YOLO COUNTY QUALITY MANAGEMENT

WORK PLAN EVALUATION

Fiscal Year 2016-2017

Evaluation Period: July 1, 2016 – June 30, 2017

Yolo County Health & Human Services Agency

Quality Management Program

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. 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 MHP's performance contract with the State Department of Health Care Services (DHCS).

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, identify and pursue opportunities for improvement, and resolve identified problems. 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 MHP staff, supervisors and managers, and the Mental Health Director. The QIC meets quarterly, 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 we plan to resume 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. 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 DHCS and regulations set forth by the Centers for Medicare and Medicaid Services (CMS). The FY16-17 QMWP identifies objectives and planned activities designed to monitor service delivery, analyze data, recommend policy, evaluate performance, and report findings.

Yolo County FY 16-17 QMWP Evaluation

Goal	Objective / Activities	Evaluation / Status
I. Quality: Develop and maintain a system that allows providers, beneficiaries, and the public to access updated information about Yolo County HHSA's QM / QI activities.	1) Review and update QM Program written description by June 30, 2017. 2) Brainstorm elements to include on internal and external QM website and required dashboards and discuss implementation strategies. 3) Identify four key indicators to regularly report out on QM website by June 30, 2017. 4) Identify strategies to improve active provider participation at QIC meetings. 5) Increase total number of QIC meetings compared to FY15-16.	**Annual Goal Items Met:** **Met**: Item # _2,4,5__ **Partially Met**: Item # _n/a__ **Not Met**: Item # _1,3__ **Continued**: Item # _1,2,3,5__

Goal I Evaluation:

1) Objective not met. QM Program description and processes will be updated in FY17-18 to ensure consistency with the 438 Federal Managed Care regulations ("Mega Rule").
2) Objective met. Outline created w/ key elements; plan to implement FY17-18.
3) Objective not met.
4) Objective met. Strategies revolved around increasing solicitation of provider input on meeting organization and topics of interest. Implemented strategies after January 2017 meeting.
5) Objective met. Held two (2) more QIC meetings in FY16-17 compared to FY15-16. Item to be carried over to FY17-18 with focus on improving meeting frequency.
FY15-16 = 3 QIC meetings total (Q1: 1, Q2: 0, Q3: 1, Q4: 1)
FY16-17 = 5 QIC meetings total (Q1: 0, Q2: 0, Q3: 2, Q4: 3)

Goal	Objective / Activities	Evaluation / Status
II. Quality: Involve stakeholders in QI activities related to improving service delivery and clinical care.	1) Invite stakeholders (e.g., beneficiaries, front line service staff, program supervisors and managers, administrators) to QIC meeting to discuss different perspectives on ongoing issues and barriers in order to inform solutions.	**Annual Goal Items Met:** **Met**: Item # _1__ **Partially Met**: Item # _n/a__ **Not Met**: Item # _n/a__ **Continued**: Item # _1__

Goal II Evaluation:

1) Objective met. See QIC email invitations and sign in sheets. Item to be carried over to FY17-18 w/ focus on strategies to continue to increase attendance from more community providers (currently the same three providers attend: CCHC, TPCP, YCCC-Safe Harbor) and consumers / family members.
FY16-17 (# of providers represented at each meeting):
Q1 and Q2: no meetings; Q3: Jan=0, March=2; Q4: April=1, May=2, June=2
FY16-17 (# of consumers / family members present at each meeting):
Q1 and Q2: no meetings; Q3: Jan=3, March=3; Q4: April=1, May=0, June=3

Goal	Objective / Activities	Evaluation / Status
III. Outcomes: Improve clinical data collection and reporting to better align with evidence based practices.	1) Identify elements to include in draft of Policies and Procedures (P&P) and discuss implementation strategies. 2) Track usage of the following measures to identify improvement opportunities: a) Adult Needs and Strengths Assessment (ANSA) b) Child and Adolescent Needs and Strengths (CANS) c) Level of Care Utilization System (LOCUS) d) Other outcome measures	**Annual Goal Items Met:** **Met**: Item # _ n/a__ **Partially Met**: Item # _n/a__ **Not Met**: Item # _1,2__ **Continued**: Item # _ n/a__

<table>
<tr><th>Goal</th><th>Objective / Activities</th><th>Evaluation / Status</th></tr>
<tr><td colspan="3"><u>Goal III Evaluation:</u>
1) Objective not met.
2) Objective not met. This data was not able to be trended due to limited Avatar staffing resources.
Note: Avatar, the County’s electronic health record (EHR), is a primary data source for several metrics related to tracking outcomes, timeliness, access, and quality of care. Due to limited Avatar staffing resources, there has been limited capacity to collect, analyze, and report different evaluation and outcome data.</td></tr>
<tr><td>IV. Outcomes: Monitor and improve beneficiary satisfaction with services.</td><td>1) Administer Consumer Perception (CP) surveys twice per fiscal year.
2) Analyze results.
3) Inform providers of results.
4) Compare CIBHS results to HHSA results to identify improvement opportunities for survey completion.</td><td>Annual Goal Items Met:
Met: Item # _1,3__
Partially Met: Item # _2__
Not Met: Item # _4__
Continued: Item # _1-3__</td></tr>
<tr><td colspan="3"><u>Goal IV Evaluation:</u>
1) Objective met. CP Surveys were administered in November 2016 and May 2017.
2) Objective partially met. Results were analyzed for the May 2017 surveys only..
3) Objective met. May 2017 survey results were presented at multiple venues for various stakeholders, including providers (e.g., QIC, Provider Stakeholder Work Group, Local Mental Health Board)
4) Objective not met</td></tr>
<tr><td>V. Beneficiary Protection: Respond to grievances in a timely manner.</td><td>1) Ensure 90% of grievances are logged and responded to within required timeframes.
2) Track and trend grievances to identify quality improvement opportunities.
3) Brainstorm ways to improve efficiency and effectiveness of tracking grievances.
4) Report grievance trends to QIC and management.
5) Brainstorm strategies to improve tracking of Change of Provider requests.</td><td>Annual Goal Items Met:
Met: Item # _1-5 __
Partially Met: Item # __ n/a_
Not Met: Item # _ n/a__
Continued: Item # _1,2,4__</td></tr>
<tr><td colspan="3"><u>Goal V Evaluation:</u>
1) Objective met. 93% of grievances were logged and responded to within the required timeframes for FY16-17.
2) Objective met. QM tracks grievances and reviews the categories of grievances to help identify opportunities for improvement in service delivery.
3) Objective met. Improvements were made to the grievance log (e.g., using the state’s definitions for “types of grievances”) and templates were created for acknowledgment and resolution processes.
4) Objective met. Grievances, including types of grievances, were shared at QIC; management staff attend QIC.
5) Objective met. The process for tracking Change of Provider requests was transferred to QM.</td></tr>
<tr><td>VI. Consistent monitoring of Notice of Action (NOA)</td><td>1) Update NOA P&P by June 30, 2017.
2) Update tracking methodology.
3) Brainstorm ways to improve tracking of timeliness for issuing NOAs.
4) Analyze data.
5) Provide results to QIC.</td><td>Annual Goal Items Met:
Met: Item # _2,3,4,5__
Partially Met: Item # _ n/a__
Not Met: Item # _1__
Continued: Item # _2-5__</td></tr>
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Goal		Objective / Activities	Evaluation / Status
Goal VI Evaluation: 1) Objective not met.. The NOA P&P will be updated in FY17-18 to meet new regulation requirements under the 42 CFR 438 Mega Rule (now called "NOABD's" – Notices of Adverse Benefit Determination). 2,3) Objective met. Implemented a parallel system of tracking NOA's in Avatar and updated the NOA tracking spreadsheet. This parallel system allows for tracking timeliness for issuing NOA's. 4,5) Objective met. NOA results were shared at QIC meetings in FY16-17.			
VII.	**Engage in ongoing performance improvement efforts.**	1) Establish one clinical Performance Improvement Project (PIP). 2) Establish one non-clinical PIP. 3) Evaluate PIP results.	**Annual Goal Items Met:** **Met**: Item # _1__ **Partially Met**: Item # _3__ **Not Met**: Item # _2__ **Continued**: Item # _1-3__
Goal VII Evaluation: 1) Objective met. The MHP established a clinical PIP (Inpatient Utilization) focused on improving discharge planning and care coordination processes for beneficiaries experiencing an acute psychiatric hospitalization, with the goal of decreasing average length of stays and readmission rates as well as increasing the rate of follow-up appointments within 7 days following discharge. 2) Objective not met. Behavioral Health Concepts, Inc. (BHC), the California External Quality Review Organization (CalEQRO), determined that the MHP's non-clinical PIP submission (Care Coordination Collaborative) did not meet criteria for a PIP. This project's goal was to improve health outcomes and increase satisfaction of older adults with SMI and chronic medical conditions by improving care coordination processes. BHC's feedback included, "While there may be a need for improved services and care for older adults with SMI, the PIP has not articulated the need sufficiently. The PIP team provided general information about what could happen, rather than what has or is happening with this population. It does not appear that the issues the MHP presented are actually concerns for their population. Not having this foundation has affected the identification of the target population, the interventions, and the outcomes of the PIP" (pp. 26 of *MHP's FY16-17 Final Report*, BHC). 3) Objective partially met; results were analyzed for the clinical (Inpatient Utilization) PIP.			
VIII.	**Treatment Authorization Requests (TARs): Ensure processing within required timeframes.**	1) Continue processing 100% of all TARs within mandated timeframe. 2) Develop a mechanism to capture TARs within Avatar.	**Annual Goal Items Met:** **Met**: Item # _2__ **Partially Met**: Item # _1__ **Not Met**: Item # _n/a__ **Continued**: Item # _1__
Goal VIII Evaluation: 1) Objective partially met. Of the 641 TARs processed, 638 (99.5%) were processed beyond the Title 9 mandated 14-calendar days due to internally mishandled mail that resulted in misplaced packages and therefore, untimely delivery to process within 14 days of when received. 2) Objective met. Administrative and Clinical TAR forms were developed in Avatar with a plan to implement in FY17-18.			
IX.	**Clinical Documentation: Improve quality of clinical documentation and reduce disallowances.**	1) Develop Authorization & Access Committee (AAC), whose overall goal is to help improve the quality of clinical documentation so that it adheres to state standards / mandates. 2) Continue internal peer review process at least quarterly. 3) Develop Utilization Review Committee (URC) comprised of community providers and HHSA providers by June 30, 2017. 4) Draft URC P&P by June 30, 2017.	**Annual Goal Items Met:** **Met**: Item # _1,3__ **Partially Met**: Item # _2__ **Not Met**: Item # _4__ **Continued**: Item # _n/a__

Goal		Objective / Activities	Evaluation / Status
Goal IX Evaluation: 1) Objective met. AAC was instituted in July 2016. 2) Objective partially met. Peer Review did not meet in Quarter 1; met 1x in Quarter 2 (12/16/2016); met 3x in Quarter 3 (1/20/2017, 2/17/2017, 3/17/2017); met 2x in Quarter 4 (5/26/2017, 6/23/2017). On average, 1.5x per quarter. 3) Objective met. The URC's first meeting was held 5/1/2017. 4) Objective not met. The URC P&P will be updated in FY17-18 to meet new regulation requirements under the 42 CFR 438 Mega Rule; plan to complete FY17-18.			
X.	**Access: Improve quality and utilization of the 24/7 Access Line.**	1) Review Access log to identify a baseline for follow-up on service requests (after hours). 2) Develop plan to improve data collection for business hours. 3) Complete at least 6 Access Line test calls per quarter. 4) Maintain 90% or higher test call logging for after hours. 5) Increase test call logging for business hours by 50% by June 30, 2017	**Annual Goal Items Met:** **Met**: Item # _2,5__ **Partially Met**: Item # _3__ **Not Met**: Item # _1,4__ **Continued**: Item # _3-5__
Goal X Evaluation: 1) Objective not met. 2) Objective met. QM provided a training to business hours front line staff on 6/26/2017 focused on the "Access Log Must Haves" for reporting Access Line utilization to the State. 3) Objective partially met.; averaged 7 test calls per quarter. Total number of test calls conducted: FY16-17: conducted test calls during 3 quarters, 9 per quarter, 28 total (15 business hours, 13 after hours), 28% in language other than English 4) Objective not met. % of after-hours test calls logged: FY16-17: 46% (13/28) test calls logged 5) Objective met: FY15-16 (April – June, 2016): 0% test calls logged FY16-17: 33% (5/15) test calls logged Note: Access Test Calls and Logging were not consistently monitored / tracked prior to the end of FY15-16. Also, the contract provider who covers the after-hours Access Line has a separate process for tracking the Access Line calls they receive. This provider does not enter their calls into the same Access Log used by HHSA business hours staff and instead provides HHSA with individual call sheets; these call sheets are not consistently entered into the Access Log due to limited staffing resources. These disparate processes complicate after-hours Access Line utilization data tracking and monitoring. QM plans to resolve this in FY17-18.			
XI.	**Access: Linguistic Capacity – Ensure services and written correspondence are provided in the beneficiary's preferred language.**	1) Track and trend documentation of beneficiaries' language preference in Avatar. 2) Ensure availability of updated treatment / informational documents for beneficiaries printed in threshold languages (Spanish and Russian). 3) Add service language data element to UR process.	**Annual Goal Items Met:** **Met**: Item # _2,3__ **Partially Met**: Item # _1__ **Not Met**: Item # _n/a__ **Continued**: Item # _ n/a__
Goal XI Evaluation: 1) Objective partially met. This data element is being tracked in two places in Avatar (admission form, progress notes). However, this data was not able to be trended due to limited Avatar staffing resources. 2) Objective met, ongoing. 3) Objective met. Added cultural considerations element (including service language preference) to UR form (see Intake Assessment and Progress Notes).			

Goal		Objective / Activities	Evaluation / Status
XII.	**Access: Cultural Competency / Health Equity – Identify and decrease access disparities by age and race / ethnicity.**	1) Track and trend documentation of beneficiaries' race / ethnicity in Avatar. 2) Review penetration rates by age and race/ethnicity on an annual basis 3) Improve methodologies for examining and tracking penetration rates for target populations.	**Annual Goal Items Met:** **Met**: Item # _n/a__ **Partially Met**: Item # _1__ **Not Met**: Item # _2,3__ **Continued**: Item # _ n/a__

Goal XII Evaluation:
1) Objective partially met. This data element is being tracked in two places in Avatar (admission form, progress notes). However, this data was not able to be trended due to limited Avatar staffing resources.
2,3) Objective not met. The MHP continues to receive and use penetration rates provided annually by the EQRO.

Goal		Objective / Activities	Evaluation / Status
XIII.	**Timeliness to Services: Monitor and improve timely access to services.**	1) Continue tracking timeliness measures specified by EQRO. 2) Track and trend wait times to the following data points: a) Initial request for services to first available appointment b) initial request for services to first available psychiatry appointment c) Develop tracking mechanism for urgent appointments. 3) Analyze no-show rates and identify strategies to improve ameliorate findings.	**Annual Goal Items Met:** **Met**: Item # _n/a__ **Partially Met**: Item # _1, 2a-b,3__ **Not Met**: Item # _2c__ **Continued**: Item # _ n/a__

Goal XIII Evaluation:
1) Objective partially met. QM continued to track follow-up after hospitalization measures. The MHP identified issues related to the reliability of other timeliness measures and plan to address in FY17-18.
2a-b) Objective partially met. QM continues to track these timeliness metrics but identified reliability issues with the data that is pulled from the Access Log in Avatar; plan to address in FY17-18.
2c) Objective not met. Urgent requests are currently monitored by supervisors and managers on a weekly basis by direct oversight of the nurse's schedule. The MHP has not yet identified a reliable means to track in Avatar due to limited Avatar staffing resources.
3) Objective partially met. QM analyzed no-show rates for medication support services for the FSP program; based on analyses, interventions were proposed by FSP program. A tracking mechanism is in place for medication support services and assessments. A process to consistently track no-shows for all clinical appointments will be developed in FY17-18.

Goal		Objective / Activities	Evaluation / Status
XIV.	**Compliance: Hire a full time person whose primary duty will be that of the compliance officer.**	1) Submit request to leadership to hire this person. 2) Hire this person.	**Annual Goal Items Met:** **Met**: Item # _1,2__ **Partially Met**: Item # _n/a__ **Not Met**: Item # __n/a_ **Continued**: Item # _n/a__

Goal XIV Evaluation:
1,2) Objective met. A Behavioral Health Compliance Officer was hired on 4/3/2017.