Quality Assessment and Performance Improvement Plan

Fiscal Year 23-24

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

Contents

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 23/24 QAPI consists of three main categories under which the topics and goals will fall: Quality Monitoring, Program Integrity and Quality Improvement Projects. The Quality Monitoring section includes our routine monitoring activities, while the PIP section focuses exclusively on projects being pursued as formal PIPs and other improvement projects that SYBH would like to pursue.

Within the main categories, 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

Betsy Gowan, PHD-Adult Services Branch Director

Paula Kearns, MSW-Youth Services Branch Director

Susan Redford, LMFT-Acute Psychiatric Services Branch Director

Phillip Hernandez-Adult Services Deputy Director

Steven Leahy-Deputy Director-Finance and Administration Services

Melissa Clavel, MPA-Quality Assurance Officer

April Tate, LMFT-Adult Services Program Manager

Stacy Lee-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

Adam Reeb, LMFT-Psychiatric Health Facility Program Manager

Tara Cole-Admin and Accounting Supervisor

Connie Ayala-Office Services Supervisor

Tina Wilson-Baker-Medical Records Supervisor

Tony Vang-Quality Assurance Staff Services Manager

Rusti Bradford, LMFT-Quality Assurance Utilization Review Specialist

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

Xay Chue, LMFT-Quality Assurance Therapist-SUDS

Tammy Andersen, Quality Assurance Staff Analyst

Jesse Hallford-Adult Services Staff Analyst

Amy Heir-Children's Services Staff Analyst

Jaime Gascon-Quality Assurance Secretary

Brooke Chambers-Youth for Change

Stephanie Feingold-Youth for Change-Program Director

Lori Chambers-Telecare

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.

FY23/24 Goals:

Goal 1: Ensure all timeliness standards are achieved for all complaints received through the problem-resolution process FY 23/24.	
Measurement/KPI	• Annual report to QIC and SUDS QIC for all grievances, appeals, and State Fair Hearings to include % of problem/resolutions resolved by their respective timeliness standard. (KPI 1.1-PRshare) • 4 quarterly reviews of cases to include % of each grievance/appeal category and any notable trends. Individual cases will be reviewed in individual program QIC meetings and SUDS QA. (KPI 1.2-PRquarterly)
Intervention	• Develop training on Problem Resolutions and investigating grievances/appeals to be provided to new staff and management and annually thereafter. • Analyze billing disputes/financial grievances and develop interventions to decrease the amount of billing disputes/financial grievances from 44% of all grievances to 25%. • 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 2024 meeting to include any notable trends.
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QIC, Business Office, SUDS QIC

Goal 2: Monitor client satisfaction through the semi-annual Consumer Perception Survey	
Measurement/KPI	• Results shared with staff annually and posted to the Sutter County website. (KPI 2.1-CPSshare) • Meet or exceed 80% adult overall satisfaction rate. (KPI 2.2-CPSsatis) • Meet or exceed 80% adult satisfaction with cultural sensitivity. (KPI 2.3-CPScultr)
Intervention	• Develop action plan and interventions to increase satisfaction with positive outcomes of services/functioning for youth and adults. • 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. • Implement program codes for administering CPS for analysis of results on a program level and develop baseline measures for MH and SUDS programs. • Develop interventions for programs based on analysis.
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QIC, SUDS QIC and SUDS QA

Goal 3: Monitor consumer satisfaction through Change of Provider Requests	
Measurement	• Identify providers that represent 25% or more of total requests. (KPI 3.1-COPreq) • Trend analysis of reasons for requests of those representing 25% or more of all requests. (KPI 3.2-COPtrend) • Annual results to be shared with QIC. (KP1 3.3-COPshare)
Intervention	• Quarterly analysis of change of provider requests • Results to be shared and trends/interventions developed around concerns or trends. • Discuss goals not met to determine appropriate intervention. • Evaluate the change of providers staff training model to determine if additional training is needed for therapists.
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QIC, SUDS QA

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.

FY23/24 Goals:

Goal 4: Improve the compliance rate of test call compliance.	
Measurement/KPI	• 12 test calls completed in FY 23/24. (KPI 4.1-tccompleted) • 4 quarterly reports to PES leadership. (KPI 4.2-tcresults) • Annual outcomes and analysis shared with QIC.(KPI 4.3-tcshare) • Increase in test calls meeting verbal requirements from 92% to 100%. (KPI 4.4-verbrequ) • Increase in test calls meeting written requirements from 60% to 100%. (KPI 4.5-writrequ) • Ensure at least one test call per quarter is made on the Problem Resolution process. (KPI 4.6-PRtc) • Ensure 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. (KPI 4.7 tclangu)
Intervention	• Report tests call outcomes that do not meet verbal or written requirements monthly to PES leadership. • Report tests call results to QIC. • Include Hmong, Punjabi and Spanish speakers in the test call rotation schedule. • Assign one test caller per quarter to test on the problem resolution process.
Due Date	June 30, 2024
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	• 80% of MH and SUDS clients being offered or receiving an assessment appointment 10 days from request to first appointment (KPI 5.1-tmlns offered) • 80% of MH and SUDS 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) • 80% of new clients receiving Opioid Treatment program services within 3 business days of request. (KPI 5.4-tmlnsOPT) • Implement staff trainings on entering timeliness data in EHR. (KPI 5.5 tmlnstrain) • At least 4 meetings where timeliness monitoring and/or timeliness data quality are discussed (KPI 5.6-tmlnsmeet) • 1 new monitoring system for post-hospitalization follow-up appointments within 7 days and 30 days to be aligned with State qualifiers and parameters. (KPI 5.7-tmlnsFUH7) • 1 developed system monitoring the number of hours between urgent requests and appointments. (KPI 5.8-tmlnsurgent) • 1 developed workflow and training for SUDS timeliness (KPI 5.9-tmlnsSUDStrain) • 1 developed SUDS timeliness monitoring system (KPI 5.10 - tmlnesSUDSmonitor)
Intervention	• Develop workflow on psychiatry data. • Develop adult urgent process and provide training to staff. • Continue development of the timeliness dashboard development for routine timeliness monitoring of non-urgent services. • Develop action plans as needed for timeliness measures not actively being monitored (urgent requests, psychiatry, post-hospitalization follow-up). • Review timeliness dashboard to monitor for access and data quality issues at QIC and the Dashboard Development Meetings. • Review timeliness on a quarterly basis in the QIC meetings and document the timeliness review and analysis. • Develop workflow on SUDS timeliness measures. • Develop SUDS timeliness training and provide to staff. • Develop SUDS timeliness monitoring system.
Due Date	June 30, 2024
Responsible Party	QA Staff Analyst, QIC, Youth Staff Analyst, Adult Staff Analyst, Transcription, SUDs QA

Goal 6: Monitor the provider network adequacy

Measurement	• 1 analysis of the anticipated needs and shared with QIC (KPI 6.1-NAneeds) • Participation in the monthly 274 submissions. (KPI 6.2-274submit)
Intervention	• Monitor the number of providers monthly. • Use the annual Meds anticipated needs data to inform the number of providers that must be maintained throughout the year
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QA Secretary, QIC

Goal 7: Ensure a culturally competent workforce

Measurement	• Ensure beneficiary/client forms are translated into Spanish, Punjabi and Hmong and easily available to clients. (KPI 7.1-tranlfrms) • 1 root cause analysis of the Foster Care (FC) penetration rate drop (KPI 7.2-FCpenrate) • Annual analysis of penetration rates shared with both QIC and CCC (KPI 7.3-CCpenrateshare) • Annual analysis of cultural competence workforce shared with QIC, CCC and HR. (KPI 7.4-CCworkforce) • Annual analysis of cultural competence services shared with QIC and CCC. (KPI 7.5 CCServices) • Annual analysis of participation in the Building Communities through Health workshops provided for the African American community. (KPI 7.6-AAworkshops)
Intervention	• Create a translated materials inventory and storage platform. • Update SYBH website to ensure client accessibility to beneficiary materials in Spanish and Hmong. • Monitor penetration rates for trends. • Conduct a root cause study on the FC penetration rate decrease. • Develop cultural competence staff survey to administer annually. • Develop cultural competence client survey to administer annually. • Participate in Building Communities through Health committee to develop educational workshops on accessing BH services for the AA community. • Develop evaluation for educational workshops to gather information on what workshop topics are needed in the African American community.
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QIC, DEIC, Youth Staff Analyst, Youth Services Program Managers, Adult Services Program Manager, PEI Supervisor, Latino Outreach Center Supervisor, SUDS QA.

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.

FY23/24 Goals:

Goal 8: Ensure compliance with NOABD issuance	
Measurement	• 1 developed formal training plan on NOABDs. (KPI 8.1-NOAtrain) • 1 developed formal training for business office staff on financial liability NOABD issuance. (KPI 8.2-FinanNOAtrain • 90% NOABD compliance rate determined from peer chart audits. (KPI 8.3-NOAaudit) • 2 URC meetings that have reviewed NOABD issuance rates and compliance monitoring results. (KPI 8.4-NOAshare)
Intervention	• Conduct a process review of financial liability NOABD issuance. • Identify process and knowledge gaps in the financial liability NOABD issuance. • Develop formal training for staff on financial liability NOABD issuance. • Conduct 2 sample audits to monitor compliance, include peer chart audits data to determine percentage of time NOABDs are being completed.
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QA staff Mental Health Therapist III, QIC, Business Office leadership and staff, SUDS QIC, SUDS QA

Goal 9: Ensure consistency in the authorization system	
Measurement/KPI	At least 2 meetings of results being shared with URC. (KPI 9.1- authshare)

Intervention	• Monitor and analyze all authorization types for trends of services offered and underutilization.
	  ○ ICC
	  ○ IHBS
	  ○ TFC
	  ○ TBS
	  ○ SARS
	  ○ TARS
	• Create benchmarks and standards for TARS to monitor against and share the findings at URC.
	• Conduct sample TARS audit to monitor quality and consistency.

Due Date	June 30, 2024
Responsible parties	QA Utilization Review Specialist, QA Mental Health Therapist III, 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) • Analyze and share results quarterly at the URC meeting. (KPI 11.5-HEDISshare)
Intervention	• Implement a monitoring system for Children and Adolescents using the AB1299 HEDIS measures
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, URC, 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 12.4 - readmitplan)
Intervention	• Identify tracking issues • Align benchmarks with State standards • Share readmission rates with URC routinely
Due Date	June 30, 2024
Responsible parties	QA Staff Analyst, QIC, Transcription staff, Inpatient leadership

Goal 13: Compliance and oversight of psychiatric inpatient submissions	
Measurement/KPI	• Achieve an overall compliance rate of at least 90% of unresolved cases. (KPI 13.1 - unresolvedcompliance) • Achieve an overall compliance rate of at least 90% of resolved cases. (KPI 13.2 - resolvedcompliance) • Analyze compliance three times a year. (KPI 13.3 – AnalyzeCompli) • Share analysis with URC three times a year. (KPI 13.4 – ShareCompli)
Intervention	• Monitor psychiatric inpatient case statuses in order to identify issues that may delay timely claim submission/payment. • Identify cases that contain submitted, rejected, or denied status and coordinate with facility and Acentra (Kepro) as appropriate for timely resolution. • Address issues with treating facility or Acentra (Kepro) when not in compliance with Title 9 regulation or BHIN 22-017 to determine appropriate course of action.
Due Date	June 30, 2024
Responsible parties	Utilization Review Specialist, URC Committee

Goal 14: Implement a system for utilization of services and monitoring and analyzing level of care and outcomes.	
Measurement/KPI	• 1 developed monitoring system for IHBS utilization. (KPI 14.1 – IHBSmonitor) • 1 developed monitoring system for children utilizing PES services or Hospitalization while in treatment with SYBH. (KPI 14.2. – PES&HOSPmonitor) • 1 developed system for level of care reporting and data analysis. (KPI 14.3 – LOCanalysis) • Review trends for clients receiving IHBS with URC Committee every other month. (KPI 14.4 – IHBStrend) • Review trends for children utilizing PES or Hospitalizations while in treatment with SYBH. (KPI 14.5 PES&HOSPtrend)
Intervention	• Develop a monitoring system for IHBS, PES and Hospitalizations for children. • Develop benchmarks for utilization of IHBS services. • Develop benchmarks for utilization of PES services and/or Hospitalization. • Develop benchmarks for LOCUS and MORS. • Explore the use of our new EHR to develop a system for reporting and data analysis of level of care.
Due Date	June 30, 2024
Responsible parties	Utilization Review Specialist, URC Committee

Program Integrity

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

FY23/24 Goals:

Goal 15: Conduct MH and SUDS Chart Audits	
Measurement/KPI	• Achieve an overall compliance rate of at least 80% on quarterly audits of contractors and internal program chart audits of SMHS and SUDS. (KPI 15.1-auditcompliance) • Analyze and review compliance rates at quarterly QIC, SUDS QIC and SUDS QA (54.2 – auditanalysis)
Intervention	• Conduct quarterly chart audits of services provided by both contractors and internal programs to score each programs overall rate of compliance with DHCS documentation rules and regulations. • Issue and monitor Corrective Action Plans (CAPS) to program leadership for charts that required services be voided/reimbursement recouped. • Provide individualized/targeted trainings for any programs that score below the 80% overall compliance rate.
Due Date	June 30, 2024
Responsible parties	QA Therapist, QIC, Youth Services Leadership, Adult Services Leadership, Contracted Provider Leadership, SUDS QA and SUDS QIC

Quality Improvement Projects

Performance Improvement Projects (PIP)

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

FY23/24 Goals:

Goal 16: 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 16.1-PIPFUH) • 1 developed PIP write-up including baseline data (KPI 16.2-PIPFUHplan)
Intervention	• Increase the rate of follow-up services within 7 days to post-psychiatric hospitalized clients from 46% to 57% • Implement follow up call measures to increase appointment attendance. • Plan additional interventions and implement as needed.
Due Date	June 30, 2024
Responsible parties	Outpatient leadership, inpatient leadership, discharge planners, QIC, QA Staff Analyst, QA Staff Services Manager

Goal 17: Implement CalAIM BHQIP PIP: Follow-Up Care After Emergency Department Visit for Mental Illness (FUM)	
Measurement/KPI	• 1 centralized referral tracking mechanism (KIP 17.1 FUMtrack) • 80% of clients discharged from PES/ED receiving minimum of 2 follow-up calls. (KIP 17.2 FUMfucalls) • Increase number of clients discharged from PES/ED who receive follow up appointment within 7 days by 5%. (KIP 17.3 FUM7dayFU) • Increase number of clients discharged from PES/ED who receive follow up appointments within 8-30 days by 5%. (KIP 17.4 FUM30dayFU
Intervention	• Implement assertive outreach and check-up via a minimum of 2 follow up calls to ensure client remains engaged and shows up for follow up appointments. • Implement an improved centralized referral tracking mechanism to enhance referral coordination from the ED. Referral coordinator to monitor and follow up on referrals in a timely manner.
Due Date	June 30, 2024
Responsible parties	Quality Assurance, Psychiatric Emergency Services (PES) Leadership, Adult Outpatient Leadership, Youth Outpatient Leadership

Goal 18: Implement CalAIM BHQIP PIP: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	
Measurement/KPI	• 1 centralized referral tracking mechanism (KIP 18.1 FUAtrack) • 80% of clients discharged from ED visits for substance use receiving minimum of 2 follow-up calls. (KIP 18.2 FUAfucalls) • Increase number of clients discharged from PES/ED for substance use who receive follow up appointment within 7 days by 5%. (KIP 18.3 FUA7dayFU) • Increase number of clients discharged from PES/ED for substance use who receive follow up appointments within 8-30 days by 5%. (KIP 18.4 FUA30dayFU)
Intervention	• Implement outreach and check-up via a minimum of 2 f/u calls to ensure client remains engaged and shows up for follow up appointments. • Implement an improved centralized referral tracking mechanism to enhance referral coordination from the ED. Referral coordinator to monitor and follow up on referrals in a timely manner.
Due Date	June 30, 2024
Responsible parties	Quality Assurance, Psychiatric Emergency Services (PES) Leadership, Adult Outpatient Leadership, Youth Outpatient Leadership

Goal 19: Implement CalAIM BHQIP PIP: Pharmacotherapy for Opioid Use Disorder (POD)	
Measurement/KPI	• 1 developed screening tool for SDOH needs and co-occurring mental health and substance use disorder needs. (KIP 19.1- PODscreentool) • 1 developed tracking mechanism to enhance referral coordination to and from SDOH resources. (KIP 19.2-PODtrack) • 80% of clients screened for co-occurring mental health, medical, and other substance use needs. (KIP 19.3-PODsceening) • 80% of screened clients who received a referral to address those needs. (KIP 19.4-PODreferral)
Intervention	• Develop and implement screening tool for SDOH needs and co-occurring mental health and substance use disorder needs. • Implement an improved centralized referral tracking mechanism to enhance referral coordination to and from SDOH resources. Referral coordinator to monitor and follow up on referrals in a timely manner.
Due Date	June 30, 2024
Responsible parties	Quality Assurance, SUDS Leadership

Goal 20: Implement Non-clinical PIP to improve communication with families regarding hospital transfer and step-down services Develop action plan and interventions to increase satisfaction with positive outcomes of services/functioning for youth and adults.	
Measurement/KPI	• 1 pre-surveys to look further into issues identified by the consumer focus group (KPI 20.1-PIPpresurvey) • 1 developed PIP write-up including baseline data (KPI 20.2-PIPcommplan) • 1 post-survey after interventions have been implemented (KPI 20.3-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, 2024
Responsible parties	Quality Assurance,

CalAIM Behavioral Health Quality Improvement Projects

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

FY23/24 Goals:

Goal 21: Implement and monitor CalAIM Payment Reform changes	
Measurement/KPI	• 1 CPT codes implemented staff training. (KPI 21.1-CPTtrain) • 1 IGT implemented staff training. (KPI 21.2-IGTtrain) • Quarterly payment reform implementation analysis shared with BH leadership at QIC to include approval rates, denial rates and reimbursement revenues. (KPI 21.3-IMPshare)
Intervention	• Update claiming rates and system. • Implement CPT codes including training and update system with new codes. • Develop IGT protocols and implement including training. • Align benchmarks with State standards. • Review Payment Reform implementation routinely.
Due Date	June 30, 2024
Responsible parties	Quality Assurance, BH Leadership

Goal 22: Implement, monitor, and provide continuous training on CalAIM Behavioral Health Policy changes	
Measurement/KPI	• 1 implemented training for staff and subcontractors on CalAIM behavioral health policy changes. (KPI 22.1-Train) • 1 pre and post test score analyses for all CalAIM behavioral health policies and procedures. (KPI 22.2-Analyze) • Annually share analysis with QIC. (KPI 22.3-Share)
Intervention	• Develop, update and implement behavioral health policies and procedures to align with CalAIM changes, including all aforementioned categories as reference in the goal description • Develop and implement new and ongoing training plan on all behavioral health policy changes, including but not limited to use of the screening and transition tools, ASAM, documentation • Update EHR documentation to align with documentation reform.
Due Date	June 30, 2024
Responsible parties	Quality Assurance, BH Leadership

Goal 23: Improve data exchange capabilities	
Measurement/KPI	• Track and meet benchmarks for progress on HIE onboarding and successful data sharing transactions. (KPI 23.1 – Trackdatashare) • Track and meet benchmarks for progress on implementation of the FHIR API. (KPI 23.2 – TrackimplemtFHIR) • Track and meet benchmarks for progress on mapping data elements to the USCDI. (KPI 23.3 – TrackMapping) • Annually analyze benchmarks and share results with QIC. (KPI 22.4 – AnalyzeBench)
Intervention	• Onboard to an HIE and develop project plan to implement data exchange • Enable an active Fast healthcare Interoperability Resources (FHIR) application programming interface (API) to be compliant with CMS-mandated interoperability rules • Map data elements to the United States Core Data for Interoperability (USCDI) standard set • Align benchmarks with State standards
Due Date	June 30, 2024
Responsible parties	Quality Assurance, BH Leadership, EHR Vendor, IT