YOLO COUNTY QUALITY MANAGEMENT

WORK PLAN

Fiscal Year 2019-2020

Evaluation Period: July 1, 2019 – June 30, 2020

Yolo County Health & Human Services Agency (HHSA)

Behavioral Health Quality Management Program

Behavioral Health Quality Management (QM) Program

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 governing the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), 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 and Title 22, 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

The Quality Improvement Committee (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 QAPI activities, identify and pursue opportunities for improvement, and resolve identified problems. Trends and issues identified through the beneficiary protection processes 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, Local Mental Health Board, QM Program staff, contract provider and HHSA staff, and supervisors and managers. The QIC meets quarterly 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.

Quality Management Work Plan

The annual Quality Management Work Plan (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 Management Team. Its purpose is to organize and provide structure for QM activities throughout Yolo County and to systematically ensure adherence to the County-State Contracts with the California DHCS for the MHP and DMC-ODS, as well as regulations set forth by the Centers for Medicare and Medicaid Services (CMS). The QMWP provides a structured way to monitor 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.

Notes for FY 19-20 QMWP: CMS approved Yolo County HHSA to go live with DMC-ODS, effective June 30, 2018 through June 30, 2020. If a work plan goal applies only to one Plan (MHP or DMC-ODS), the applicable Plan is identified at the beginning of the goal. If a goal applies to both Plans, the goal is stated without identifying a specific Plan.

The Yolo County HHSA Behavioral Health Quality Management (BH-QM) team established 34 goals for the FY19-20 Work Plan. Of the 34 goals, 91% (n=31) were evaluated as either met (44%, n=15) or partially met (47%, n=16), and 3 goals (9%) were not met. Results from the FY19-20 Work Plan will inform goal development for FY20-21.

<table>
<tr><th>Category</th><th>Goals</th><th>Annual Evaluation</th></tr>
<tr><td>1. Outcomes: Beneficiary and Family Satisfaction with Services.</td><td>1) Administer Consumer Perception (CP) and Treatment Perception (TP) Surveys according to DHCS schedule
2) Analyze CP and TP survey results</td><td>Met: 1,2
Partially Met: N/A
Not Met: N/A</td></tr>
<tr><td colspan="3">1,2) Met
The Plan administered CP Surveys in November 2019 and June 2020 and TP surveys in October 2019. The Plan received TP survey results and data analysis from UCLA. CP survey analysis was completed for Fall 2019. DHCS extended the Spring 2020 survey collection period to June 2020 due to the public health pandemic; the Plan administered surveys via the new electronic portal and is awaiting aggregate data from CIBHS for analysis.</td></tr>
<tr><td>2. Outcomes: Continuous quality and performance improvement.</td><td>1) MHP: One active and ongoing clinical Performance Improvement Project (PIP)
2) MHP: One active and ongoing non-clinical PIP
3) DMC-ODS: One active and ongoing clinical PIP
4) DMC-ODS: One active and ongoing non-clinical PIP</td><td>Met: 2
Partially Met: 1, 3, 4
Not Met: N/A</td></tr>
<tr><td colspan="3">1, 3, 4) Partially Met
The Plan is conducting a Clinical PIP on Co-Occurring Disorders (COD) for the MHP and DMC-ODS as well as a Non-Clinical PIP for DMC-ODS on improving wait times to residential treatment admissions. However, at the time of the FY19-20 EQRO reviews, the Plan was unable to submit a write-up for these PIPs in the requested format using the “PIP Implementation & Submission Tool”. Baseline data, indicators, study questions, and interventions have been reviewed / discussed. CalEQRO provided technical assistance and categorized the PIPs as Concept Only.

2) Met
The MHP Non-Clinical PIP focused on improving tracking access and timeliness to mental health services; CalEQRO assigned an overall rating of 93.75% and was designated as “active and ongoing” for FY19-20.</td></tr>
<tr><td>3. Outcomes: Improve data collection and reporting to support decision making.</td><td>1) MHP: Implement routine tracking and reporting of key performance indicators (KPIs) and complete 80% of KPI data within the identified frequency timelines
2) DMC-ODS: Identify strategies to track the following metrics:
a) Access to after-hours care; and
b) Strategies to reduce avoidable hospitalizations</td><td>Met: 2
Partially Met: 1
Not Met: N/A</td></tr>
<tr><td colspan="3">1) Partially Met
BH-QM implemented routine tracking and reporting of key performance indicators pertaining to MH clinical documentation; MH timeliness to care for adults; Network Adequacy; and CP surveys.</td></tr>
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2) Met

The Plan tracks after-hours service requests and crisis contacts through the 24/7 BH Access Line using the Access Log. The Plan also tracks psychiatric hospitalization admissions through episode management in Avatar, concurrent inpatient review, and TARs. The Plan has implemented the following strategies to reduce avoidable hospitalizations:

- Contracted with David Mee Lee to provide trainings with a focus on ensuring that providers build treatment plans based on all of the dimensions of the SUD Assessment so that medical and mental health issues are addressed early in treatment and do not become a larger crisis that requires hospitalization.
- Embedded clinicians with law enforcement to help reduce unnecessary hospitalizations and improve connection to care.
- Developed Addiction Intervention Court and Mental Health Court Programs with dedicated treatment teams and track data on local and state hospitalizations.
- Hired a HHSA SUD Access Clinician whose primary role is be a liaison for and support SUD providers and clients; for example: facilitating linkage to SUD residential services for clients who are psychiatrically hospitalized and either need to return or enter into treatment post-discharge to reduce likelihood of re-hospitalization; providing liaison services for clients exhibiting or expressing need for mental health linkage or crisis/risk services while in SUD residential treatment.

4. Access: Improve responsiveness, quality, and utilization of the 24/7 BH Access Line.	1) Conduct an average of 7 test calls per quarter 2) Conduct at least 30% of test calls in non-English languages 3) Increase the percentage of test calls logged during business (BH) and after hours (AH) to a minimum of 80% (AH Baselines: FY16-17 46%; FY17-18 42%; FY18-19 25%) (BH Baselines: FY16-17 33%; FY17-18 9%; FY18-19 50%)	**Met**: N/A **Partially Met**: 1, 2, **Not Met**: 3

1,2) Partially Met

The Plan conducted an average of 3.75 test calls per quarter for a total of 15 in FY19-20, representing a 25% increase in test calls completed compared to FY18-19; 20% of test calls were conducted in a non-English language.

3) Not Met

None of the test calls that required logging were logged. In response to these results, QM formalized a reporting process to communicate test call findings to leadership who shares feedback with Access Line staff to provide needed guidance and improve results; test call results will be shared quarterly, at minimum, unless more prompt reporting is indicated.

	Goal	FY19-20 Outcome
# Test Calls Completed	28	15
# Logged (after hours)*	5	0/6
# Logged (business hours)*	5	0/6
% in Non-English Language	30%	20%
**Based on the goal of at least 80% of test calls that require logging being logged*		

5. Quality &	1) Review and update Cultural Competence Plan annually 2) DMC-ODS: Monitor to CLAS standards in 100% of SUD	**Met**: 1, 2

Appropriateness of Care: Cultural and Linguistic Competency and Capacity.	monitoring site reviews	**Partially Met**: N/A **Not Met**: N/A
1) Met The Yolo County Cultural Competence Plan is updated annually via regular review, discussions, and planning efforts overseen by the Cultural Competence/Ethnic Services Manager and implemented by the Cultural Competence Committee (CCC) and designated CCC Workgroups. The Plan was last updated in December 2019 and is posted on the Yolo County's CCC website. The next update is scheduled to be posted in December 2020. The CCC identified 2020 goals/objectives as well as outreach strategies to address health disparities. **2) Met** CLAS standards are monitored during annual SUD provider contract monitoring, which includes an attestation that CLAS standards are met.		
6. Timeliness to Services: Monitor and improve timely access to services.	1) MHP: Develop methodology to reliably track urgent services rendered 2) DMC-ODS: Identify strategies to track timely access to care, specifically: a) Timeliness of first initial contact to face-to-face appointment; b) Frequency of follow-up appointments in accordance with individualized treatment plans; c) Timeliness of first dose of NTP services	**Met**: N/A **Partially Met**: 1, 2 **Not Met**: N/A
1) Partially Met The Plan implemented a strategy to track urgent requests in the Access Log and Scheduling Calendar. However, review of this data revealed that it is likely not reflective of all urgent service requests (e.g., missing urgent requests of existing clients currently in treatment). The Plan is currently developing an Avatar form to track urgent request across the system with the goal to implement in FY20-21. **2) Partially Met** The Plan tracks all service requests in the Avatar Access Log and has the ability to track timeliness to DMC-ODS treatment admission using episode management. However, 100% of DMC-ODS services are delivered by contract providers who do not document progress notes in Avatar, which presents a challenge for capturing other important timeliness data metrics. The Plan is currently developing an Avatar form to track metrics (a) and (c) with the goal to implement in FY20-21. Frequency of services in accordance with individualized treatment plans is incorporated as part of the annual SUD provider monitoring process.		
7. Beneficiary Protection and Informing Materials.	1) Ensure grievances and appeals are processed within mandated timeframes 2) Provide training / technical assistance to BH staff on beneficiary protection processes and forms	**Met**: 1,2, 3 **Partially Met**: 4,5 **Not Met**: N/A

	3) Continue to track and trend Beneficiary Protection data to identify quality improvement opportunities and share results with QIC / management staff 4) MHP: Update Beneficiary Handbook in accordance with MHSUDS IN 18-043 by 9/30/19 5) DMC-ODS: Update Beneficiary Handbook in accordance with state guidance by 12/31/19	

1) Met
Beneficiary protection communications (e.g., acknowledgement and resolution letters) and related action items were completed within mandated timeframes.

2) Met
For the MHP, BH-QM instituted new employee orientation trainings, which incorporate an overview of beneficiary protection forms as well as policies and procedures. Technical assistance is provided by BH-QM on beneficiary protection processes, as needed. For DMC-ODS providers, BH-QM has provided guidance and technical assistance during monitoring, SUD provider meetings, and on an as-needed basis.

3) Met
Beneficiary protection data is tracked by BH-QM. BH-QM informs BH leadership, including the BH manager who oversees the contract or program where the incident occurred, in order to inform quality improvement processes. In FY20-21, BH-QM plans to further improve reporting to summarize beneficiary protection data trends for BH management and other QI stakeholders to review and offer input on system improvements.

4) Partially Met
The MHP Beneficiary Handbook was updated and is in the process of finalization.

5) Partially Met
The Plan updated the DMC-ODS Beneficiary Handbook in accordance with state guidance by 12/31/2019. The DMC-ODS Beneficiary Handbook has been translated into Russian and posted on the Yolo County website; the Spanish translation is in process.

8. Clinical Documentation: Improve quality and regulatory compliance.	1) MHP: Institute routine clinical documentation training and support for staff, including providing a minimum of 12 new employee orientation trainings and 6 all MH staff documentation trainings 2) MHP: Complete updates to the Clinical Documentation Manual by 9/30/19 3) MHP: Fully implement updated BH-QM HHSA utilization review process by 9/30/19; review a minimum of 5% of open HHSA charts 4) DMC-ODS: Complete development of the DMC-ODS Clinical Documentation guide by 12/31/19 5) DMC-ODS: Conduct a minimum of 2 SUD provider documentation trainings	**Met**: 1,5 **Partially Met**: 2, 3, 4 **Not Met**: N/A

1) Met
BH-QM implemented routine clinical documentation training, including new employee orientations (NEO) and a monthly training series with rotating topics on: Assessments, Treatment Plans, and Progress Notes.

2) Partially Met
The updated Clinical Documentation Manual and Companion Guide were released on 11/15/19.

3) Partially Met
Routine utilization review of 5% of open HHSA charts has not been implemented. BH-QM had significant staffing changes starting in September 2019, made updates to the utilization review tool, and implemented with HHSA program staff to conduct peer chart review.

4) Partially Met
The DMC-ODS Clinical Documentation Guide has been drafted. However, it is still in the review process and will need to be finalized and disseminated.

5) Met
The Plan provided three (3) SUD provider documentation trainings, which included Residential provider training in October 2019 and February 2020 and Outpatient/Intensive Outpatient provider training in November 2019.

9. Network Adequacy: Maintain and monitor a network of providers that is sufficient to provide adequate access to services.	1) Complete quarterly MHP and annual MHP and DMC-ODS Network Adequacy submissions according to DHCS schedule	**Met**: 1 **Partially Met**: N/A **Not Met**: N/A

1) Met
Network Adequacy submissions were completed within the required time frames for both MH (quarterly) and SUD (annually).

10. Avatar: Continue to improve Avatar usability to promote efficiency and support service delivery.	1) Conduct a needs assessment to identify Avatar-related workgroup needs (Clinical / Fiscal / Steering); identify workgroup membership; and develop a consistent meeting schedule for Avatar workgroups 2) Increase clinical Avatar support to end users (e.g., develop training materials).	**Met**: N/A **Partially Met**: 2 **Not Met**: 1

1) Not Met
HHSA does not have adequate staffing resources to identify, develop, and maintain a consistent schedule for Avatar workgroups.

2) Partially Met
HHSA purchased a year subscription of Netsmart's Learning Pointe, and an implementation plan is in development. Additionally, a BH-QM clinician was cross-trained to provide Avatar end user support.

11. Update Specialty Mental Health Service Authorization policies and procedures.	1) MHP: Develop policies and procedures for the following: inpatient concurrent review, crisis residential concurrent review, adult residential concurrent review, and outpatient specialty mental health service authorizations.	**Met**: 1 **Partially Met**: N/A **Not Met**: N/A
1) Met Policies and procedures for inpatient concurrent review, crisis residential concurrent review, adult residential concurrent review, and outpatient mental health service authorizations were drafted and submitted to DHCS for review and approval. On July 7, 2020, Yolo County received a letter from the DHCS county analyst communicating that the polices were determined to include all the requirements per Information Notice 19-026.		
12. Utilization Management: Improve Medication Monitoring policies and procedures.	1) MHP: Implement the developed mechanism for capturing medication monitoring data in Avatar and report back to prescribing staff and Medical Director on findings. 2) DMC-ODS: Expand medication monitoring utilization review to include newly contracted Substance Use Disorder (SUD) providers.	**Met**: 1 **Partially Met**: N/A **Not Met**: 2
1) Met The mechanism for capturing medication monitoring data in Avatar was fully implemented and utilized beginning 12/19/2019. Plans of correction are being issued to prescribers as a "To Do" item for any "no" responses during medication audits and prescribers are completing those items. A Medication Monitoring Summary Report was also implemented for ease of data reporting/viewing for each medication audit. **2) Not Met** This service has not yet been expanded due to budget, contract, and current COVID-19 pandemic reasons.		
13. Improve provider Relations and Communication Strategies.	1) Continue to improve communication between BH-QM team and staff / contract partners via sending email updates / notifications, attending staff team and stakeholder meetings, etc.	**Met**: 1 **Partially Met**: N/A **Not Met**: N/A
1) Met BH-QM continued to improve communication between BH-QM team and staff/ contract partners in the following ways: provided TA through emails, as well as during on-site monitoring; routinely attended monthly SUD Provider Stakeholder meetings to provide updates and answer questions, sent notifications and reminder emails regarding upcoming regulation requirements.		
14. Develop a more robust BH Monitoring and Compliance Program.	1) Develop a process for routinely updating HHSA BH-QM Policies and Procedures (P&P's) in accordance with regulation requirements 2) Develop FY19-20 site monitoring and Medi-Cal Certification review calendars; distribute to providers and	**Met**: N/A **Partially Met**: 1, 2 **Not Met**: N/A

	post on website.	

1) Partially Met
BH-QM started a weekly P&P workgroup in FY19-20 where several MHP and DMC-ODS policies were developed, updated, and/or reviewed. However, due to staffing resources, this workgroup was not able to be maintained. Further, through this process, it became increasingly apparent that non-QM stakeholder input would be necessary to the success of such a workgroup, as many procedures are implemented by teams outside of QM (e.g., Fiscal, Compliance, Clinical Programs and Providers). The HHSA BH Compliance Committee identified a strategy to implement a P&P Committee with varied stakeholder representation, including but not limited to QM, in FY20-21.

2) Partially Met
BH-QM created SUD site monitoring and Mental Health Medi-Cal site certification review calendars.