Quality Assessment and Performance Improvement Plan

Fiscal Year 22-23

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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

Sutter-Yuba Behavioral Health
Quality Assessment & Performance Improvement Plan for Mental Health and SUDS July 2022-2023

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Mission

Set quality standards through collaborative leadership to provide high-quality care for those we serve.

Vision

Our vision is a quality culture driven by compassion and informed by timely and accurate data.

Navigating this Plan

FY 22/23 brings a new look and strategy to our Quality Assessment & Performance Improvement (QAPI). In prior years, we have made targeted changes and updates to the existing QAPI. However, this strategy will no longer suffice as some goals are outdated or lack the measurable qualities needed to track progress. In addition, our EQRO findings have indicated their preference to revise this plan and incorporate quantifiable goals. We have taken that feedback and made it a priority; we hope that is reflected in this plan.

The QAPI now consists of two main categories under which the topics and goals will fall: Quality Monitoring and Performance Improvement Projects (PIP). The Quality Monitoring section includes our routine monitoring activities, while the PIP section focuses exclusively on projects being pursued as formal PIPs.

Within the Quality Monitoring section, goals are grouped by a specific function. Each goal includes interventions and measures/Key Performance Measures (KPIs). The interventions are the roadmap to achieving the goal, and the measure/KPI includes specific quantifiable qualitative and quantitative measures. In addition, each KPI has a code reference that will be used on a project management tool to better monitor and track all activities.

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

The QAPI Program delineates the structures and processes 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 engages stakeholders to identify gaps, analyze data, and seek input for planning and implementation.

About the Quality Improvement Committee (QIC):

The role and function of the Quality Improvement Committee (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 provide stakeholder input to the Sutter Yuba Behavioral Health (SYBH) Quality Assessment and Performance Improvement Program.

Members:

Rick Bingham, LMFT-Sutter-Yuba Behavioral Health Director

Dr. Hardeep Singh, MD-Medical Director

Dr. Mark Schlutsmeyer, PhD-Adult Services Branch Director

Paula Kearns, MSW-Youth Services Branch Director

Susan Redford, LMFT- Acute Psychiatric Services Branch Director, Interim

Betsy Gowan-Adult Services Deputy Director

Vacant-Deputy Director-Finance and Administrative Services

Melissa Clavel, MPA-Quality Assurance Officer

April Tate, LMFT-Adult Services Program Manager

Phillip Hernandez-SUDS Program Manager

Josh Thomas, LCSW -Clinical Program Manager, Youth and Family Services

Darrin Whittaker, LMFT -Clinical Program Manager, Youth and Family Services

Gina Duran, LCSW-Psychiatric Emergency Services Program Manager, Interim

Adam Reeb, LMFT-Psychiatric Health Facility Program Manager

Kristine Hughes, LMFT-Quality Assurance Marriage and Family Therapist III

Vacant-Quality Assurance Staff Analyst

Jesse Hallford-Adult Services Staff Analyst

Amy Bryer-Youth Services Staff Analyst

Jaime Gascon-Quality Assurance Secretary

The Quality Improvement Committee Role

QIC provides oversight to ensure the implementation of the QAPI Work Plan. QIC sets priorities and delegates authority to the various staff, who then study processes, implement interventions for improvement, and subsequently analyze the effectiveness of any changes which may have occurred. QIC's responsibilities are as follows:

- Provides oversight of all QI activities within mental health, substance use, and administrative service functions.
- Ensures that the results of various studies are publicized for employee and consumer review.
- Elicits and responds to employee and consumer input regarding 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 regarding SYBH's contract with the State Department of Health Care Services.
- Conducts and reviews specialized quality improvement activities.

Quality Monitoring

Client Satisfaction Monitoring

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

FY22/23 Goals:

Goal 1: Ensure all timeliness standards are achieved for all complaints received through the problem-resolution process FY 22/23	
Measurement/KPI	• Annual report to QIC for all grievances, appeals, and State Fair Hearings to include % of problem/resolutions resolved by their respective timeliness standard (KPI 1.1-PRshare) • 4 quarterly reviews of cases (KPI 1.2-PRquarterly)
Intervention	• The QA Staff Analyst quarterly monitors cases at risk of being out of compliance in October, January, April, and July. • QA Staff Analyst prepare an annual report for the July 2023 meeting to include any notable trends.
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC

Goal 2: Monitor client satisfaction through the semi-annual Consumer Perception Survey	
Measurement/KPI	• Results shared with staff at least twice (KPI 2.1-CPSshare) • Meet or exceed 80% overall satisfaction rate (KPI 2.2-CPSsatis) • Meet or exceed 80% satisfaction with access to language (KPI 2.3-CPSlangacs) • Meet or exceed 80% satisfaction with cultural sensitivity (KPI 2.4-CPScultr) • Meet or exceed 80% received access in preferred written language (KPI 2.5-CPStranslate)
Intervention	• Collect the findings and analyze the data upon release from State contracted entity overseeing the CPS surveys • Distribute/notify/share the results with all leadership and staff
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC

Goal 3: Monitor consumer satisfaction through Change of Provider Requests	
Measurement	• Identify providers that represent 25% or more of total requests (KPI3.1-COPreq) • Trend analysis of reasons for requests of those representing 25% or more of all requests (KPI3.2-COPtrend) • Annual results to be shared with QIC (KPI3.3-COPshare)
Intervention	• Quarterly analysis of change of provider requests • Results to be shared and trends/interventions developed around concerns or trends • Maintain goals of 80% satisfaction rate and 80% satisfaction with language access • Discuss goals not met to determine appropriate intervention
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC

Access and Timeliness

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

FY22/23 Goals:

Goal 4: Improve the compliance rate of test call compliance	
Measurement/KPI	• 12 test calls completed in FY 22/23 (KPI 4.1-tccompleted) • 1 training developed, uploaded, and assigned in Relias (KPI 4.2-tctrain) • Training adopted as part of onboarding for PES staff (KPI 4.3-tconboard) • 4 quarterly reports to PES leadership (KPI 4.4-tcresults) • Annual outcomes and analysis shared with QIC (KPI 4.5-tcshare)
Intervention	• Institute one formal training for access line staff to take upon hire and annually after that • Include PES Staff in test call rotation as a training mechanism • Report tests call outcomes to PES leadership • Report tests call results to QIC
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC, PES leadership

Goal 5: Monitor timeliness of access to services to ensure compliance with all timeliness measures	
Measurement/KPI	• 85% of clients being offered or receiving an assessment appointment 10 days from request to first appointment (KPI 5.1-tmlns offered) • 80% of clients receive their first treatment appointment within 60 days (KPI 5.2-tmlnstreat) • 85% of new clients with a receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service (KPI 5.3-tmlns psych) • One resource developed for staff on accurate data entry (KPI 5.4-tmlnstrain) • At least 6 meetings where timeliness monitoring and/or timeliness data quality are discussed (KPI 5.5-tmlnsmeet) • 1 root cause analysis of psychiatry data quality issues (KPI 5.6-tmlnscause) • 1 action plan to address psychiatry data quality issues (KPI 5.7-tmlnsplan) • Elimination of youth outpatient waitlist (KPI 5.8-tmlnsyouthwait) • Elimination of adult outpatient waitlist (KPI 5.9-tmlnsadultwait) • 1 new monitoring system for post-hospitalization follow-up appointments within 7 days to be aligned with State qualifiers and parameters (KPI 5.10-tmlnsFUH7day) • 1 new monitoring system for post-hospitalization follow-up appointments within 30 days to be aligned with State qualifiers and parameters (KPI 5.11-tmlnsFUH30day) • 1 developed system monitoring the number of hours between urgent requests and appointments (KPI 5.12-tmlnsurgent)
Intervention	• Continue development of the timeliness dashboard development for routine timeliness monitoring of non-urgent services • Conduct root cause analysis for data entry and workflow issues related to all timeliness systems • Develop action plans as needed for timeliness measures not actively being monitored (urgent requests, psychiatry, post-hospitalization follow-up) • Develop resources for accurate data entry for applicable staff to include guidance and definitions • Review timeliness dashboard to monitor for access and data quality issues at QIC and the Dashboard Development Meetings
Due Date	June 30, 2023
Responsible Party	QA Staff Analyst, QIC, Youth Staff Analyst, Adult Staff Analyst, Transcription

Goal 6: Monitor the provider network adequacy

Measurement	• 1 system for accurate provider reporting to feed to the 274 (KPI 6.1-NA274) • 1 analysis of the anticipated needs and shared with QIC (KPI 6.2-NAneeds) • Participation in the 274 submissions by all target deadlines (KPI 6.3-NA274submit)
Intervention	• Monitor the number of providers monthly • Develop a streamlined reporting system to support the transition to the 274 Project • Use the annual Meds anticipated needs data to inform the number of providers that must be maintained throughout the year
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC

Goal 7: Ensure a culturally competent workforce

Measurement	• Increase our penetration rates for the Latino/Hispanic and API populations by 1% (KPI 7.1-CCpenrates) • 1 root cause analysis of the Foster Care (FC) penetration rate drop (KPI 7.2-FCpenrate) • 1 action plan to address the FC penetration rate if applicable (KPI 7.3-FCplan) • Annual analysis of penetration rates shared with both QIC and CCC (KPI 7.4-CCpenrateshare)
Intervention	• Monitor penetration rates for trends • Conduct a study on the FC penetration rate decrease to determine the root cause • Increase outreach to the Hispanic/Latino and API population
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC, CCC, Youth Staff Analyst, Youth Services Program Managers

Utilization and Care Quality

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

FY22/23 Goals:

Goal 8: Ensure compliance with NOABD issuance	
Measurement/KPI	• 1 system analysis (KPI 8.1-NOAsystem) • 1 implemented action plan (KPI 8.2-NOAplan) • 1 implemented mandatory staff training on NOABDs (KPI 8.3-NOAtrain) • 1 sample audit system developed (KPI 8.4-NOAaudit) • 1-2 URC meetings that have reviewed NOABD issuance rates and compliance monitoring results (KPI 8.5-NOAshare)
Intervention	• Conduct a process review of NOABD issuance and tracking system • Identify process and knowledge gaps in the system • Reinstitute routine monitoring system in URC • Develop formal training for staff on NOABD issuance • Conduct sample audits to monitor compliance
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC, Outpatient leadership, Reception staff

Goal 9: Ensure consistency in the authorization system

Measurement/KPI	• 1 developed monitoring system for each applicable service type (KPI 9.1-authtrack) • At least 2 meetings of results being shared with URC (KPI 9.2-authshare)

Intervention	• Develop a cohesive and effective monitoring system for all authorization types
	  ○ ICC
	  ○ IHBS
	  ○ TFC
	  ○ TBS
	  ○ SARS
	  ○ TARS
	• Create benchmarks and standards for each auth type to monitor against and share the findings at URC

Due Date	June 30, 2023
Responsible parties	QA Utilization Review Specialist, QA Staff Analyst, URC

Goal 10: Ensure compliance with concurrent review standards

Measurement/KPI	• 2 Reports developed from Atrezzo (KPI 10.1-CRreport) • At least 2 meetings of results being shared with URC (KPI 10.2-CRshare)
Intervention	• Learn how to run reports from the system being used by the contractor conducting concurrent review • Analyze the results and share findings with URC
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, URC, UR Specialist

Goal 11: Implement a system for monitoring and documenting the review of the indicators from California Child Welfare Indicators Project	
Measurement/KPI	• 1 monitoring system for follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (KPI 11.1-HEDISADD) • 1 monitoring system for the use of multiple concurrent psychotropic medications for children and adolescents (KPI 11.2-HEDISAPC) • 1 monitoring system for metabolic monitoring for children and adolescents on antipsychotics (KPI 11.3-HEDISAPM) • 1 monitoring system for the use of first-line psychosocial care for children and adolescents on antipsychotics (KPI 11.4-HEDISAPP)
Intervention	• Implement a monitoring system for Children and Adolescents using the AB1299 HEDIS measures
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC, Medical Director, Youth Services Program Managers, Youth Services Staff Analyst

Goal 12: Monitor hospital readmission rates	
Measurement/KPI	• Readmission rate within 7 days post-hospitalization (KPI 12.1-readmit7days) • Readmission rate within 30 days post-hospitalization (KPI 12.2-readmit30days) • Share readmission rates with URC at least 2 times (KPI 12.3-readmitshare) • 1 plan to address data inaccuracies (KPI 12.4readmitplan)
Intervention	• Identify tracking issues • Align benchmarks with State standards • Share readmission rates with URC routinely
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC, Transcription staff, Inpatient leadership

Performance Improvement Projects (PIPs)

Goal 13: Implement Clinical PIP to improve the rate of Post-Psychiatric Hospitalization Follow-up within 7 days	
Measurement/KPI	• Post-psychiatric follow-up services within 7 days rate (KPI 13.1-PIPFUH) • 1 list of CPT and HCPCS codes that qualify as follow-up (KPI 13.2-FUHservices) • 1 root cause analysis (KPI 13.3-PIPFUHissues) • 1 developed PIP write-up including baseline data (KPI 13.4-PIPFUHplan)
Intervention	• Increase the rate of follow-up services within 7 days to post-psychiatric hospitalized clients from 46% to 57% • Conduct root cause analysis to identify contributing factors • Plan interventions and implement
Due Date	June 30, 2023
Responsible parties	Outpatient leadership, inpatient leadership, discharge planners, QIC

Goal 14: Implement Non-clinical PIP to improve communication with families regarding hospital transfer and step-down services	
Measurement/KPI	• 1 pre-surveys to look further into issues identified by the consumer focus group (KPI 14.1-PIPpresurvey) • 1 developed PIP write-up including baseline data (KPI 14.2-PIPcommplan) • 1 post-survey after interventions have been implemented (KPI 14.3-PIPpostsurvey)
Intervention	• Survey to develop baseline data • Conduct a root cause analysis • Plan interventions • Conduct follow-up surveys to evaluate improvement efforts
Due Date	June 30, 2023
Responsible parties	QA Staff Analyst, QIC, Outpatient leadership, Inpatient leadership