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: December, 2017

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 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, the MHP operates a comprehensive Behavioral Health Quality Management (QM) Program encompassing several Quality Assessment and Performance Improvement (QAPI) activities. Accountable to the Mental Health 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 MHP's 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 Mental Health Plan Contract 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 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 MHP's 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 MHP staff, supervisors and managers, and the Mental Health 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 the MHP plans to resume include:

1. Performance / Outcome Data Workgroup
2. Utilization Review Workgroup
3. Clinical Documentation Workgroup
4. System Utilization Review (SUR) 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, also referred to as the Quality Improvement (QI) Work Plan by DHCS, 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 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.

Yolo County Quality Management Work Plan FY 17-18

	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 QAPI activities.**	1) Update external QM website. 2) Develop a process for creating and routinely updating a data dashboard.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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).	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___

	Goal	Objective / Activities	Evaluation / Status
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___

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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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
X.	**Access: Improve quality and utilization of the 24/7 Access Line.**	1) On average 7 Access Line test calls per quarter. a) 50% during Business Hours and 50% during After Hours 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%).	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___

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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).	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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 programs National Health Service Corp (NHSC) a) Track number of HHSA applications to NHSC. b) Track number of NHSC funded HHSA applications. c) Develop a tracking mechanism to capture provider applications via NHSC / incentive and NHSC scholars hired.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___

	Goal	Objective / Activities	Evaluation / Status
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	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___
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 6/30/17. 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.	**Annual Goal Items Met:** **Met**: Item # ___ **Partially Met**: Item # ___ **Not Met**: Item # ___ **Continued**: Item # ___