YOLO COUNTY QUALITY MANAGEMENT

WORK PLAN

Fiscal Year 2017-2018

Evaluation Period: July 1, 2017 – June 30, 2018

Yolo County Health & Human Services Agency (HHSA)

Quality Management Program

Last Updated: March, 2018

Quality Management Program

The Yolo County Health and Human Services Agency (HHSA) Behavioral Health is committed to providing high quality, culturally competent services and supports that are consumer-focused, clinically appropriate, cost-effective, data-driven, and enhance recovery from serious mental illness (SMI), substance use disorders (SUD), and serious emotional disturbance (SED). To oversee the quality of these services and maintain compliance with all applicable Federal, State and local laws and regulations, Yolo County HHSA operates a comprehensive Behavioral Health Quality Management (QM) Program encompassing several Quality Assessment and Performance Improvement (QAPI) activities. Accountable to the HHSA director, the QM Program supports program, administrative, and fiscal staff to improve the quality of services provided to behavioral health clients; its purpose is to develop, implement, and monitor processes and activities, and ensure behavioral health clients receive value-based services that adhere to regulatory standards. The QM Program's activities are guided by the relevant sections of federal and California state regulations, including the Code of Federal Regulations Title 42, the California Code of Regulations Title 9, Welfare and Institutions Codes (WIC), as well as the County performance contract with the California Department of Health Care Services (DHCS). Program activities and responsibilities include:

- Monitoring Yolo County's adherence to the State-County Contracts in all categories, including, but not limited to: beneficiary protection, provider relations, utilization management, utilization review, Medi-Cal documentation, quality improvement, access and authorization, network adequacy, and program integrity
- Monitoring and assisting contract agencies' adherence to their contracts with HHSA
- Operation and oversight of the Electronic Health Record
- Tracking, monitoring, analyzing, and reporting utilization data for specialty mental health and substance use disorder services
- Recommending improvement strategies pertaining to access, timeliness, quality, and outcomes of care

Quality Improvement Committee (QIC)

The QIC is responsible for the overall quality review of all behavioral health services provided in Yolo County. The QIC's goal is to review and evaluate the quality and appropriateness of services to beneficiaries and the results of QM activities, identify and pursue opportunities for improvement, and resolve identified problems. Trends and issues identified through the beneficiary protection processes (grievances, appeals, and expedited appeals) are transmitted to the QIC for review. On an annual basis, the QIC is responsible for reviewing the QM Program, 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 HHSA staff, supervisors and managers, and reports to the HHSA Director. The QIC meets six times per year at minimum, while the frequency of meetings of QIC subcommittees and workgroups vary depending upon identified need. QIC subcommittees and workgroups report back to stakeholders at QIC meetings. Current active subcommittees and work groups and those which are planned to resume include:

1. Performance / Outcome Data Workgroup – active in FY17-18
2. Utilization Review Workgroup
3. Clinical Documentation Workgroup – active in FY17-18
4. System Utilization Review (SUR) Committee – active in FY17-18
5. Medication Monitoring Committee
6. Clinical Information Systems Workgroups – active in FY17-18
7. Drug Medi-Cal Organized Delivery System – active in FY17-18

Quality Management Work Plan (QMWP)

The annual QMWP, also referred to as the Quality Improvement (QI) Work Plan by DHCS, is developed and monitored by the QM Program with input from the HHSA Behavioral Health Leadership Team. Its purpose is to organize and provide structure for QM activities throughout the Yolo County and to systematically ensure adherence to the County-State Contract with the California DHCS and regulations set forth by the Centers for Medicare and Medicaid Services (CMS). The QMWP provides a structured way of monitoring QAPI activities, including but not limited to: review of beneficiary grievances, appeals, expedited appeals; fair hearings, expedited fair hearings; provider appeals; clinical records; performance improvement projects (PIPs); service accessibility, timeliness, quality, and outcomes; and the requirements for cultural and linguistic competence. The QMWP also includes evidence of whether QAPI activities have contributed to meaningful improvement in clinical care and beneficiary service. Progress toward QMWP goals are monitored routinely and reviewed annually, at minimum. The QMWP is a key tool for evaluating the QM Program's impact and effectiveness so program updates and improvements can be made, as needed.

FY17-18 Quality Management Work Plan Annual Evaluation

The Yolo County HHSA Quality Management team established 18 goals comprised of 78 objectives for the FY17-18 Work Plan. Of the 78 objectives, 56% were evaluated as met (*n*=44), 41% were partially met (*n*=32), and 3% were not met (*n*=2). Results from the FY17-18 Work Plan will inform goal development for FY18-19.

Goal	Objectives / Activities	Annual Evaluation
I. Quality: Develop and maintain a system that allows providers, beneficiaries, and the public to access updated information about Yolo County HHSA's QAPI activities.	1) Update external QM website. 2) Develop a process for creating and routinely updating a data dashboard.	**Objectives / Activities:** **Met**: 2 **Partially Met**: 1 **Not Met**: n/a **Continued:** 1
Goal I Evaluation: 1) Partially met. QM began website restructuring efforts and made updates to the website, including uploading the FY17-18 QM Work Plan and FY16-17 Work Plan Evaluation, and the MHP EQRO FY17-18 Final Report. This goal will be continued in FY18-19 to ensure access to updated information for both Mental Health and Drug Medi-Cal (e.g., new documents, forms, policies and procedures, information notices, calendar event notices). Members of the QM team received training on updating the external QM website in April 2018 and were granted access to do so in June 2018, which will help facilitate timely and routine updating moving forward. 2) Met. The QM team was granted access to update the external QM website directly in June 2018; this will allow for timely and routine posting of the data dashboards received by DHCS.		
II. Quality: Strengthen relationships with behavioral health providers and involve other important stakeholders in QAPI activities related to improving clinical service delivery.	1) Identify strategies to increase attendance of contract providers at QIC. 2) Increase communication with behavioral health providers regarding new regulations and requirements (438 Mega Rule, DMS-ODS, Parity, Title 22, Title 9, DHCS Info Notices).	**Objectives / Activities:** **Met**: 1 **Partially Met**: 2 **Not Met**: n/a **Continued:** TBD
Goal II Evaluation: 1) Met. Solicited feedback at the 12/1/17 QIC meeting, particularly from providers in attendance, on ways to increase involvement from other providers. Recommendations included specifically addressing overlap with providers; based on feedback, incorporated more discussion topics on updates to regulatory requirements and implementation for providers. 2) Partially met. The QM team initiated the process of distributing HHSA Behavioral Health (BH) Information Notices (IN's) to providers via email and at the Provider Stakeholder Workgroup (PSWG). Two IN's were distributed regarding new Federal 438 Managed Care regulations and new Provider Directory requirements. Further, two overview presentations were provided at the PSWG on Federal Medicaid Managed Care Regulations (9/18/17) and Network Adequacy and Certification (6/21/18). This goal will be carried over and updated for FY18-19 to include continued development of BH IN's as well as posting BH IN's to the QM website as forums for ensuring standard and routine communication to BH providers.		
III. Access: Ensure the Provider Directory is updated and accessible to beneficiaries.	1) Update the Provider Directory in accordance with new regulations. a) Gather necessary information to update the current directory b) Establish a mechanism to collect necessary information from providers to update on a monthly basis c) Update the directory in paper form and on the external HHSA QM website every 30 days.	**Objectives / Activities:** **Met**: 1 **Partially Met**: n/a **Not Met**: n/a **Continued:** TBD

Goal	Objectives / Activities	Annual Evaluation

Goal III Evaluation:

1a-c) Met. In accordance to Federal and State requirements, the Yolo County HHSA Mental Health Provider Directory has been updated to meet 438 regulations. Additionally, the Policy and Procedure 5-5-002 Provider Directory has been executed which outlines the requirements for updating the Provider Directory on a monthly basis to include the procedures for ensuring that the directory is made available to beneficiaries and family members upon intake and upon request. Providers submit a monthly update through Survey Monkey and provide any staffing updates using the staff directory spreadsheet. This information is then included in the Provider Directory template and posted on the website every 30 days, or as necessary.

While a process has been established for obtaining the necessary information from providers on a monthly basis, how to make the updates more automatic is currently being reviewed. A new goal for FY18-19 is to determine if a database may be utilized to input updates and report generated rather than manual data entry. Additional goals for FY18-19 shall include assessing the current provider directory and ensuring compliance to the new requirements of MHSUDS IN 18-020.

Goal	Objectives / Activities	Annual Evaluation
IV. Outcomes: Monitor and improve beneficiary satisfaction with services.	1) Administer Consumer Perception (CP) surveys twice per fiscal year. 2) Analyze results. 3) Inform providers of results.	**Objectives / Activities:** **Met**: 1-3 **Partially Met**: n/a **Not Met**: n/a **Continued:** 1-3

Goal IV Evaluation:

1-3) Met. Consumer Perception (CP) Surveys were administered per DHCS schedule. Results from 2017 were analyzed and shared in multiple venues with providers, including the Yolo County Provider Stakeholder Workgroup, the Quality Improvement Committee (QIC) meeting, the Local Mental Health Board, and the Healthy Yolo external facing website as part of the Mental Health workgroup of the Community Health Improvement Plan.

Figure 1: There was an 8% decrease in the number of surveys returned from Spring to Fall 2017. On average, about two-thirds of surveys returned had a least one client response (not blank). The decrease in the number of surveys returned might have been impacted by a change in the survey administration procedures from Spring to Fall (i.e., QM staff were not present in the HHSA clinics to offer additional survey support during data collection). QM plans to establish a CP Survey response rate baseline and goal for FY18-19 based on the total number of scheduled / rendered appointments during the designated survey collection week.

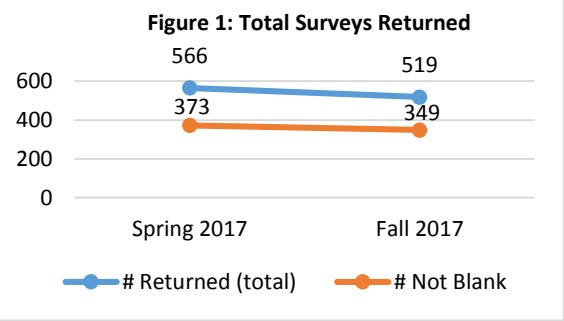

Figure 2: During both Spring and Fall 2017, General Satisfaction with Services was the highest Domain for adults age 18+ (ranging from 84% to 87% satisfaction responses), and Service Cultural Sensitivity was the highest Domain for youth and family of youth (ranging from 86% to 97% satisfaction responses). Alternatively, Improved Outcomes and Functioning were the lowest Domains across all survey populations in 2017 (ranging from 62% to 73% satisfaction responses). These preliminary results suggest, while clients and family members completing CP Surveys are generally satisfied with aspects of their care (e.g., staff treated them with respect, were sensitive to their cultural / ethnic / spiritual backgrounds; they would recommend services to others), an area for further exploration and potential improvement is around outcomes of care (e.g., improving symptoms and functioning in life domains such as school, work, housing, social relationships, etc.). QM plans to expand on the Beneficiary Outcomes goal during FY18-19 to improve data collection and reporting to support decision-making.

	Figure 2: Preliminary Domain Results (2017)			
	Highest Domains		**Lowest Domains**	
	Spring	**Fall**	**Spring**	**Fall**
Adult & Older Adult *(combined due to small sample size of older adults)*	General Satisfaction (87%)	General Satisfaction (84%)	Improved Functioning (73%)	Improved Outcomes (70%)
Youth	Service Cultural Sensitivity (86%)	Service Cultural Sensitivity (89%)	Improved Functioning / Outcomes (69%)	Improved Functioning / Outcomes (65%)
Family of Youth	Service Cultural Sensitivity (97%)	Service Cultural Sensitivity (97%)	Improved Functioning / Outcomes (66%)	Improved Functioning / Outcomes (62%)
**Domain percentages calculated by averaging responses to the questions that make up each Domain*				

Goal	Objectives / Activities	Annual Evaluation
V. Beneficiary Protection: Respond to client grievances and appeals in a timely manner.	1) Ensure 100% of grievances and appeals are logged and responded to within required timeframes. 2) Update the following beneficiary informing materials to incorporate guidelines set forth by new regulations: a) Notices of Adverse Benefit Determination (NOABD's) b) Grievance Form c) Appeal Form d) Change of Provide Request Form e) Request for Second Opinion Form. 3) Translate the above forms into threshold languages (Spanish, Russian). 4) Provide training to staff on new forms. 5) Ensure beneficiaries and all providers have access to the updated forms. 6) Update NOABD tracking methodology. 7) Improve process for tracking timeliness for issuing NOABD's. 8) Continue to track and trend Beneficiary Protection data to identify quality improvement opportunities and share results with QIC and management staff.	**Objectives / Activities:** **Met**: 1-3,8 **Partially Met**: 4-7 **Not Met**: n/a **Continued:** TBD

Goal V Evaluation:

1) Met. 100% (32/32) of grievances were logged, acknowledged, and resolved within required timeframes. Two (2) grievances are still pending resolution but are still within the required timeframe.

Grievance Category	Total # of Grievances	# Resolved within Required Timeframe	# Pending within Required Timeframe
Access	**5**	**5**	**0**
Scheduling/Timeliness	5	5	0
Quality of Care	**25**	**23**	**2**
Treatment Issues	16	14	2
Staff Behavior	5	5	0
Medication Concerns	3	3	0
Other Quality Concerns	1	1	0
Other	**2**	**2**	**0**
Physical Environment	1	1	0
Peer Behaviors	1	1	0
Total	**32**	**30**	**2**

2-3) Met. All of the Beneficiary Protection forms have been updated to meet 438 regulatory requirements and have been translated into the County's threshold languages (English, Spanish, Russian).

4) Partially met. A NOABD training was provided to HHSA Access Team staff in March 2018. This goal will be carried over into FY18-19 to provide training on Beneficiary Protection forms for both mental health and DMC-ODS providers.

5) Partially met. The following Beneficiary Protection forms have been made accessible to beneficiaries and providers on the Yolo County Mental Health website: Appeal; Grievance; Change of Provider Request; State Fair Hearing; Request for Second Opinion. Additional website development and redesign is anticipated for FY18-19 to ensure (a) uniform guidance pertaining to each form is included on the Yolo external website and (b) website "e-subscriptions" are active, which will inform subscribers of any form updates and changes automatically.

6-7) Partially met. Due to changes to the NOABD form requirements and state-issued templates, the old NOA forms are in the process of being updated in Avatar. This goal will be carried over to FY18-19 to standardize / centralize the NOABD process and tracking methodology within the Quality Management team and Avatar.

8) Met. Beneficiary Protection data and trends were routinely discussed at QIC meetings in FY17-18.

VI. Engage in ongoing performance improvement efforts.	1) Establish one clinical Performance Improvement Project (PIP). 2) Establish one non-clinical PIP. 3) Evaluate PIP results. 4) Participate in HHSA Quality Improvement activities.	**Objectives / Activities:** **Met**: 1 **Partially Met**: 2-4 **Not Met**: n/a **Continued:** 1-4

Goal	Objectives / Activities	Annual Evaluation
Goal VI Evaluation: 1) Met. The MHP established a clinical PIP focused on improving outcomes for high utilizers of intensive services by helping them develop skills needed to re-integrate back into their communities. The California External Quality Review Organization (CalEQRO) designated this PIP as active and ongoing for FY17-18. 2) Partially Met. The MHP established a non-clinical PIP focused on improving tracking access and timeliness to outpatient mental health services and identifying strategies to improve timely access. The CalEQRO designated this PIP as "concept only" for FY17-18 because interventions had not yet been implemented at the time of the on-site EQRO review February 14-15, 2018. 3) Partially met. Preliminary results have been analyzed for the clinical PIP, with planned ongoing quarterly data analysis. Since the non-clinical PIP was "concept only" there was no post-intervention data to analyze. 4) Partially Met. QM staff participate in monthly HHSA Operational Excellence committee meetings; the purpose of this committee is to provide technical assistance, resources and peer support for the creation and maintenance of a culture of continuous quality improvement. QM staff are also routinely involved in helping develop performance measures using the Results Based Accountability (RBA) framework to gather consistent data on how much and how well Behavioral Health programs are doing at improving outcomes for populations served. Lastly, QM successfully advocated for the non-clinical PIP to be recognized and supported as one of two agency-wide Quality Improvement (QI) projects; as a result, two consultants trained in the Plan-Do-Check-Act (PDCA) model joined the PIP team.		
VII. Ensure processing of Treatment Authorization Requests (TARs) within mandated timeframes.	1) Continue to process 100% of all TARs within 14 calendar days. 2) Develop a mechanism for tracking TARs within Avatar so information can be accessed by appropriate staff.	**Objectives / Activities:** **Met**: 1 **Partially Met**: 2 **Not Met**: n/a **Continued:** 1-2
Goal VII Evaluation: 1) Met. From 7/1/17 to 6/13/18, 469 TARs have been received, and all have been processed within the mandated timeframe of 14 calendar days, with an average processing time of 3.78 days. 2) Partially Met. All TARs for Yolo Medi-Cal beneficiaries are entered into Avatar for tracking purposes. A report was created to reconcile the data tracked in Avatar with the existing parallel TAR log process to ensure data reliability. During this process, QM found discrepancies between the Avatar report and TAR log – the report captured all inpatient hospital admissions and did not identify specific Yolo County Medi-Cal hospital episodes. QM initiated a solution by creating an out-of-county guarantor in Avatar to capture only Yolo County Medi-Cal TARs. Next steps include developing either an Avatar report or widget available to fiscal and Quality Management staff, at minimum, so TARs can be accessed by appropriate staff via Avatar (projected date: Quarter 1 of FY18-19).		
VIII. Improve Medication Monitoring policies and procedures.	1) Develop a mechanism to capture medication monitoring data within Avatar. 2) Develop a mechanism for tracking medication monitoring plans of correction and verifying corrections that are made. 3) Update and re-format all medication services policies and procedures by the end of FY17-18. 4) Implement electronic Medication Consent and Medication Service Client Plan (MSCP) forms in Avatar by the end of FY17-18.	**Objectives / Activities:** **Met**: 4 **Partially Met**: 1-3 **Not Met**: n/a **Continued:** 1-3
Goal VIII Evaluation: 1) Partially met. The Medication Monitoring Form remains on paper and was updated and re-formatted on 3/21/18. This revised form is serving as the template to be developed in Avatar. As of 6/1/18, the electronic version of this form is being built in Avatar by IT staff, and will then need to have corresponding reports and widgets developed. Once fully developed, testing will begin, which is anticipated by 8/1/18. 2) Partially met. The mechanism by which to track plans of correction for medication monitoring findings will be contingent upon the Medication Monitoring Form being fully implemented and in use in Avatar. Discussions of what mechanisms might be available to utilize began on 5/1/18 and will continue after implementation of the electronic Medication Monitoring Form. Currently, medication monitoring plans of correction remain on paper. A fully implemented mechanism for electronically tracking medication monitoring plans of correction is anticipated by 1/1/19. 3) Partially met. Two of ten previously existing medication support services policies and procedures have been updated and re-formatted, and two new medication support services policies and procedures (one for MH, one for SUD) have been developed and finalized. The remaining eight previously existing MH medication policies and procedures, and an additional eight new MH medication policies and procedures, are currently being updated or drafted with an anticipated completion by 10/1/18. 4) Met. Both the Medication Consent Form and MSCP are fully implemented and in use in Avatar.		

Goal	Objectives / Activities	Annual Evaluation
IX. Clinical Documentation: Improve clinical documentation processes in order to support fiscal sustainability, increase communication and transparency with providers, and improve the delivery of client-centered care.	1) Develop a mechanism for tracking outpatient treatment authorizations in Avatar. 2) Institute the Clinical Documentation Workgroup (CDWG) with clinical supervisors, with the goal of increasing inter-rater reliability in charting and authorizations, communication / transparency as well as accuracy and efficiency of the charting process. 3) Develop a process and structured mechanism to routinely communicate updates regarding charting to HHSA managers. 4) Develop a process for monitoring efficiency and effectiveness of Access & Authorization Committee (AAC) and CDWG. 5) Develop Treatment Plan instructional guide a) Develop and implement standardized procedure for Treatment Plan start / end date b) Provide training to staff (content and Avatar functionality). 6) Develop Assessment Instructional guide a) Work collaboratively with supervisors in CDWG to identify elements to include b) Research Triennial protocol requirements and DHCS info notices re: documentation c) Research prompts to add to assess for complexity of trauma history d) Provide training to staff. 7) Develop Progress Note Instructional guide a) Work collaboratively with supervisors in CDWG to identify elements to include b) Research Triennial protocol requirements and DHCS info notices re: documentation c) Provide training to staff. 8) Update Clinical Documentation Manual. 9) Restructure the internal Peer Review process to allow for more focused time spent reviewing progress notes and improve the feedback process for staff. 10) Evaluate / discuss the frequency, structure, scope, and purpose of the following: a) Utilization Review Committee (URC) b) Peer Review c) AAC d) CDWG. 11) Streamline / reduce the amount and redundancy of client intake packet paperwork.	**Objectives / Activities:** **Met**: 2,5,9 **Partially Met**: 1,3-4,6-8,10-11 **Not Met**: n/a **Continued:** TBD

Goal IX Evaluation:

1) Partially met. The Managed Care Authorization form in Avatar continues to be used for Internal HHSA authorizations (children and adults) and children's community providers. Adult provider authorizations are not currently tracked using this process. This goal will be carried over to next fiscal year to include developing Avatar reports for fiscal and clinical staff.

2) Met. The first CDWG meeting was held in the 4th Quarter of FY16-17; this workgroup, comprised of QM clinicians and supervising clinicians, meets weekly. Evidence suggesting the CDWG's effectiveness includes improved compliance scores on the FY17-18 Triennial Chart Audit compared to FY14-15 (from 37% to 87%).

3) Partially met. QM staff held two meetings with HHSA Managers to present and discuss charting processes / updates. CDWG meeting minutes were also emailed to Clinical Supervisors and Managers in order to facilitate transparency and communication. While the capacity to regularly distribute CDWG minutes and facilitate meetings with Managers was impacted by decrease in QM staff overseeing clinical documentation, this will be a continued goal for FY18-19.

4) Partially met. QM increased staff training, developed a protocol to standardize how AAC chart reviewers communicate needed follow-up chart corrections, and developed an inter-rater reliability tool to ensure consistent application of review criteria for

Goal	Objectives / Activities	Annual Evaluation

authorization decisions. QM staff continue to work with Avatar staff to create an electronic tracking system to monitor efficiencies and areas of needed improvement in the AAC chart review process. This goal will be carried over to FY18-19.
5) Met. The initial Treatment Plan Instructional guide was completed in November 2017. By December 2017, an additional guide was created to standardize the procedure for Treatment Plan start/end dates. Both the Treatment Plan guide and the Treatment Plan start/end guide have been updated to incorporate new state requirements / regulations. Both guides are used as training tools for newly hired staff.
6-7) Partially met. Both the Assessment Instructional Guide and Progress Note Instructional Guide are under development with planned completion dates during the first two quarters of FY18-19.
8) Partially met. QM has reviewed regulatory requirements and collected clinical documentation samples from other counties. The updated Clinical Documentation Manual is in development with the planned completion date of 10/31/18.
9) Met. The internal Peer Review process was restructured to allow for more focused time spent reviewing progress notes and improve the feedback process for staff, and currently includes the following: (a) reviewing of charts presented in AAC with accurate and sufficient documentation; (b) adding necessary intake paperwork as determined by the custodian of records; (c) updating the chart review tool; (d) providing peer reviewers with copies of current assessment and treatment plan for clinical context during progress note review, as well as a list of (non-psychiatric) services provided during the review period, so that the corresponding progress notes can be adequately reviewed.
10) Partially met. Evaluations of the frequency, structure, scope, and purpose of Peer Review, AAC and CDWG have occurred. Changes to when CCWG is scheduled so that it occurs after AAC has increased the efficiency with which charts are reviewed. CDWG working standards are kept as a printed document and referenced by AAC chart reviewers. The Peer Review structure has been discussed in the CDWG. Supervisors identified the value of them attending at least one Peer Review within the year so they can acquaint staff with Peer Review process. This goal will be carried over to next fiscal year, with a particular focus on the URC.
11) Partially met. A proposed list of simplified intake packet items was created and is currently being evaluated prior to finalization. This goal will be carried over to next fiscal year.

X. Access: Improve quality and utilization of the 24/7 Access Line.	1) On average 7 Access Line test calls per quarter a) At least 5 Business Hours and 5 After Hours calls b) At least 30% in non-English languages. 2) Increase test call logging for after hours by 50% (FY16-17 Baseline: 46%). 3) Increase test call logging for business hours by 50% (FY16-17 Baseline: 33%).	**Objectives / Activities:** **Met**: n/a **Partially Met**: 1 **Not Met**: 2-3 **Continued:** 1-3

Goal X Evaluation:
1) Partially met. In FY17-18, the MHP averaged 5.75 test calls per quarter (Objective 1a), 48% were conducted during business hours and 52% after hours (Objective 1b), and 22% were conducted in a non-English language (Objective 1c). The MHP averaged 7.3 test calls per quarter through the Quarter 3 (Objective 1a) but only conducted one test call in the 4th Quarter. During the 4th Quarter, and consistent with feedback regarding test calls from the Department of Health Care Services (DHCS) during the MHP Triennial Audit in March 2018, significant changes were being developed to the Access flow process, the 24/7 Access Line, and the Access Log in Avatar. Additionally, the County was preparing to go live with DMC-ODS on June 30, 2018, and there were significant changes to the QM and Access team staff during this time.
2) Not met. There was a decrease in the percentage of calls logged during business hours (from 33% to 9%).
3) Not met. There was a decrease in the percentage of calls logged after hours (from 46% to 42%).

	Goal	FY17-18 Outcome	FY16-17 Baseline
Test Calls Placed	28	23	28
Test Call Logging % (business hours)	50%*	9%	33%
Test Call Logging % (after hours)	69%*	42%	46%
% Test Calls in Non-English Language	30%	22%	28%
**based on goal of 50% increase from FY16-17*			

Effective the first Quarter of FY18-19, the County entered into a new contract with a single provider to operate the County's 24/7 toll-free Access Line. Prior to this contract, coverage of the 24/7 Access Line was provided by different agencies using disparate systems for logging calls across business hours and after hours. The County has streamlined the access process so that *all* Access Line calls related to specialty mental health and DMC-ODS services are fielded by one provider and captured in the newly updated Access Log in Avatar (implementation July 2018). The County anticipates that these initiatives will lead to improvements in test call results in FY18-19. The test call goal will be updated and carried over into next fiscal year.

Goal		Objectives / Activities	Annual Evaluation
XI.	**Access: Cultural and Linguistic Capacity – Ensure the behavioral health provider network meets the cultural and linguistic needs of the beneficiary population.**	1) Monitor Cultural Competency annual training requirements for internal and external behavioral health providers. 2) Evaluate linguistic capacity of providers. 3) Evaluate providers' adoption and implementation of National Standards for Culturally and Linguistically Appropriate Services (CLAS).	**Objectives / Activities:** **Met**: 1-3 **Partially Met**: n/a **Not Met**: n/a **Continued:** TBD
Goal XI Evaluation: 1) Met. As part of the process for updating the Provider Directory monthly, BH providers are required to submit updates to HHSA QM on staffing, licensures, and training, including staff's annual Cultural Competency training requirements. In November 2017 as part of the County's Cultural Competence Plan update, the Cultural Competence Coordinator also sent out a survey to all internal HHSA staff and contract providers assessing cultural competence training experiences, interests, and needs. The Cultural Competence Coordinator, who also serves as the MHSA Workforce Education and Training Coordinator, will plan future trainings based on survey results. 2) Met. In FY17-18, provider linguistic capacity was evaluated using three avenues: (a) when the County's Cultural Competence Coordinator distributed a survey to all internal HHSA staff and contract providers inquiring about staff language proficiencies; (b) during annual SUD site monitoring visits; and (c) as part of the Network Adequacy Certification tool submission. 3) Met. The FY17-18 review of providers' implementation of the CLAS standards included Site Monitoring Visits, Medi-Cal Site Certification Reviews, verification of language capabilities and Cultural Competency trainings through monthly Provider Directory updates, and the availability of translated materials in Yolo County threshold languages (English, Spanish, and Russian).			
XII.	**Access: Initiate, develop, and improve quality and utilization of Telepsychiatry services.**	1) Develop a Telepsychiatry Policy and Procedure. 2) Evaluate and assess technology needs for optimum utility and implementation. 3) Contract with Psychiatrists. 4) Implement Telepsychiatry services. 5) Track utilization and trend wait times. 6) Develop / implement Client Satisfaction Survey. 7) Develop / implement a telepsychiatry consent form. 8) Increase full scope of prescribing authority by: a) Board of Pharmacy licensure b) DEA registration.	**Objectives / Activities:** **Met**: 1-5,7-8 **Partially Met**: 6 **Not Met**: n/a **Continued:** TBD
Goal XII Evaluation: 1) Met. The Telepsychiatry Policy and Procedure was signed by HHSA Director in August, 2017. 2) Met. The MHP utilizes privacy- and security-enabled VSee software as the telepsychiatry interface. 3-4) Met. The MHP hired one extra help psychiatrist for telepsychiatry in August 2017. The MHP's goal is to expand the availability of telepsychiatry services in the future. 5) Met. A mechanism was developed for tracking prescriber availability, including telepsychiatry (next 30 and 60 minute appointments available, # of 30 minute appointments available in the next 2 weeks). This data has been utilized to trend prescriber availability and will be used for ongoing QI purposes. 6) Partially met. A Telepsychiatry Client Satisfaction Survey was created; the MHP plans to implement in FY18-19. 7) Met. All clients who agree to receive services via telepsychiatry must complete a consent form. 8) Met. The MHP successfully increased full scope prescribing authority by obtaining California Board of Pharmacy licensure and DEA registration.			
XIII.	**Access: Evaluate the Yolo County Mental Health Professional Shortage Area for re-designation.**	1) Request Yolo HHSA Mental Health Professional Shortage Area (HPSA) re-evaluation by California's Office of Statewide Health Planning & Development. 2) Collect data on the number of Psychiatrists providing full- or part-time services, accept Medi-Cal, percent FTE Medi-Cal, accepting new patients, percent FTE Low Income. 3) Resubmit documentation for sole county re-evaluation. 4) Obtain updated Yolo HHSA County Mental HPSA Designation Score. 5) Improve access and utilization of federal resources surrounding Recruitment and Retention program, National Health Service Corp (NHSC): a) Track number of HHSA applications to NHSC	**Objectives / Activities:** **Met**: 1-5 **Partially Met**: n/a **Not Met**: n/a **Continued:** n/a

Goal	Objectives / Activities	Annual Evaluation
	b) Track number of NHSC funded HHSA applications c) Develop a tracking mechanism to capture provider applications via NHSC / incentive and NHSC scholars hired.	
Goal XIII Evaluation: 1,2) Met in FY16-17 (April, 2017). 3) Met. Submitted for sole-county designation in early July, 2017. 4) Met. Obtained updated Yolo HHSA County Mental HPSA Designation Score (19, increase from 11) in August, 2017. 5) Met. HHSA clinical staff were notified about available loan repayment opportunities through the NHSC Loan Repayment Program. The application cycle opened April 2018 and NHSC applications were successfully submitted. By the closing of FY17-18, staff were awaiting NHSC award notification letters. The process has been mechanized and subsequent supporting verification will be a function of Human Resources.		
XIV. Timeliness to Services: Monitor and improve timely access to services.	1) Develop a mechanism for tracking prescriber availability / wait times. 2) Improve existing tracking mechanisms for capturing initial requests for services in order to improve the reliability of timeliness data. 3) Develop a tracking mechanism to reliably track no-shows for all clinical services. 4) Develop a tracking mechanism to reliably track urgent appointments. 5) Survey Behavioral Health community providers' timeliness tracking capacity and discuss results at QIC.	**Objectives / Activities:** **Met**: 1-2 **Partially Met**: 3-5 **Not Met**: n/a **Continued:** 3-5
Goal XIV Evaluation: 1) Met. A spreadsheet titled "Doctor Availability" was developed for tracking prescriber availability (next 30 and 60 minute appointments available, # of 30 minute appointments available in the next 2 weeks). This spreadsheet will continue to be used for ongoing QI purposes. 2) Met. The County has streamlined the access process so that all initial requests for SMHS – whether made during business hours or after hours, in person, via phone, or in writing – are captured in the newly updated Access Log in Avatar (implementation during July 2018). The new Access Log was designed to more reliably track and monitor requests for services (SMHS and DMC-ODS). As part of the implementation process, trainings were provided on June 27 and 28, 2018 to Access Point staff who utilize the Access Log and schedule appointments. Next steps will include ongoing monitoring and training to ensure initial service requests are being appropriately logged. 3) Partially met. The MHP identified root causes for lack of reliable no-show data, which included service code availability and training and the use of Avatar's scheduler. This goal will be carried over to FY18-19 with plans to implement changes to the Avatar no-show service codes and provide appropriate training to staff by the end of Quarter 2. 4) Partially met. The MHP developed methodology to capture urgent appointments within the new Access Log in Avatar; similar methodology is being included in the updated version of the scheduling calendar; implementation projected by October 2018. 5) Partially met. QM developed a survey monkey version of CalEQRO's FY17-18 Timeliness Self-Assessment (Timeliness Tracking Capacity), sent it to all contracted behavioral health community providers in December 2017, and had discussions at QIC around timeliness metric reporting requirements related to EQRO and Network Adequacy. This goal will be carried over to FY18-19 and discussed at future QIC meetings.		
XV. Compliance: Develop the Behavioral Health (BH) Compliance Committee.	1) Develop a BH Compliance Committee. 2) Create documents for tracking the BH Compliance Committee Meetings (i.e. Agendas and Sign In Sheets). 3) Create BH Compliance Plan Binder and Electronic Folders for BH Compliance Committee. 4) Draft and have approved the BH Compliance Committee Policy and Procedure.	**Objectives / Activities:** **Met**: 1-4 **Partially Met**: n/a **Not Met**: n/a **Continued:** TBD
Goal XV Evaluation: 1) Met. The first BH Compliance Committee meeting was convened in September 2017 and second meeting was held in October 2017 and included participation from the BH Managers and the BH Compliance Officer. 2) Met. Documents for tracking the BH Compliance Committee Meetings were created and saved in the electronic Compliance Folder and in the BH Compliance Binder.		

Goal	Objectives / Activities	Annual Evaluation
3) Met. The BH Compliance Plan Binder was created and contains the agendas, sign in sheets for attendees and any materials that were distributed during the meeting. Electronic Folders re the BH Compliance Committee were created and have been used to maintain the BH Compliance Committee documents. 4) Met. Several core Compliance P&P's were developed and approved in February 2018, along with the revisions to the HHSA BH Compliance Plan. Relevant documents regarding the BH Compliance Committee include the HHSA BH Compliance Plan; HHSA BH Code of Conduct; and BH P&Ps 5-4-008, 5-4-009; 5-4-010, 5-4-011; 5-4-012; 5-4-013; 5-4-014; 5-4-015; 5-4-016; 5-4-017 (for MH); and P&Ps 6-4-008, 6-4-009, 6-4-010, 6-4-011; 6-4-012; 6-4-013; 6-4-014; 6-4-015; 6-4-016; 6-4-017 (for SUD).		
XVI. Compliance: Develop a more robust BH Compliance Program.	1) Develop a process for routinely updating HHSA QM BH Policies and Procedures (P&P's) in accordance with regulation requirements. 2) Develop a fiscal and program monitoring process for SUD and MH programs. 3) Update the Compliance Training Program. 4) Promote BH Privacy & Confidentiality information to BH staff and providers. 5) Update BH Program Integrity Core: a) Identify P&P's / Supporting Documentation needed b) Draft P&P's / Supporting Documentation c) Have P&P's / Supporting Documentation reviewed and approved by the HHSA Director.	**Objectives / Activities:** **Met**: 5 **Partially Met**: 1-4 **Not Met**: n/a **Continued:** TBD
Goal XVI Evaluation: 1) Partially met. While substantive steps have been taken towards this goal, including the development of a P&P tracker and finalization process, an ongoing work group focused on the development of a routine process is still needed. Since the inception of this goal, P&Ps have continued to be revised or created on an "as needed" basis. Yet, there are many P&P's that require revision, updating to new departmental format, or rescinded. Approximately 300+ previous ADMH P&P's have been identified. Since then, 97 MH and 46 SUD P&P's have been either been revised or created (24 are duplicate P&Ps that pertain to both MH and SUD). 2) Partially met. QM developed a new program monitoring process for contracted SUD programs. The program monitoring component of this goal will be carried over to FY18-19, with specific focus on development of program monitoring process for internal and external MH programs. QM will also meet with HHSA BH Fiscal as needed regarding the fiscal monitoring process for SUD and MH. 3) Partially met. The BH Compliance Officer updated the Fraud, Waste, and Abuse (FWA) training materials; created a FWA staff training tracking log; and investigated training methods and education management platforms (i.e. Relias Learning Management System). Approximately 75% BH staff persons had access to Relias, and of those staff, 100% completed the FWA training. The BH program obtained approval for purchase of additional Relias licenses to cover all BH staff persons. Once those licenses are assigned to the appropriate staff, the expectation of 100% course completion will be implemented. Additionally, Relias should be used to provide and track additional compliance related trainings, including the those related to the privacy and confidentiality of BH client information to include the HHSA BH P&P's, the BH Code of Conduct, as well as Relias-provided trainings on privacy and confidentiality. 4) Partially met. The BH Compliance Officer developed and finalized HHSA BH P&P 5-4-002/6-4-002 regarding the privacy and confidentiality of BH client information (BH Client Info P&P) and related agreement form (BH Client Info Agreement) for HHSA BH staff and contract providers; created a BH staff roster; rolled out BH Client Info P&P and BH Client Info Agreement to HHSA BH staff; and created a tracking log for employees. The BH staff roster needs to be audited to ensure accuracy based on staffing changes. A HHSA BH contract provider roster and update mechanism requires development, possibly using the provider directory process as a starting point (all contract provider staff that participate in the provision of BH services for Yolo HHSA need to be included in the roster, not just direct service providers); Roll out and ongoing monitoring of contract providers is needed. 5a) Met. The required P&P's / Supporting Documentation have been identified, which included: HHSA BH Code of Conduct; P&P's regarding the 7 elements of a Compliance Program; & the HHSA BH Compliance Plan. 5b-c) Met. The BH Compliance P&Ps 5-4-008, 5-4-009; 5-4-010, 5-4-011; 5-4-012; 5-4-013; 5-4-014; 5-4-015; 5-4-016; 5-4-017 (for MH) ; and P&Ps 6-4-008, 6-4-009, 6-4-010, 6-4-011; 6-4-012; 6-4-013; 6-4-014; 6-4-015; 6-4-016; 6-4-017 (for SUD) were developed and approved in February 2018, along with the revisions to the HHSA BH Compliance Plan and HHSA BH Code of Conduct.		

Goal		Objectives / Activities	Annual Evaluation
XVII.	**Avatar: Continue to improve Avatar functionality and usability to allow for increased ease of information flow and data collection / reporting (clinical, fiscal, regulatory).**	1) Develop an Avatar Strategic Plan by 6/30/18. 2) Develop a workgroup (Avatar / Clinical / Fiscal / Steering) and identify strategies to assist with meeting consistently. 3) Restructure episodes in Avatar in order to (a) allow clinical staff to see how a client is moving through the system, and (b) set up the system to allow provider access. 4) Develop staff productivity report and implement.	**Objectives / Activities:** **Met**: 3-4 **Partially Met**: 1-2 **Not Met**: n/a **Continued:** 2

Goal XVII Evaluation:

1) Partially Met. The HHSA System Administrator, Deputy Mental Health Director, and Avatar IS Analyst developed a preliminary Avatar Strategic Plan in May 2018, which aligns with Yolo County and HHSA Strategic Plans. The Avatar Strategic Plan defines projects with recommended timelines and key stakeholders. It will be presented to HHSA Behavioral Health management team within the first quarter of FY18-19, followed by a presentation to the QIC (proposed: Quarter 2 of FY18-19) to obtain feedback prior to final adoption. Upon final adoption the strategic plan will be posted on the website and disseminated to staff via email.

2) Partially met. The original vision for this workgroup was to identify and implement new Avatar innovations as well as receive input about possible modifications to improve efficiencies and aid with troubleshooting. Ad hoc workgroups have occurred in conjunction with existing workgroups (e.g., Performance Outcomes / Performance Improvement Project workgroup). This goal remains in progress and will likely be modified in the coming fiscal year to align with the Avatar Strategic Plan. The IS Analyst has also instituted weekly Avatar drop-in office hours with requests for additional drop-in hours / locations, which is still under consideration. Three Avatar trainings were provided to HHSA staff and contract providers this fiscal year based on staff feedback / identified needs (i.e., episode management, productivity, and Cal-OMS/DATAR).

3) Met. Episodes for Mental Health programs were restructured in July 2017. The new episode structure allows appropriate staff to easily see where a client is receiving services (current and past) and their level of care; it also sets up the system to allow for contract providers to access Avatar in the future. Episode management training was provided to HHSA staff in October 2017 and contract providers in June 2018. Additionally, Avatar instructional guides were developed on how to open and close episodes.

4) Met. With input from HHSA Clinical and Branch Managers, the IS Analyst developed and implemented a new productivity report within Avatar over the course of July to December 2017. This report allows staff to review their productivity and supervisors to track productivity, revenue, and timeliness of notes. A reporting mechanism was developed outside of Avatar to store historical productivity data, which allows supervisors and managers to analyze the data to identify strengths and opportunities for improvement as well as develop dashboards to report to executive management.

XVIII.	**Access / Network Adequacy: Strengthen access to BH services for Yolo County beneficiaries by monitoring and improving the network of BH service providers to ensure an appropriate range of services are available and accessible, and the network's providers are adhering to time and distance standards.**	1) Develop a policy and procedure for network adequacy and timely access to services. 2) Develop a strategic plan for submitting the Network Adequacy Certification Tool (NACT) and supporting documentation. 3) Submit NACT and supporting documentation to DHCS by March 30, 2018. 4) Develop a strategic plan for implementation and routine evaluation of Network Adequacy standards that become effective July 1, 2018. 5) Develop Geographic Access maps.	**Objectives / Activities:** **Met**: 1-3,5 **Partially Met**: 4 **Not Met**: n/a **Continued:** 4

Goal XVIII Evaluation:

1) Met. See PP 5-5-004 Behavioral Health Network Adequacy and Timely Access to Services

2) Met. Completed initial submission for the March 30, 2018 deadline. DHCS postponed July 1, 2018 quarterly reporting period to October 1,2018. QM to strategize ongoing data collection and reporting quarterly to DHCS to meet next submission deadline in October.

3) Met. Submitted 42 documents on March 29, 2018.

4) Partially met. QM discussed Network Adequacy / NACT at the QIC meeting on 4/13/18. DHCS to provide additional technical assistance on July 23, 2018 regarding network adequacy certification methodology, mental health plan network certification results overview, certification tool revisions, timely access, and networking infrastructure. As further guidance is provided by DHCS, the implementation plan will be updated accordingly.

5) Met. Completed 10 Geographic Access maps for the March 30, 2018 submission. Need to identify frequency of mapping requirements per DHCS and develop plan to routinely complete.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

The Centers for Medicare and Medicaid Services (CMS) approved Yolo County HHSA to go live with DMC-ODS, effective June 30, 2018 through June 30, 2020. As part of the Readiness Review process, HHSA developed preliminary goals for the QM Work Plan (see below). These goals will be incorporated into and further developed in the FY18-19 QM Work Plan.

Goal		Objectives / Activities	Annual Evaluation
I.	**DMC-ODS: Timeliness of first initial contact to face to face appointment**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
II.	**DMC-ODS: Timeliness of services of the first dose of Narcotic Treatment Program**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
III.	**DMC-ODS: Access to afterhours care**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
IV.	**DMC-ODS: Responsiveness of the beneficiary access line**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
V.	**DMC-ODS: Strategies to reduce avoidable hospitalizations**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
VI.	**DMC-ODS: Coordination of physical and mental health services with waiver services at the provider level**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
VII.	**DMC-ODS: Assessment of the beneficiaries' experiences**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___
VIII.	**DMC-ODS: Telephone access line and services in English as well as in the prevalent non-English languages**	In development for FY18-19	**Objectives / Activities:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued: Item #** ___