Appeals, and Expedited Appeals will be resolved within regulation timelines.	At the time of this Evaluation, conducted in August 2022, the fiscal year had closed with a total of 21 total cases for all categories, all of which were grievances. Of the 21 cases, 6 were open, 2 of which are past due. Of the resolved cases, 1 was past due. If we resolve the 4 remaining open cases within 90 days, our timeliness compliance rate will be 86%, meaning we have fallen short of our 100% target. Therefore, this goal will remain on the 22/23 plan.
	3.6) Analyze Grievances, Appeals, and Expedited appeals annually, looking for trends and implement system improvements as needed	The most significant trend noted is the category of billing disputes represented 57% of all cases. The other types demonstrated no concerning patterns as the quality of care and customer service cases were low in numbers and had no common root cause. Trend analysis will remain in the 22/23 plan.

	3.1) Administer the Client Perception Survey (CPS) as per direction of CiBHS under contract with DHCS to meet requirements and mandates. • Improve the number of surveys taken by 20 percent • Conduct at least 5 youth surveys • A minimum of 25 surveys	The CPS survey was administered during the week of May 16-20th. We successfully obtained the minimum goal, the goal of 5 being youth surveys. However, we cannot determine if the 20% increase goal was met as we still await feedback from UCLA on the final numbers based on the number deemed valid. There was a tiny sample size for the Results made available during the 21-22 year as this survey was conducted out of rhythm during the COVID pandemic. However, 91.6% recommended or are satisfied with SYBH services of the Adults surveyed, and 94.7% for Youth/Family satisfaction. For this same survey, 76.5% of Adults felt they had access to services in the language they preferred, while 86.4% of Youth/families respondents agreed. The results were not shared from the prior survey as planned. Due to a gap in the QA Office and lack of access to the data source, these results were not shared. A new goal related to sharing the findings will be included for the 22-23 plan.
	3.2) Monitor % of Consumers who report that staff is sensitive to their ethnicity and language culture. • Goal: 80% Satisfaction Rate on the Client Perception Survey (CPS) Survey.	75% and 73% of Adult and Youth/Family respondents reported satisfaction with staff cultural sensitivity for the June 2021 Survey. We have fallen short of our goal; this will remain a goal for the 22/23 plan.

	3.3) Percentage of those surveyed had access to written information in their primary language (*75% goal set per DHCS Protocol) • Goal: 80% received access in their written language on the Client Perception Survey (CPS) Survey.	92.3% and 95% of Adult and Youth/Family respondents reported that written information was available in the language client preferred. We have met and exceeded this goal; we will continue to monitor with the same target in the 22.23 plan
	3.4) Inform providers and staff of results of surveys • Staff receive within 30 days of data being received by QA	The results were not shared from the prior survey as planned. Due to a gap in the QA Office and lack of access to the data source, these results were not shared. A new goal related to sharing the findings will be included for the 22-23 plan.
Analyze change of provider requests to determine if trends or areas that need QI.	3.7) Evaluate requests to change persons providing services. • Flag any provider that appears 3 times in a fiscal year	For FY 21-22, 63% of providers on the log surpassed the minimum threshold of three change of provider requests. Two providers made up 54% of requests, while three providers represent the remaining number of requests that meet the minimum of three or more standard and represents 34% of total requests. The two largest categories in the reasons cited for the request are needs not being addressed and preferring another gender, representing 21% of the total requests. Medication concerns represent 24% of request reasons making it the second-highest cause for the request. There were no concerning trends related to reasons. Clients who cited needs not being addressed were re-assigned to another provider, as were clients who preferred a different gender. The medication concerns had a trend of clients feeling strongly about taking a medication that was not being prescribed. While QIC sheds

		light on the trends, prescribing practices are monitored through our Medication monitoring Committee, where expertise and analysis on these topics is more fitting, and the participants have proper qualifications. See Figures 1-4. For FY 22-23, we will continue to monitor the change of provider requests. We will modify the monitoring criteria to include: Providers that account for 25% or more of total change requests and have a trend analysis of reasons for the recommendations made.
To ensure the issuance of NOABDs follows state regulations and allows beneficiaries 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.	This goal wasn't evaluated for lack of criteria and measurement standards. This will be modified in the 22-23 plan as a monitoring activity under "utilization." The NOABD tracking system has been identified as an area of opportunity after the loss of institutional knowledge over the past year, impacting the tracking system. Measurable goals and monitoring will be included in the 22-23 plan
Ensure timely access for beneficiaries	2.2) Test the 24 hr./7 days per week toll-free line/SYBH departments. • 100% of test calls 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	In FY 21-22, our test calls did not meet the goal of meeting 100% of the verbal requirements. The overall verbal requirements were met 71% of the time for all test calls for the FY. For written needs, they were completed for 77% of all calls. The results were shared with QIC in August 2021 to review the FY 20-21 results. The FY 21-22 results are scheduled to be reviewed at a meeting after this Evaluation was written. The annual FY reviews with committees linger after the QAPI eval and plan are written in August.

		All quarterly reports were submitted to DHCS by their appropriate deadlines. While each quarter did not meet the minimum of three test calls, some included more than three. This allowed us to achieve 13 total test calls for the FY. See Table 1. We will continue to monitor this activity in the 22-23 FY and develop goals around closing the feedback loop quarterly with the access line staff leadership and include goals to build capacity, including revamping/requiring formal training for the 24/7 access line staff.
Effectiveness of Care/Clinical Issues	4.2) Have 100% of the staff and providers receive documentation training	This goal was met as all providers received this training upon hire. This no longer requires goals as our onboarding process regiments this standard effectively.

Access and Timeliness

Evaluation of FY21/22:

21/22 GOAL	PLANNED ACTIVITY	FY 21/22 EVALUATION
Maintain and improve penetration rates of underserved population(s).	1.1) Monitor penetration rates of ethnic groups with low penetration and retention rates. • Compare these rates across ethnic groups, ages, and gender • Compare these rates by ethnic groups to the total Medi-Cal population • Goals: decrease unknown • penetration rates by 2 percent	According to EQRO data derived from Med-Cal claims data, in CY 2020, the percentage of beneficiaries identified as white, African-American, Native American, and those categorized as "other" exceeded the percentage of eligible. Conversely, we see the opposite trend for our Hispanic/Latino and API populations. While we have two ethnic outreach centers dedicated to our Latino and API populations, we still face challenges in increasing our penetration rates. While COVID made outreach opportunities more limited, we will aim to increase the outreach and stigma reduction

	• Add more grouping for Asian populations and ethnicity options	program so long we see lower risks and a reduction in COVID restrictions in FY 22/23. We have seen a marked decrease in our Foster Care penetration Rates. Therefore, this will be an area of focus in FY 22/23.
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. • Increase Network Provider by one in Sutter-Yuba County.	We fell short of our goal to add one Network Provider. A result of not employing our usual outreach event to entice new providers. In years before COVID, the QA Office would conduct a luncheon with an open invitation to local providers to attract new interest. This has historically yielded an increase in interest and participation. Unfortunately, this has not taken place since 2019. Furthermore, the agency's focus on our network has been on our internal staff as we continue to be impacted by the provider shortage affecting the entire State. In FY 22/23, we hope to retain our staff while filling vacancies. In addition, we will focus on ensuring our network adequacy certification meets or exceeds the State-required ratios and standards.
Ensure timely access for beneficiaries	2.1) Monitor Timeliness: • The average length of time from the first request for service to the first offered • The average length of time from the first request to offered specialty mental health service. • The average time from the first request for service to the first offered medication appointment.	We monitored our timeliness metrics for FY 21-22 and discussed them in QIC twice. Our average length of time from the first request to first offered within 10 days was 78.98% of new encounters, with an average of 5.59 days from first contact to first offered. The average time from first contact to first treatment is 75 days. See Figure 5. Through this year, we have learned more about the data shortcomings, including the issues related to tracking medication appointments.

	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	Our agency continued to be impacted by staffing shortages, which has impacted our timeliness and ability to eliminate waitlists. We currently have a waitlist for both Adult and Youth outpatient services. For FY 22-23, we will continue monitoring the same timeliness metrics while creating goals to address gaps in medication/psychiatry appointments and ensure improved data quality on all other timeliness measures. We will also include goals around post-hospitalization follow-up services to build capacity and enhance awareness across the agency in a meaningful way. Finally, we will keep the goal of eliminating waitlists as this has become a top priority amongst the leadership.
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.	This item will not be evaluated through the QAPI as it is duplicative. Instead, this is considered annually in the Cultural Competence Plan.
	7.2) Have 100% of staff receive annual training on client culture that includes a client's personal experience.	This item will not be evaluated through the QAPI as it is duplicative. Instead, this is considered annually in the Cultural Competence Plan.
Increase service delivery to the unserved/underserved consumers	7.3) Conduct outreach and engagement to provide behavioral health education and access information. • Heart team engaging in the homeless • population. Increase homeless served. • PEI outreach targeting the general population • iCare Mobile engagement team for unengaged high utilizer population	This component will not be evaluated through the QAPI as such would be duplicative. However, this activity and indicators are thoroughly assessed in the MHSA Plan and can be found there. This will be removed from the FY 22-23 plan.

	• Full-service partnership mobile • engagement DCR data– key event tracking	

Utilization and Care Quality

Evaluation of FY21/22:

21/22 GOAL	PLANNED ACTIVITY	FY 21/22 EVALUATION
Reduce the number of clients receiving inpatient hospital services who are readmitted within 30 days.	2.3) No more than 10% of clients receiving inpatient hospital services are readmitted with 30 days. Measure: Readmission Rate for: • Adult PHF • Adult Managed Care Hospital • Youth Managed Care Hospitals Data source: Inpatient PHF and TAR service logs	For FY 21-22, we evaluated the readmission rates of CY 2019 and 2020. This is due to a lack of an accurate internal mechanism to monitor real-time and uses claims data for alignment with EQRO on the data used. In 2019 and 2020, the 7-day and 30-day readmission rates are lower than the State rates. However, we did not achieve the 10% or less readmission rate we set out to. In 2019, our 30-day readmission rate was 18%, and for 2020 it was 19%. Though the upward trend is slight, we will consider why this is increasing. In addition, upon reviewing the internal tracking system, we determined issues with the methods contributing to our data's accuracy. Therefore, in the FY 22-23 plan, we will include interventions to address the data quality issues with our internal tracking. See Figure 6.
Monitor consistency of authorization system	2.4) Conduct an annual review of the consistency in the authorization system. • TAR Logs and SARS	This was not achieved in the past year. This will remain a goal and be a heightened priority. With the transitions of staff creating many vacancies, the bandwidth to execute this in FY 21/22 was limited.

		We have a new position in QA that is dedicated to utilization review. This position was hard to fill before a reclassification last year. This will be a priority for the current role.
SYBH will approve or deny TARs within 14 calendar days of receipt of the TAR and in accordance with title 9 regulations.	2.5) 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. • Continue to meet the benchmark of approving or denying out-of-county inpatient admissions within 14 calendar days of receipt of final TAR.	This goal has been consistently met, and with long-anticipated guidance on Concurrent Review, this goal will transform into monitoring our contractor for timeliness with concurrent review standards for FY 22/23.
The Utilization Review The committee (URC) will monitor compliance of consumer charts.	4.1) 100% of client treatment plans will have a staff signature.	This goal has been consistently met and will be removed in FY 22/23 as CalAIM has modified this requirement.
Monitor Provider Appeals.	6.1) Monitor provider appeals and provider appeal resolution process.	We received no provider appeals in FY 21-22. This item will be removed as an indicator in the FY 22-23 plan.

Figures and Tables

FIGURES 1 AND 2: CHANGE OF PROVIDER REQUESTS FY 21/22

Frequency Analysis by Provider

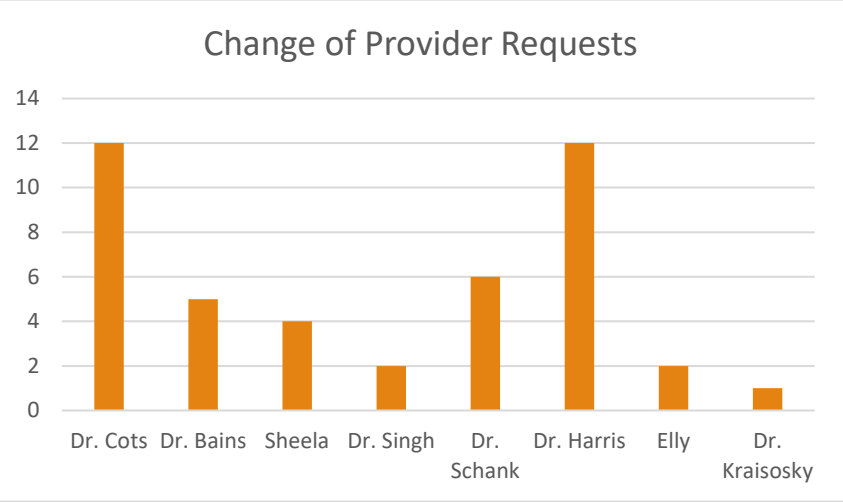


Figure 1: Count of requests by provider

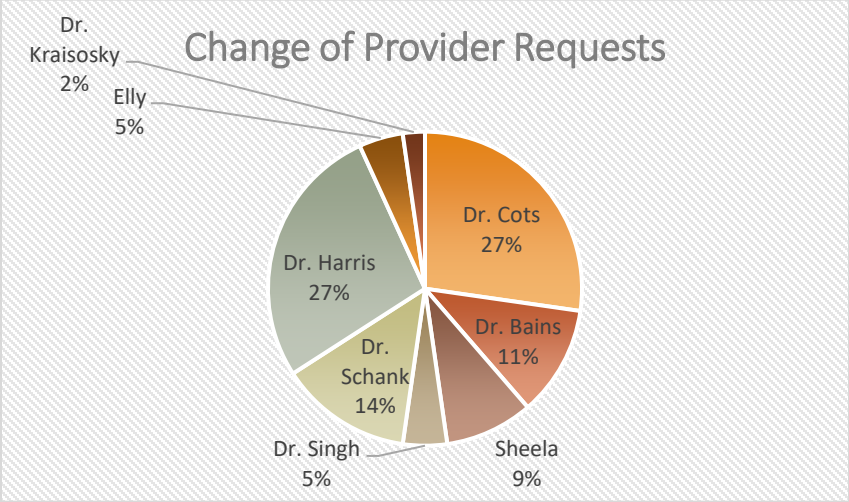


Figure 2: Proportion of requests by provider

FIGURES 3 AND 4: CHANGE OF PROVIDER REQUESTS FY 21/22

Frequency analysis by reason

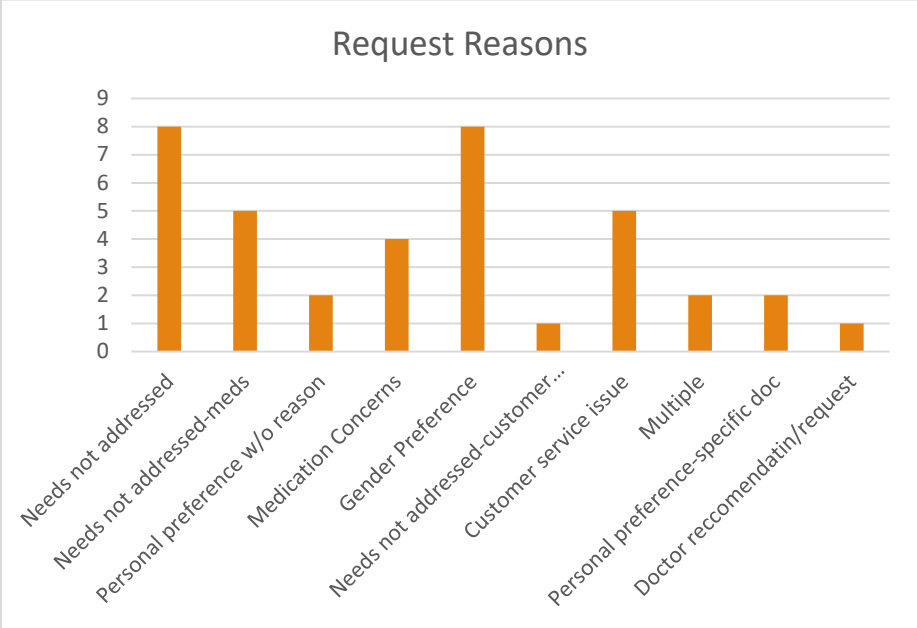


Figure 3: Count of requests by reason

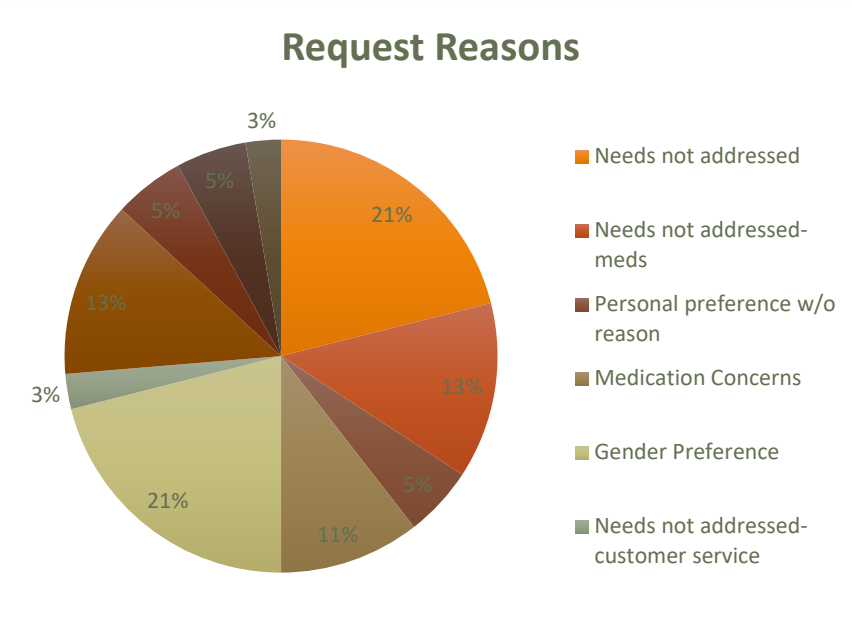


Figure 4: Proportion of requests by reason

TABLE 1: QUARTERLY TEST CALL RESULTS FY 21/22

FY 21-22 Test Calls	Number of calls completed	Verbal Requirements met	Written Requirements met
Q1	3	33%	33%
Q2	1	100%	100%
Q3	5	100%	100%
Q4	4	50%	75%
Totals	13	71%	77%

Table 1: Quarterly breakdown of verbal and written compliance rate

FIGURE 5: TIMELINESS DASHBOARD FY 21/22

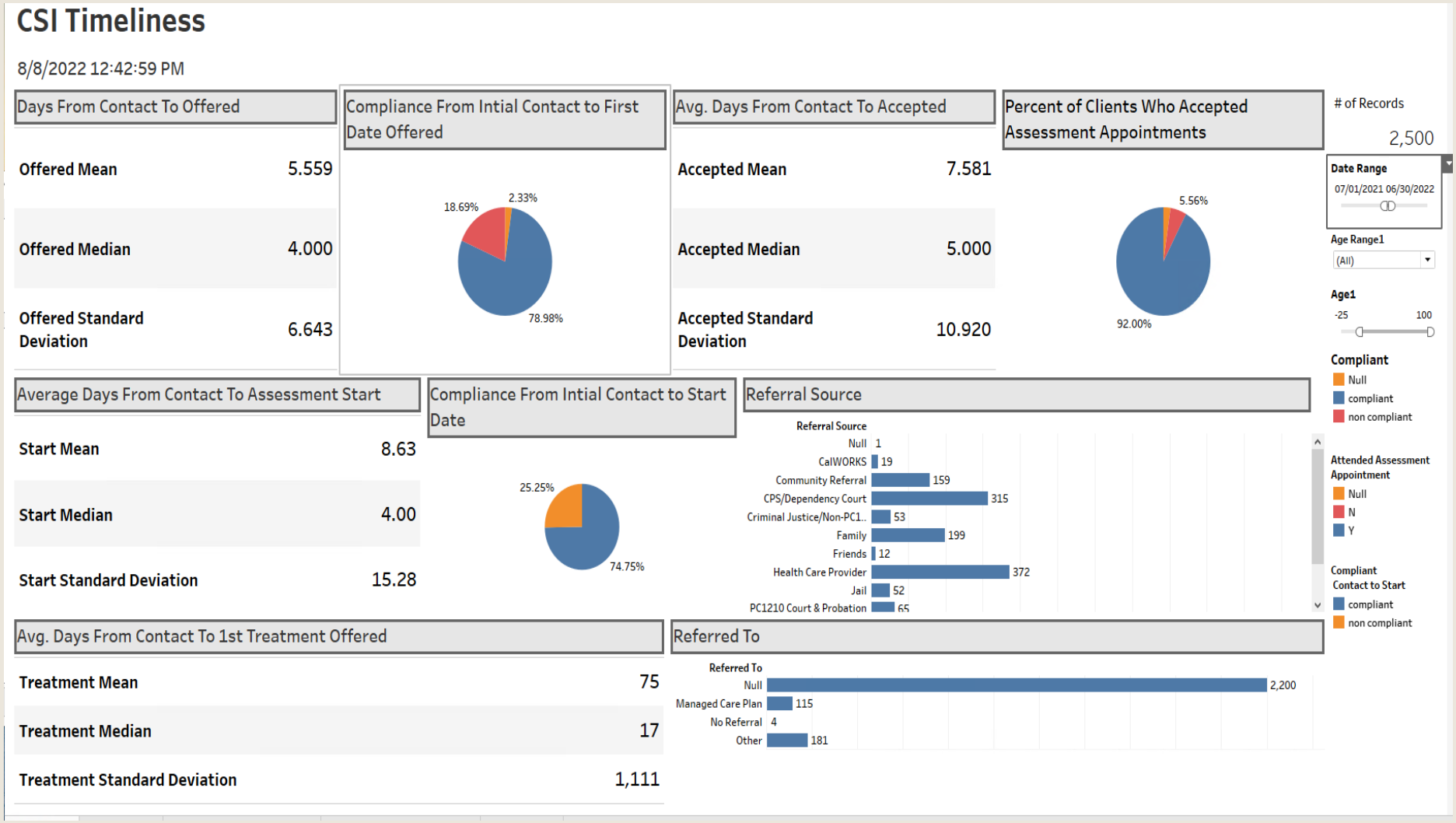
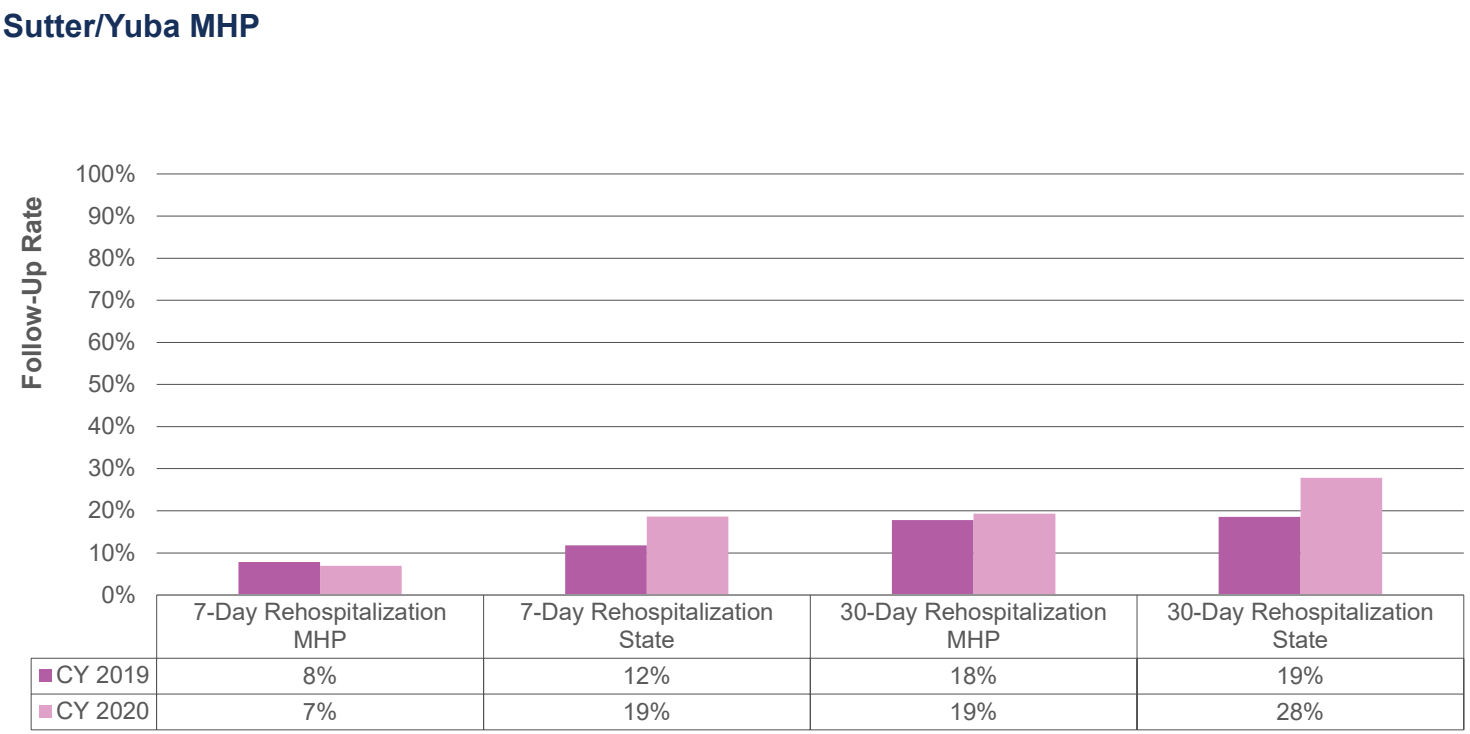


Figure 5: Screenshot of Tableau dashboards developed by Kings View

FIGURE 6: 7-DAY AND 30-DAY PSYCHIATRIC READMISSION RATES CY 2019-2020



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	8%	12%	18%	19%
CY 2020	7%	19%	19%	28%

Figure 6: Table provided by BHC in 2022 EQRO Final Report. Readmission rates from Medi-Cal claim data 2019 and 2020