YOLO COUNTY BEHAVIORAL HEALTH QUALITY MANAGEMENT

WORK PLAN

Fiscal Year 2020-2021

Evaluation Period: July 1, 2020 – June 30, 2021

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, monitor, coordinate and/or assign activities with appropriate individuals / programs to 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 (QI), access and authorization, and network adequacy
- 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 strategies to improve access, timeliness, quality, and outcomes of care

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.

Note: CMS approved Yolo County HHSA to go live with DMC-ODS, effective June 30, 2018. If a work plan goal applies only to one Plan (MHP or DMC-ODS), the 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 (QM) team established 38 goals for the FY20/21 Work Plan. Of the 38 goals, 92% (n=35) were evaluated as either met (60%, n=23) or partially met (32%, n=12), and 3 goals (8%) were not met. Results from the FY20/21 Work Plan will inform goal development for FY21/22 and beyond.

<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:
Not Met:</td></tr>
<tr><td colspan="3">1) Met
The Plan administered TP Surveys in November 2020 and CP Surveys in June 2021.

2) Met
The Plan reviewed the results of the TP surveys and shared that information with contracted providers for improvement. The CP results were recently received by the Plan (in late November 2021) and will be analyzed.</td></tr>
<tr><td>2. Outcomes: Continuous quality and performance improvement</td><td>1) MHP: One clinical Performance Improvement Project (PIP)
2) MHP: One non-clinical PIP
3) DMC-ODS: One clinical PIP
4) DMC-ODS: One non-clinical PIP</td><td>Met: 1,3
Partially Met: 2,4
Not Met: N/A</td></tr>
<tr><td colspan="3">1,3) Met
The Plan is completing a Clinical PIP focused on improving identification, screening, and linkage of clients with co-occurring mental health and substance use needs in the MHP and DMC-ODS systems of care.

2,4) Partially Met
The Plan has developed a non-clinical PIP to improve tracking of timeliness metrics for DMC services, with the overarching goal of improving timely access and linkage to SUD services. A concept for the non-clinical MHP PIP is under development, and the Plan has scheduled TA with the California External Quality Review Organization.</td></tr>
<tr><td>3. Outcomes: Improve data collection and reporting to support decision making</td><td>1) MHP: Maintain routine tracking and reporting of key Performance Measures (PMs)
2) DMC-ODS: Continue to identify strategies to monitor / improve accessibility of services, including:
a) Access to after-hours care;
b) Strategies to reduce avoidable hospitalizations;
c) Coordination of physical and mental health services</td><td>Met: 2
Partially Met: 1
Not Met:</td></tr>
<tr><td colspan="3">1) Partially Met</td></tr>
</table>

The MHP collects PMs but is focused on making that process routine. The MHP has recently added additional staff whose duty will be collecting, compiling, and analyzing PMs for improvement.

2) Met
The County has continued to identify strategies and take steps to improve client care in these domains.

- ***Strategy 2a***: The County has provided trainings to its 24/7 Behavioral Health Access and Crisis Line provider to ensure their staff are versed on ASAM, the County's SUD provider network, and any changes to the system that occur. Additionally, the County has continued its contract with David Mee Lee to provide trainings to providers and the 24/7 Access Line, as well as purchased / distributed licenses for two ASAM eModules from the Change Companies to ensure understanding and enhance knowledge of HHSA staff and providers.
- ***Strategy 2b***: While the County previously reported embedded clinicians with law enforcement as a strategy, the County only had one (1) clinician during the previous reporting period; however, four (4) more clinicians have been added in partnership with jurisdictions and criminal justice partners (5 total: 2 in West Sacramento, 1 in Woodland, 1 in Davis, 1 split between Sheriff/Probation) to offer increased crisis support, de-escalation interventions, and linkage to appropriate resources. The County has also trained its hospital discharge clinician and 2 office-based crisis clinicians to conduct ASAMs and provide linkage to appropriate treatment to expand access, coordination, and avoid unnecessary hospitalization. Additionally, two of the County's local hospital systems added Substance Use Navigators (SUNs) as part of the Emergency Department (ED) Bridge project; this partnership assists hospitals in better understanding the County's SUD system of care to inform appropriate referrals, as well as identify strategies to reduce length of stay in acute settings and improve connections to needed treatment following discharge, thus reducing the likelihood of re-hospitalization. The County has also pursued prevention initiatives with the understanding that this is one of the most effective ways to avert avoidable utilization of acute services. For example, given the first 2-4 weeks post-discharge from custody has the highest potential for overdose, the County has partnered with WellPath to increase their staffing in custody in order to serve more clients in need of medication assisted treatment (MAT). Further, the County has partnered with CommuniCare to add a re-entry MAT position to ensure clients are closely monitored and connected to ongoing care post-release.
- ***Strategy 2c***: Yolo was selected as 1 of 6 counties in the State of California to participate in the Systems of Care (SOC) Initiative, which is a 24-month technical assistance, system review, and process improvement project that brings together stakeholders from the County's substance use provider network along with local hospitals, education partners, housing partners, and law enforcement partners to review the entire substance use ecosystem, identify gaps and develop countywide goals for achieving better outcomes. This group meets quarterly to track progress and make strategy adjustments as needed. Additionally, QM added information to Clinical Documentation Training PowerPoints regarding the importance of coordinating physical and mental health services, including identifying needs during assessment, documenting in the treatment plan to ensure appropriate follow-up on needed referrals, and the importance of warm handoffs between providers to increase engagement. QM also looked for evidence of coordination of physical and mental health services during FY20/21 SUD Provider Monitoring.

4. Access: Improve responsiveness, quality, and utilization	1) Conduct an average of 7 test calls per quarter 2) Conduct at least 30% of test calls in non-English languages	**Met: 2** **Partially Met: 1** **Not Met: 3**

of the 24/7 BH Access Line	3) Increase the percentage of test calls logged during business (BH) and after hours (AH) to a minimum of 80%	

1) Partially Met
The Plan successfully completed 10 Test Calls for the fiscal year, which is below the goal but, this has highlighted the need for the Plan to implement changes regarding Test Calls. The Plan is focused on increasing Test Calls with the creation of scripts and identifying specific Staff for call completion.

2) Met
40% of the Test Calls made this fiscal year were in a non-English language. The Plan will continue to focus on calls made in non-English languages by identifying bi-lingual Staff for call completion.

3) Not Met
Only one of the test calls that required logging was logged. In response to these results, QM formalized a reporting process to communicate test call findings to leadership who ongoingly 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. The MHP is considering changing Access Line vendors due to consistently poor performance by the current vendor in this regard.

	Goal	FY20-21 Outcome
# Test Calls Completed	28	10
# Logged (after hours)*	5	0
# Logged (business hours)*	5	1
% in Non-English Language	30%	40%
**Based on the goal of at least 80% of test calls that require logging being logged*		

5. Quality & Appropriateness of Care: Cultural and Linguistic Competency and Capacity	1) Review and update Cultural Competence Plan annually 2) DMC-ODS: Monitor to CLAS standards in 100% of SUD monitoring site reviews	**Met: 1,2** **Partially Met:** **Not Met:**

1) Met
The Yolo County Cultural Competence Plan is updated annually via regular review, discussions, and planning efforts overseen by the Cultural Competence Unit and implemented by the Cultural Competence Coordinator. The Plan was last updated in March 2021, which was the DHCS extended deadline due to the public health pandemic.

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 and implement an Avatar form to track urgent requests across the system. 2) DMC-ODS: Develop and implement an Avatar form to track: a) Timeliness of first initial contact to face-to-face appointment	**Met:** **Partially Met: 2** **Not Met: 1**

<table>
<tr><td></td><td>b) Timeliness of first dose of NTP services
c) Begin tracking frequency of follow-up appointments in accordance with individualized treatment plans as part of the annual SUD provider monitoring process</td><td></td></tr>
<tr><td colspan="3">1) Not Met
The Plan continues to track urgent requests in the Access Log and Scheduling Calendar. However, prior 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 began developing an Avatar form to track urgent request across the system with a goal to implementing in FY20-21. However, this goal was not met and will be revisited in FY21/22.

2) Partially Met
The Plan tracks all service requests in the Avatar Access Log and can track timeliness to DMC-ODS treatment admission using episode management and claims data. However, 100% of DMC-ODS services are delivered by contract providers who do not use the Plan's electronic health record (Avatar) as their primary medical record, which presents challenges for capturing important timeliness data metrics. The Plan has developed a Performance Improvement Project with a plan to implement a Form / Widget within Avatar where all providers can update timeliness metrics in real time (e.g., appointments offered). The Plan hopes to fully implement these tracking methods within FY 22/23.</td></tr>
<tr><td>7. Beneficiary Protection and Informing Materials</td><td>1) Continue to ensure grievances and appeals are processed within mandated timeframes
2) Continue to track and trend Beneficiary Protection data to identify quality improvement opportunities and share results with BH leadership / QI stakeholders
3) Update policies on grievances, notices of adverse benefit determination (NOABD), appeals, and state fair hearings
4) MHP: Ensure staff / providers have access to the updated Beneficiary Handbook, including in translated threshold languages.
5) DMC-ODS: Translate the Beneficiary Handbook into Spanish in order to comply with state guidance around threshold languages.
6) DMC-ODS: Provide training / technical assistance to SUD providers on the completion of NOABDs.</td><td>Met: 1-6
Partially Met:
Not Met:</td></tr>
<tr><td colspan="3">1) Met
100% of grievances and appeals were resolved by QM within mandated timeframes.

2) Met
QM consistently involves leadership in Beneficiary Protection investigations and provides QI recommendations for consideration / implementation. The following QI activities resulted from Beneficiary Protection processes in FY20/21: updated signage regarding use of the HHSA Community Garden to reduce confusion by clients and staff; provided training / feedback to staff in an effort to</td></tr>
</table>

improve processes; proposed policy and documentation recommendations to a contract provider; refined HHSA injection ordering procedures to improve clarity / efficiency.

Further, QM conducted an analysis comparing trends in grievances and NOABDs between the FY19/20 and FY20/21 ABGAR submissions:

- ***Significant decrease in grievances (64 vs. 39)***: The decrease in the number of grievances received was attributed to two factors; 1) The COVID-19 pandemic crisis, as beneficiaries' focus on personal safety and monitoring the evolving situation likely took precedence over any potential dissatisfactions with services, 2) MHP staffing changes, as some staff who were named in multiple grievances in FY19-20 separated from Yolo County at the end of FY19-20 and at the beginning of FY20-21.
- ***Significant decrease in NOABDs (385 vs. 196)***: Yolo County HHSA had an increase in the total number of assessments completed between FY19-20 and FY20-21. The largest decrease in NOABD type was in Delivery System NOABDs (from 306 to 132). Based on the assessment data, it appears more clients have been determined to meet medical necessity, contributing to the decrease in NOABDs. Due to the unfortunate and unforeseen stressors associated with the pandemic, an increase in the number of beneficiaries determined to meet medical necessity is not surprising.

Additionally, during collaboration on the Cultural Competency Plan update due in December 2021, a goal was identified to analyze grievance trends based on beneficiary race / ethnicity. This will be incorporated as a goal in the FY21/22 QM Work Plan.

3) Met
Policies on Grievances, NOABDs, Appeals, and Fair Hearings were updated in March 2021 and posted to the Yolo County website. Updated polices were also distributed to HHSA staff and SUD / MH contract providers via email, alerting them to the changes. After finalization, it was discovered that the Grievance policy required an additional update for the SUD system of care. This update is currently in draft and will be distributed once finalized.

4) Met
The MHP Beneficiary Handbook (in English, Spanish, Russian, Large Print) is posted on the Yolo County website here: https://www.yolocounty.org/government/general-government-departments/health-human-services/mental-health/mental-health-services

5) Met
The DMC-ODS Beneficiary Handbook (in English, Spanish, Russian, Large Print) is posted on the Yolo County website here: https://www.yolocounty.org/government/general-government-departments/health-human-services/substance-abuse/substance-use-disorder-services

6) Met
QM provided training on NOABDs during SUD QI provider meetings, incorporated NOABD guidance into MH and SUD Clinical Documentation training materials and developed a NOABD Quick Reference guide that was distributed to HHSA staff and MH / SUD contract providers. QM has also issued multiple email notifications outlining additional resources and guidance for NOABDs and posted guidance documents on the Yolo County website for providers to access. Further, ongoing technical assistance and feedback was provided to programs as questions arose. Additionally, the SUD Program Monitoring Tool was updated to include NOABD regulations, which will be utilized to identify further trainings

<table>
<tr><td colspan="3">needs for providers.</td></tr>
<tr><td>8. Improve MHP Providers Ability to Assess and Document Suicide Risk</td><td>1) Conduct training on documentation of suicide risk
2) Standardize the investigation process of beneficiary suicides for continued root cause analysis / quality of care improvements</td><td>Met:
Partially Met: 1,2
Not Met:</td></tr>
<tr><td colspan="3">1) Partially Met
While HHSA did not conduct an organized all BH staff training on this topic, the HHSA Crisis Supervisor provided 5150 training to HHSA, UC Davis, and CommuniCare staff during FY20/21. Further, all clinical staff are required to maintain their state licensure which demanded continuing education hours in Suicide Risk Assessment during 2020 or 2021 (e.g., Board of Psychology, BBS) for license renewal.

As part of a Beneficiary Protection investigation, QM provided recommendations to a provider on: (a) clear documentation of Safety Plans in the client’s medical record and (b) developing a policy around routine risk assessments by a qualified provider, including how to identify clients in need of a screening based on risk or symptom severity, frequency of administration and follow-up, and documentation in the medical record (e.g., if a client is not presenting with an acute crisis but presents with suicide risk and has a current Safety Plan, the policy should speak to how this risk is routinely assessed by a qualified provider).

2) Partially Met
QM introduced / piloted a Root Cause Analysis process in FY20/21, though this process will continue to be reviewed / revised as incidents arise to formalize and ensure maximum utility for QI efforts.</td></tr>
<tr><td>9. Clinical Documentation: Improve quality and regulatory compliance</td><td>1) MHP: Continue implementing routine clinical documentation training and support for staff
2) MHP: Develop updated QM HHSA utilization review process by 12/31/20
3) DMC-ODS: Complete development of the DMC-ODS Clinical Documentation guide
4) DMC-ODS: Conduct a minimum of 3 SUD provider documentation trainings, which shall include 1 training for Narcotic Treatment Programs.</td><td>Met: 1,2
Partially Met: 3,4
Not Met:</td></tr>
<tr><td colspan="3">1) Met
QM continued providing routine clinical documentation training in FY20/21, including new employee orientations (NEO) and a monthly training series with rotating topics on: Assessments, Treatment Plans, and Progress Notes. Given the pandemic, training was done via Zoom, which increased participation by staff and providers. Specifically, QM: provided seven (7) HHSA NEO trainings, which included an overview of clinical documentation standards; provided six (6) Clinical Documentation trainings (series: 2 on Assessments, 2 on Client Plans, and 2 on Progress Notes); expanded the Clinical Documentation training series to contract providers in November 2020 (3 of the 6 trainings included provider attendance); and developed a Documentation Q&A as a resource for staff and providers. In addition to formal trainings, QM consistently provided documentation TA to direct service staff, supervisors, and managers from HHSA and contract providers who routinely email the QM team with documentation questions. Given forthcoming DHCS CalAIM initiatives anticipated to take effect in FY21/22 and FY22/23 that will impact documentation standards, training materials will continue to be reviewed /</td></tr>
</table>

revised as implementation guidance is clarified.

2) Met
QM updated the utilization / chart review tool and process and developed a schedule for FY21/22 chart monitoring for HHSA and contract provider programs. Given forthcoming DHCS CalAIM initiatives anticipated to take effect in FY21/22 and FY22/23 that will impact documentation standards, chart monitoring tools will continue to be reviewed / revised as implementation guidance is clarified by DHCS.

3) Partially Met
The draft DMC-ODS Clinical Documentation Guide has been updated throughout the Fiscal Year. However, due to frequent and pending regulation changes as a part of CalAIM, this document has not been finalized and distributed to providers yet to avoid potential confusion given forthcoming regulatory changes. In the interim, QM has provided documentation TA and trainings, including distribution of clarifying guidance / FAQs based on questions that arise and needs identified through provider chart monitoring.

4) Partially Met
QM provided two (2) SUD Clinical Documentation trainings for Residential and Outpatient providers in October 2020. QM sought additional guidance from DHCS on several NTP documentation requirements. As this guidance was pending, QM was unable to update the training materials in time to provide accurate training to NTP providers in FY20/21. However, QM provided documentation TA to providers (including NTPs) as questions arose.

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

1) Met
Network Adequacy submissions were completed within the required time frames for both the MHP and DMC-ODS. Both the MHP and DMC-ODS are on a corrective action plan and are working to resolve deficiencies in network provider capacity, with a particular emphasis on youth (age 0-17) DMC-ODS services (outpatient, intensive outpatient, residential, and opioid treatment programs).

11. Avatar: Continue to improve Avatar usability to promote efficiency and support service delivery	1) Increase clinical Avatar support to end users (e.g., develop training materials). 2) Implement use of Netsmart's Learning Pointe 3) Implement CareConnect Inbox in order to securely exchange/receive information and referrals with providers from within Avatar 4) Increase contract provider use of Avatar	**Met:** **Partially Met: 1,3,4** **Not Met: 2**

1) Partially Met
Although this has been an area of consistent staffing resource shortages for the County, the following actions were taken:

- QM provided training / technical assistance on specific Avatar functions as new reports, forms, and widgets have been developed (e.g., SUD residential treatment authorizations). Additionally, new desk guides were developed and disseminated to providers and posted on Yolo County's MyAvatar website. As individual MH / SUD contract providers and HHSA staff have reached out with questions regarding Avatar, QM has provided individual technical assistance via phone calls, video conferences, and email.
- An Avatar Quick Start Guide was developed by the IT Department and posted on the MyAvatar website. This Guide documents core functionality based on frequently asked questions / identified needs from staff and providers (e.g., signing in, self-service password resets, home / chart reviews, how to set up 'My Forms' and search for a form or client, exporting reports).
- FY21/22 goals include developing a holistic approach to Avatar training, which incorporates stakeholders from clinical program, QM, fiscal, and IT. Further, the IT Department is recruiting for three (3) full time staff whose roles will include supporting Avatar end users. Additionally, the County is working on developing an Avatar roadmap in FY21/22 that will include implementing various user groups, including but not limited to a steering committee, fiscal user workgroup, clinical user workgroup, and provider user workgroup.

2) Not Met
Due to the pandemic, Netsmart discontinued offering trainings on Learning Pointe and has since overhauled the platform. It is unknown whether the platform will support the County's training needs in the future. With the goal to develop an Avatar Steering Committee in FY21/22, the Committee will assist with formulating a plan to meet trainings needs.

3) Partially Met
CareConnect inbox was enabled in Avatar but has not been tested or implemented due to superseding priorities. With the goal to develop an Avatar Steering Committee in FY21/22, the Committee will assist with setting project priorities and implementation dates.

4) Partially Met
The County continues to increase contract provider usage of Avatar. For example, three (3) new MHP contractors document their clinical services directly in Avatar. Further, the IT Department is in the process of formulating an Avatar roadmap in FY21/22, which will assist the County in identifying needs and a plan to increase provider access.

12. Improve provider Relations and Communication Strategies	1) Continue to improve communication between QM team and staff / contract partners via sending email updates / notifications, attending staff team and stakeholder meetings, etc.	**Met: 1** **Partially Met:** **Not Met:**

1) Met
The County has continued to make concerted efforts to improve communication and working relations with its MH and SUD contract providers. Though the pandemic has led to unprecedented challenges for the County's BH systems of care, it has also presented unique opportunities to navigate alternative methods to maintain open lines of communication and support with providers. For example:

- The County continued to send emails with updated guidance encouraging MH and SUD provider response / feedback; this included sending routine email communications to distribute updated desk references, FAQs, policies and procedures, etc. and ensuring guidance materials were

posted on the Yolo County website for easy access.

- QM offered and provided technical assistance calls, emails, and video conferences for support in a variety of areas (e.g., residential authorizations, CalOMS, documentation, monitoring, access to care, Avatar).
- QM altered how trainings were delivered (i.e., from in-person to Zoom), which significantly increased the number of HHSA staff and providers who could attend, particularly providers who are not local.
- QM staff were present at provider stakeholder meetings to respond to questions and present on important topics (e.g., timeliness, NOABDs, monitoring).
- The County also provided updates / communications surrounding the COVID-19 pandemic, including changing state guidance, safety protocols, and guidance from the County's Public Health Officer.

Providers consistently reach out with questions (e.g., via emails, calls), and QM ensures they receive responses, which includes contacting DHCS when regulatory guidance clarification is needed.

13. Develop a more robust BH Monitoring and Compliance Program	1) MHP: Develop FY20-21 monitoring tool(s) and calendars. 2) DMC-ODS: Update the contract provider monitoring tool to allow for clarity and greater usability by providers and QM staff by the first monitoring review.	**Met: 1,2** **Partially Met:** **Not Met:**

1) Met
QM updated the chart / utilization review tool, piloted the tool on two HHSA programs in FY20/21, and developed a monitoring schedule for HHSA programs and contract providers for FY21/22. Given forthcoming DHCS CalAIM initiatives anticipated to take effect in FY21/22 and FY22/23 that will impact documentation standards, monitoring tools and training materials will continue to be reviewed / revised as implementation guidance is clarified. QM also has a MHP Site Certification and Re-Certification tool and schedule for each fiscal year. Additionally, the County conducted enhanced monitoring of a provider through a joint effort between the BH Compliance Officer and QM staff.

2) Met
QM updated the SUD Program / Provider Monitoring Tools and updated / developed instructional guidance on completing the tools and submissions. This included developing a separate NTP monitoring tool to ensure less confusion on applicable regulations. Further, QM provided a training during a QI SUD Provider meeting in December 2020 on the SUD monitoring process to assist providers in preparation for FY21/22 monitoring.

14. Update and Implement Process Improvements for SUD Residential Treatment Authorizations	1) Update the SUD Residential Authorizations Policy and Procedure to align with the updated Intergovernmental Agreement and change in processes 2) Develop Forms and Widgets in Avatar to allow for transitioning SUD residential authorization tracking, communication, and decision making in Avatar 3) Develop a Desk Guide and provide training to SUD residential providers on the policy changes and updated processes	**Met: 1-3** **Partially Met:** **Not Met:**

1-3) Met QM updated and implemented a new residential treatment authorization policy and related Avatar system improvements in December 2020, which included developing and implementing new Avatar forms and adding new widgets to streamline tracking of and communication around authorization requests between the County and contracted residential providers. This process also involved coordinating with multiple stakeholders (e.g., HHSA fiscal staff, access point staff) and training providers on the updated process. Updates were also made to the documentation being submitted to further streamline the process and reduce administrative burden for providers. A PowerPoint presentation outlining these changes was developed for providers. This presentation was disseminated, and a training was held for providers to ensure their understanding of these changes.		