YOLO COUNTY MENTAL HEALTH PLAN

Fiscal Year 2015 - 2016

Quality Management Work Plan

Yolo County Health and Human Services Agency

Quality Management Department

August 31, 2015

Revised January 2016

Yolo County Health and Human Services Mental Health Plan
Quality Management Work Plan
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INTRODUCTION

Quality Management Program

The Yolo County Health and Human Services Agency (HHSA) Mental Health Plan (MHP) is committed to providing high quality, culturally competent services and supports that enhance recovery from serious mental illness (SMI), substance use disorders (SUD), and serious emotional disturbance (SED). The Quality Management (QM) Program is accountable to the Mental Health Director. Our function is to ensure equity, value – clinical health outcomes per dollar spent – and efficiency of the service delivery system.

Quality Improvement Committee (QIC)

The QIC is responsible for the overall quality review of all mental health services provided in Yolo County. Our goal is to review and evaluate the quality and appropriateness of services to beneficiaries and the results of QM activities, pursue opportunities to improve services, and resolve identified problems. On an annual basis, the QIC is responsible for reviewing the QM, assessing its effectiveness, and pursuing opportunities to improve the Quality Management Work Plan (QMWP). The QIC is comprised of representatives from the following stakeholder groups: consumers, family members, Patients' Rights Advocate, Local Mental Health Board, QM Program staff, provider and MHP staff, supervisors and managers, and the Mental Health Director. The QIC meets quarterly, while QIC subcommittees and workgroups meet more frequently and report back to stakeholders at the QIC meetings. The frequency and duration of these meetings vary depending upon identified need. Current subcommittees include:

1. Performance/Outcome Data Workgroup
2. Utilization Review Workgroup
3. Clinical Documentation Workgroup
4. Psychiatric Care Committee
5. Medication Monitoring Committee
6. Clinical Information Systems Workgroup
7. Provider Stakeholder Workgroup
8. Drug Medi-Cal Organized Delivery System

Quality Management Work Plan (QMWP)

The annual QMWP is developed and monitored by the QM Program with input from the MHP Leadership Team. Its purpose is to organize and provide structure for QM activities throughout the Yolo County MHP and to systematically ensure adherence to the MHP Contract with the California Department of Health Care Services (DHCS) and regulations

set forth by the Centers for Medicare and Medicaid Services (CMS). The FY15-16 QMWP identifies objectives and planned activities designed to monitor service delivery, analyze data, recommend policy, evaluate performance, and report findings on the following areas :

1. Service Delivery Capacity
2. Accessibility and Timeliness of Services
3. Beneficiary Satisfaction
4. Service Delivery System and Clinical Issues Affecting Beneficiaries
5. Provider Relations
6. Continuity and Coordination of Care with Physical Health Care Providers and Other Human Services Agencies
7. Performance Improvement Projects
8. Improve audit results and reduce disallowances

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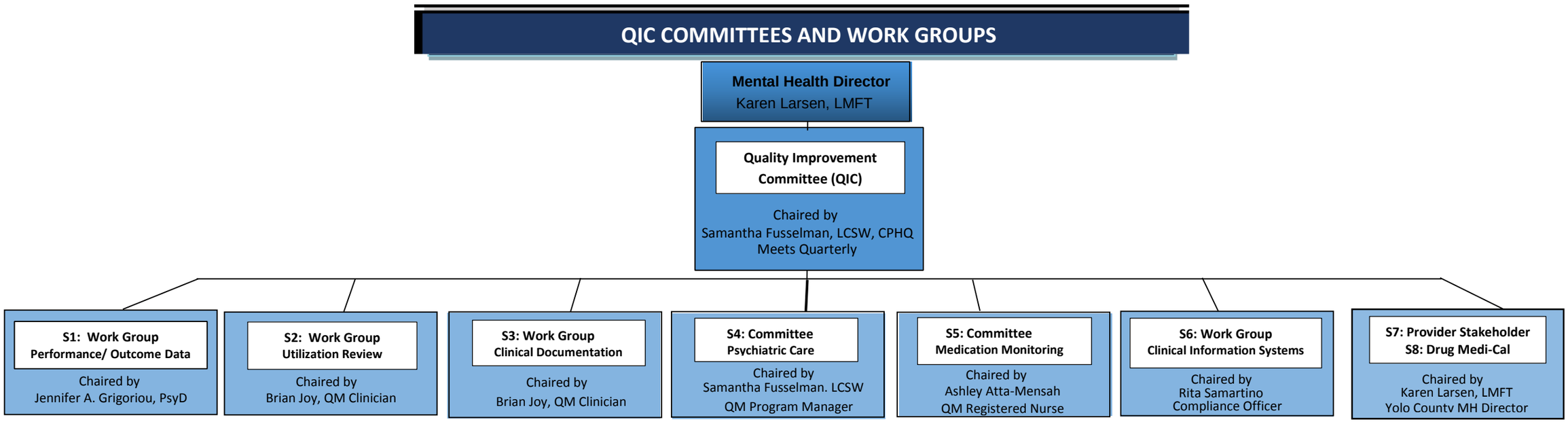
QIC COMMITTEES AND WORK GROUPS
Mental Health Director
Karen Larsen, LMFT
Quality Improvement Committee (QIC)
Chaired by
Samantha Fusselman, LCSW, CPHQ
Meets Quarterly
S1: Work Group
Performance/ Outcome Data
Chaired by
Jennifer A. Grigoriou, PsyD
S2: Work Group
Utilization Review
Chaired by
Brian Joy, QM Clinician
S3: Work Group
Clinical Documentation
Chaired by
Brian Joy, QM Clinician
S4: Committee
Psychiatric Care
Chaired by
Samantha Fusselman. LCSW
QM Program Manager
S5: Committee
Medication Monitoring
Chaired by
Ashley Atta-Mensah
QM Registered Nurse
S6: Work Group
Clinical Information Systems
Chaired by
Rita Samartino
Compliance Officer
S7: Provider Stakeholder
S8: Drug Medi-Cal
Chaired by
Karen Larsen, LMFT
Yolo County MH Director

QUALITY IMPROVEMENT COMMITTEE & WORK GROUPS

Quality Improvement Committee (QIC)

The following is a summation of QIC activities and responsibilities:

- Receives information on QI activities; reviews and evaluates QI activity results;
- Receives information on QM committees, sub-committees, and work groups;
- Reviews, tracks, monitors, and evaluates grievances, State Fair hearings, Change of Provider requests, provider appeals, Treatment Authorization Requests (TARs), and Notices of Action (NOAs);
- Evaluates the resolution of grievances on a regular basis and initiate appropriate follow up;
- Reviews, tracks, and monitors the expansion of technology infrastructure;
- Institutes QI activities such as Performance Improvement Projects (PIPs) and ensures follow through with established QI projects;
- Reviews reports, issues recommendations, and institutes appropriate actions;
- Presents concerns and policy recommendations to Mental Health Director and administrators;
- Recommends policy changes throughout the county system in order to improve the quality and delivery of Substance Use Disorders/ Specialty Mental Health services.

Section 1 Work Group: Performance/ Data Outcomes

A quarterly review of Mental Health Plan (MHP) performance improvement activities, including Consumer Perception (CP) surveys and Clinical/ Non-Clinical PIPs. This work group provides semi-annual trainings on the potential implementation of empirically-based outcome measurement throughout the mental health delivery system (i.e., direct service, population-based outreach, program development, etc.). Training is rendered by a licensed Clinical Psychologist to support performance outcomes/ measurement activities conducted by community stakeholders (e.g., administrative/ clinical/ support/ consumer staff, contract providers, local mental health board members, executive management, etc.) who actively take part in the collection and distribution of county data. Another area of focus includes standardizing procedures for conducting, evaluating, analyzing, and distributing findings from semi-annual CP surveys. CP survey findings are analyzed and reported back to the QIC. Additionally, the workgroup may transform into a structured training/ focus/ technical assistance (TA) group in order to elicit greater participation. Contracted providers are encouraged to utilize the resources/ instruction offered in this workgroup in order make meaningful use of site-specific data, which can contribute to ongoing clinical/ administrative performance improvement activities.

Section 2 Work Group: Utilization Review (UR)

A monthly review of approximately 1% of county charts from various programs (Child/Transitional Aged Youth; Adult; Older Adult) for the purpose of ensuring adequate charting standards. The desired goal of this workgroup is to review an estimated 10% of agency charts per year. To elicit stakeholder involvement, different levels of clinical staff (ranging from Mental Health Rehabilitation Specialist to Licensed Professional of the Healing Arts) are invited to participate on a rotating, quarterly basis. Clinical staff review a combination of electronic and paper charts with a QM-derived UR tool that screens for: diagnostic consistency; updated consent forms and client plans; appropriate instrumentation selection; timely assessment for monitoring progress; accurate charting of progress notes that support treatment and medical necessity; a review of medication service notes; and the inclusion of accurate/ timely discharge paperwork. Key indicators for the successful completion of the UR include:

1. Consistent documentation of diagnosis throughout all phases of service;
2. Clear documentation indicating that the presenting problem or reason for service meets medical necessity;
3. Clear documentation and support indicating that the presenting concerns are associated with the established diagnosis;
4. Clearly documented client plan goals that are specific, measurable, observable, and clearly linked to diagnosis;
5. Clearly established client plan goals that are aimed at reducing symptoms and functional impairments related to the diagnosis;
6. Progress notes containing evidence that mental health/SUD services address the diagnosis, symptoms, and functional impairments stated in the client plan;
7. Documentation of clinical interventions that relate back to the diagnosis established in the client plan.

Section 3 Work Group: Clinical Documentation (CD)

A monthly workshop devised to assist staff with increasing competence, skill level, and accuracy in documentation and charting of mental health/ SUD services. The workshop is open to all county clinical staff participants on an “as-needed” basis. Supervisors are instructed to make arrangements with staff who are in need of assistance with various aspects of CD. Topics vary from month-to-month; the following examples do not constitute an exhaustive list:

1. Assessment formulation and documentation;
2. Client plan goal formulation (that addresses diagnosis, symptoms, medical necessity);
3. Progress note differentiation and formulation (i.e., Assessment, Plan Development, Case Management, Rehabilitation, Psychotherapy, Collateral, Non-billable services, etc.);
4. Plan development and follow up notes;

5. Utilizing accurate clinical interventions to appropriately address presenting problem and diagnosis;
6. Writing comprehensive discharge plans and summaries.

Section 4 Committee: Psychiatric Care Committee (PCC)

A weekly work group of 10-15 mental health/medical providers who staff high acuity Medicare, Medi-Cal, and indigent cases. The committee is chaired by the QM Program Manager and includes representatives from various agencies, including: Yolo County Health and Human Services, Turning Point, Woodland Memorial, and Yolo Community Care Continuum. PCC members monitor the utilization of high-cost SMHS/ SUD treatment and plan for follow-up care for beneficiaries on the verge of: (1) surpassing hospital stays; (2) transferring to lower/ higher levels of care; and (3) being released from inpatient psychiatric hospitalization.

Section 5 Committee: Medication Monitoring Committee (MMC)

The MMC is a newly formed committee implemented to review and discuss medication support services as they relate to medication monitoring. The committee is chaired by the QM Senior Staff Nurse and includes the Yolo County MHP Medical Director, a contracted, Registered Pharmacist, and the Yolo County MHP Nurse Supervisor. The committee meets every other month to discuss findings found in the general SMHS population, as well as those in legal custody. The Medical Director and contracted pharmacists review medical/ mental health reports. MMC members discuss these findings, address arising questions/ concerns, propose necessary recommendations, and develop strategies that are reported back to QIC.

Section 6 Work Group: Clinical Information Systems Work Group (CISWG)

The CISWG brings Clinical and IT staff together to streamline electronic procedures (i.e., documentation, diagnosis, billing, provider certification, ICD-10 conversion, etc.) in AVATAR. This work group meets twice per month and is chaired by the Yolo County MHP Compliance Officer and Systems Coordinator. Various program managers (i.e., Child System of Care, Adult System of Care, Support Services, Crisis and QM) from the county and contracted sites attend meetings and propose strategies to maintain safe electronic record transmission. CISWG also serves to inform County/ Contract administrators on electronic documentation practices, policies, and procedures. CISWG findings and recommendations are reported back to QIC.

Section 7 Work Group: Provider Stakeholder Work Group (PSWG)

The mission of the PSWG is to: collaborate on the efficient and appropriate use of resources; maintain communication and transparency; and promote high quality services to the vulnerable populations. This work group meets monthly and is chaired by the Mental Health Director. PSWG is attended by various County departments (e.g., CAO) and community providers.

Section 8 Work Group: Drug Medi-Cal Organized Delivery System (DMC-ODS)

The purpose of the DMC-ODS is to prepare SUD/ Alcohol and other Drug (AOD) treatment providers for the implementation of the 1115 Bridge to Reform Waiver. This work group meets

quarterly and is chaired by the Mental Health Director. The work group reviews Federal/ State guidelines and develops plans for enhancing health care services for Medicaid eligible individuals with SUD. Critical elements discussed in the DMC-ODS work group include: provision of services modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services; increased local control and accountability; greater administrative oversight by Yolo County; utilization controls to improve the use of resources; the use of evidence based SUD treatment practices; and increased coordination with regional SUD/ AOD providers.

QUALITY MANAGEMENT WORK PLAN GOALS & OBJECTIVES

The following goals have been selected by the MHP's Quality Management Program that serves the interests of Yolo County SMHS/ SUD consumers and the mandates set forth by DHCS and CMS:

I. Service Delivery Capacity
II. Accessibility and Timeliness of Services
III. Beneficiary Satisfaction
IV. Service Delivery System and Clinical Issues Affecting Beneficiaries
V. Provider Relations
VI. Continuity and Coordination of Care with Physical Health Care Providers and Other Human Services Agencies
VII. Performance Improvement Projects
VIII. Improve audit results and reduce disallowances

GOAL I: MONITORING SERVICE DELIVERY CAPACITY

Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Monitor access to services by race/ethnicity.	• Penetration Rates by race/ethnicity	• Increase Hispanic Penetration Rate from 2.95% to 3.92%.	•
2.) Close inactive cases.	• Avatar	• Reduce the rate of inactive cases from 20% to 10%.	•
3.) Develop population-specific CARE teams.	• Caseloads • Staff assignments	• Intensive Services Team • Moderate Intensity Team • TAY Team	•
4.) Create crisis clinician position.	• Organizational Chart	• New clinician hired by end of 2015.	•

GOAL II: ACCESSIBILITY & TIMELINESS OF SERVICES			
Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Provide services to new beneficiaries within 14 calendar days of initial request.	• Avatar report	• 75% of all initial services will be offered within 14 calendar days of request.	•
2.) Reduce appointment wait time for beneficiaries with the most urgent mental health conditions.	• Avatar report derived from the scheduler that depicts actual numbers of urgent care appointments scheduled	• 75% of all urgent requests for services will be offered within 48 hours of request.	•
3.) Provide timely follow-up services to beneficiaries post discharge from inpatient hospitalization.	• Avatar reports	• Greater than 50% of beneficiaries discharged from an inpatient facility will have an appointment with a SMHS provider within 7 days of discharge.	•
4.) Develop test call policies and procedures for Access Line.	• Updated P&P	• Updated P&P by February 29, 2016.	•
5.) Monitor Access Line for all incoming requests for services.	• Access Line Logs • Avatar reports	• Create Access Log for business hours. • Create Access Log for after hours. • Log 95% of all incoming requests for services on the Access Line. Include: beneficiary's name, date and time of request, reason for request, and disposition. • Quarterly review of Access Log.	•
6.) Access Line test calls.	• QM test call log • Access log • DHCS quarterly test call reports	• 6 test calls will be conducted per quarter. • 75% of test calls will be recorded in the Access Log. • At least 20% of Access Line test calls in a language other than English.	•
7.) Ensure provision of culturally and linguistically appropriate services.	• Utilization Review worksheets collected at Documentation Work Group	• 75% of all progress notes will indicate language preference.	

GOAL II: ACCESSIBILITY & TIMELINESS OF SERVICES			
	• Client plans and the "Acknowledgment of Receipt" form • Access test call quarterly reports • Avatar report of timeliness for services by language preference	• Parity in wait times for English/Non-English speaking beneficiaries.	

GOAL III: BENEFICIARY SATISFACTION			
Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Administer Spring/Fall CP surveys.	• Surveys • Electronic coding of survey data • CIBHS receipt/ verification • Performance/ Outcome Data Training session attendance • FY 14-15 CP Survey Report • Establish Wellness Indicators (Non-Clinical PIP)	• Increase contract provider participation from 4 to 8. • Obtain approximately 500 surveys each collection period. • Increase participation of medical providers; care team staff; field staff; support staff; and wellness center staff. • Train all staff on surveying and data collection procedures. • Determine baseline levels of beneficiary satisfaction for FY 14-15. • Identify & analyze indicators for FY 15-16 & compare to indicators obtained FY 14-15.	•
2.) Monitor NOAs	• Notice of Action forms • NOA tracking log • QIC minutes summarizing NOA requests and activities	• Update NOA policy and procedure by 6/30/16. • Update log. • Issue 100% of NOAs within regulatory timelines. • Report findings on a quarterly basis at QIC.	•

GOAL III: BENEFICIARY SATISFACTION			
3.) Monitor and review "Change of Provider Requests."	• Change of Provider Request forms • Change of Provider tracking sheet • QIC minutes summarizing Change of Provider Request activity	• Adhere to state protocols. • Issue 100% of responses within appropriate timeframes. • Analyze data to identify culturally-influenced expectations or misunderstandings between beneficiaries and provider/clinical staff.	•
4.) Review beneficiary grievances, appeals, expedited appeals, state fair hearings and expedited state fair hearings.	• Grievance and appeal forms • Grievance and appeal log • QIC minutes summarizing activity	• Adhere to state protocols. • Issue 100% of responses within given timeframes. • Establish baseline. • Analyze data to identify culturally-influenced issues beneficiaries have w/ services.	•

GOAL IV: SERVICE DELIVERY SYSTEM AND CLINICAL ISSUES			
Activities/ Strategies/ Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Review billing system.	• AVATAR/ EA/ Crystal reports • MHP contracts with existing contract providers providing SMHS/ SUD services	• Streamline diagnostic coding with billing system within AVATAR.	•
2.) Update informing materials.	• QM webpage • Updated Guides • Updated Authorization Request forms	• Develop Clinical Documentation Guide draft by 6/30/16. • Update Provider Guide. • Update Authorization Request forms.	•
3.) Monitor clinical outcomes data.	• TF-CBT data – YOQ and UCLA PTSD • CANS • ANSA • FSP/KET Data	• Implement tracking mechanisms within Avatar to capture TF-CBT and other outcomes data by 6/30/16. • Load ANSA in Avatar. • Develop reports for monitoring CANS and ANSA.	•

GOAL IV: SERVICE DELIVERY SYSTEM AND CLINICAL ISSUES			
Activities/ Strategies/ Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
4.) Implement ICD-10 Conversion.	• AVATAR and Crystal reports • Chart documentation	• Develop P&P draft for implementation by December 31, 2015. • Identify conversion needs. • Provide system-wide training on ICD-10 in September 2015. • Implement initial conversion for the entire system (October 2015). • Monitor provider EHR entries & billing statements on a monthly basis to ensure diagnostic consistency.	•
5.) Monitor the delivery of medication support services.	• Client medication plans (in beneficiary charts) • Pharmacy reports • Utilization Review worksheets • Medication service progress notes	• Medication monitoring committee meets bimonthly. • Report findings, concerns, or recommendations from pharmacist/ medical provider/ nurse review. • Report findings, concerns, or recommendations from Utilization Review Work Group.	•
6.) Implement Level of Care tool.	• Avatar	• Include LOCUS in EHR. • Train 100% of MHP clinical staff on LOCUS.	•
7.) Monitor Community Integration Programs (CIP) fidelity to treatment.	• Findings report • POMs	• Review findings report and provider outcomes data. • Provide recommendations.	
8.) Track Treatment Authorization Requests (TARs).	• TAR log • PCC Work Group minutes • Processed TARs for Medi-Cal and non-Medi-Cal hospitalizations (approvals/ denials)	• Develop hands-on, intensive, concurrent clinical discussions with provider hospitals by conducting weekly PCC Work Group with medical providers, contract providers, QM staff, and Clinical Program managers.	•

GOAL V: PROVIDER RELATIONS

Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Monitor practitioner requests.	• Practitioner request forms • Practitioner request tracking log • QIC minutes summarizing practitioner requests and activities	• Update Practitioner Enrollment policy and procedure by 6/30/16. • Update Practitioner ID request log. • Respond to 80% of requests within 14 days. • Report findings on a quarterly basis at QIC.	•
2.) Monitor Medi-Cal Site Certification.	• Provider certification/ re-certification forms • Provider certification/ re-certification tracking log • QIC minutes summarizing Provider certification/ re-certification requests and activities	• Update provider certification/ re-certification policies and procedures by 6/30/16. • Develop tracking mechanism. • Submit quarterly reports to DHCS. • Report findings on a quarterly basis at QIC.	•
3.) Monitor SUD provider sites.	• Review tools and findings reports • SAPT findings • Triennial findings • Provider Corrective Action Plans (CAPs)	• Develop SUD review tool by 10/30/15. • Respond to SAPT/ Triennial findings by specified deadlines. • Review provider CAPs.	•
4.) Offer regular trainings/ TA.	• Training attendance sheets • Provider emails for TA requests	• Provide ICD-10 training before 10/1/15. • Provide annual Cultural Competency training. • Provide annual CP survey administration/ collection training. • Provide Training on Title 22 regulations.	•

GOAL VI: CONTINUITY AND COORDINATION OF CARE

Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Establish regular dialogue and partnerships with physical health care providers.	• PSWG attendance • MOU	• Maintain/ increase provider attendance. • Develop and finalize MOU with Dignity Healthcare.	•

GOAL VI: CONTINUITY AND COORDINATION OF CARE

2.) Monitor targeted outreach efforts of county sub-contracted provider agencies to better service the clinical, cultural and/ or linguistic needs of Yolo County beneficiaries.	• Feedback forms • Active grant writing activities and/ or new RFPs	• Identify unmet clinical, cultural and/ or linguistic needs and gaps in SMHS/ SUD services and programs. • Offer recommendations and support to outreach staff when appropriate.	•

GOAL VII: PERFORMANCE IMPROVEMENT PROJECTS

Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Participate in HHSA Quality Improvement efforts.	• Participation in CHIP meetings and development • Participation in Performance Measures Steering Committee	• Develop Performance Measures for Adult and Aging Branch – psychiatry and FSP by November 2015. • Develop mental health-specific outcome measures for CHIP application by November 2015.	•
2.) Establish one Non-Clinical PIP.	• EQRO Non-Clinical PIP submission	• Collect input from stakeholders. • Utilize CP survey outcome information to improve or adapt services. • Develop Non-Clinical PIP project and report findings by February 2016.	•
3.) Establish one Clinical PIP.	• EQRO Clinical PIP submission	• Collect input from stakeholders. • Utilize CP survey outcome information to improve or adapt services. • Develop Clinical PIP project and report findings by February 2016.	•
4.) Evaluate results of PIPs.	• Data analysis • EQRO findings	• Identify unmet needs and gaps in MHP service delivery. • Offer recommendations to remedy needs/ gaps.	•

GOAL VIII: IMPROVE AUDIT RESULTS

Activities / Strategies / Priorities	As Evidenced By	Targeted Goals	Performance Evaluation
1.) Reinstate Utilization Review (UR) process.	• Utilization Review worksheets collected at Documentation Work Groups • Documentation Work Group attendance sheets	• Establish baseline level of allowable progress note entries by December 2015. • Establish baseline level of allowable treatment plans by March 2016. • Establish baseline level of allowable assessments (includes crisis, forensic, and diagnostic assessments) by March 2016. • Reduce disallowances due to improper documentation of progress notes, treatment plans and assessments. • Quarterly reports to management team regarding findings, concerns, or recommendations from Utilization Review Work Group, by June 2016.	•
2.) Develop Healthy Chart Project plan.	• P&Ps related to documentation • Attendance sheets from documentation workshops	• Implement monthly documentation workshops by September 2015. • Develop draft clinical documentation guide by March 2016. • Identify healthy chart indicators to track and report by March 2016 • Develop Avatar reports to track healthy chart indicators by 6/30/16.	•
3.) Develop annual medication support plan.	• Avatar • CISWG Minutes	• Meet with MHP prescribers to identify needs by 6/30/16. • Develop the Medication Plan by 6/30/16.	•