YOLO COUNTY QUALITY MANAGEMENT

WORK PLAN

Fiscal Year 2021-2022

Evaluation Period: July 1, 2021 – June 30, 2022

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
- 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 is 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.

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<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, including a review of data to determine if responses reflect a diverse representation of the clients served.</td><td>Met: 1
Partially Met:
Not Met:</td></tr>
<tr><td colspan="3">1) Met
The Plan administered the TP surveys in the Fall and CP Surveys in the Summer.
2) Met
The Plan is awaiting the results of the CP Surveys to complete our analysis. TP analysis was completed once received. Results were shared with our Providers, Stakeholders and Beneficiaries at the quarterly Quality Improvement Committee meeting.</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:
Not Met: 2, 4</td></tr>
<tr><td colspan="3">1, 3) Met
The Plan has an active 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 initially developed a PIP regarding timeliness to services to increase beneficiary engagement and outcomes. With the increase to Information Technology staffing, the Plan’s EHR team has begun modeling and developing tools to collect and validate timeliness. The Plan is now completing a non-clinical PIP on Data Exchange for Follow-Up After Emergency Department Visits for Alcohol and Other Drug Abuse or Dependence (FUA), Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Pharmacotherapy for Opioid Use Disorder (POD) as part of the CalAIM Initiatives.</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). Utilize data trends to inform quality improvement efforts and contracting decisions.
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
3) Work with HHSA Child, Youth, and Family (CYF) branch and IT Department to develop reports to aggregate and trend Child and Adolescent Needs and</td><td>Met: 3
Partially Met:
Not Met:</td></tr>
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<tr><td></td><td>Strengths (CANS) data to effectively use for QI purposes.
4) Work with IT Department to develop report(s) to aggregate and trend Level of Care Utilization System (LOCUS) data for QI purposes.</td><td></td></tr>
<tr><td colspan="3">1) Met
The Plan has dedicated staff who collect and input the performance measures into our results based accountability system. This data is provided to leadership and utilized with decision making and also Provider monitoring.

2) Met a-c
a. The Plan has a 24 hour access and crisis line to provide business and after hours services. The access/crisis line is staffed by clinicians who can complete screenings and referrals for services immediately for clients.
b. The Plan has implemented tracking for high utilizers of the system and made available case management services to reduce hospitalizations.
c. The Plan actively monitors contracted Providers to ensure coordination of services are being completed.

3) Met
The Plan has successfully developed a CANS data report and released for use in the EHR system.

4) Partially Met
The Plan has successfully developed reports for the tracking and trending of Level of Care Utilization System (LOCUS) but has yet to utilize them for QI purposes.</td></tr>
<tr><td>4. Access: Improve responsiveness, quality, and utilization of the 24/7 BH Access Line</td><td>1) Develop a process to ensure test calls are conducted routinely, including developing scripts and a schedule of trained HHSA staff who will be assigned to conduct calls on a regular basis.
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%
4) For quality and performance improvement purposes, report out on test call results quarterly, at minimum, to BH leadership and Access Line vendor, unless more prompt reporting is indicated.</td><td>Met:
Partially Met: 1, 3, 4
Not Met:</td></tr>
<tr><td colspan="3">1) Partially Met
The Plan began the process of revamping the Test Call Process but, were unable to complete within the fiscal year. Since the start of the new fiscal year the new materials are being utilized and staff are assigned a time period when they should be completing their test calls.

2) Met</td></tr>
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Of the calls made, 66% of them were completed in non-English languages. The Plan will continue to focus on calls made in non-English languages by identifying and assigning bi-lingual staff for call completion. **3) Not Met** None of the test calls completed for the fiscal year were logged. The Plan had previously reviewed the Access Line's business process to ensure they were dispositioning calls appropriately. It was concluded that there was incorrect information within the business process and updated guidance was shared with Access Line staff. **4) Met** The Plan continues to monitor test calls at minimum quarterly and shares finding with leadership and Access Line Staff. The Plan is in the process of developing and implementing the Crisis Now Initiative which will be responsible for the Access Line.		
5. Quality & Appropriateness of Care: Cultural and Linguistic Competency and Capacity	1) Play an active role in the Cultural Competence Plan annual update process in collaboration with the HHSA Community Health Branch.	**Met:** **Partially Met:** **Not Met:**
5) Met The Plan is actively involved in the Cultural Competency Plan annual update, by providing reports and documents to support the plan development.		
6. Timeliness to Services: Monitor and improve timely access to services	1) MHP: Review timeliness measures and methodologies for reliability and alignment with DHCS requirements. 2) DMC-ODS: Develop and implement an Avatar form to track: a) Timeliness of first initial contact to face-to-face appointment 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	**Met:** **Partially Met:** **Not Met:**
1 & 2) Partially Met The Plan has been evaluating our existing reports and determining what is needed to ensure data collected can be mined and is valid. As a part of this process, a new timeliness tracking form is being developed within our EHR System. Once the form is available, it will be piloted with one of our existing providers and then implemented across our continuum of care.		
7. Beneficiary Protection and Informing Materials	1) Continue to ensure grievances and appeals are processed within mandated timeframes 2) Continue to track and trend Beneficiary Protection data to identify QI opportunities and share results with BH leadership / QI stakeholders. Based on feedback and	**Met:** **Partially Met: 1, 2, 3** **Not Met:**

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<tr><td></td><td>collaboration with the Plan’s Cultural Competence workgroup, include an analysis of grievance trends based on beneficiary race / ethnicity.
3) DMC-ODS: Update Grievance policy and distribute to SUD providers.</td><td></td></tr>
<tr><td colspan="3">1) Partially Met
Grievances and appeals are logged upon receipt and tracked for timeline compliance for both acknowledgement and resolution. Two grievances were not processed within mandated timeframes (one late acknowledgment and one late resolution).
2) Partially Met
Beneficiary protection data summaries have been prepared for QIC meetings and shared with HHSA management. Collaboration with the Plan’s Cultural Competence workgroup has yet to occur, including analyzing for trends based on race/ethnicity.
3) Partially Met
This policy went through initial stages of revision but was not finalized and distributed to SUD providers. This goal will be revisited in FY 22/23.</td></tr>
<tr><td>8. Clinical Documentation: Improve quality and regulatory compliance</td><td>1) MHP: Update training and chart review materials to align with finalized CalAIM documentation reform standards set forth by DHCS, in anticipation of implementation in fiscal year 22/23.
2) DMC-ODS: Conduct a minimum of 2 SUD provider documentation trainings and issue guidance to providers on finalized CalAIM documentation reform initiatives set forth by DHCS.
3) Update Medical Necessity policies and procedures by April 1, 2022 based on CalAIM information notices issued by DHCS.</td><td>Met: 2, 3
Partially Met: 1
Not Met:</td></tr>
<tr><td colspan="3">1) Partially met
These materials were partially updated to align with CalAIM documentation reform standards. However, due to needed clarification on regulations from DHCS, the plan was not able to fully update their training and chart review materials. Upon receipt of additional information from DHCS, the Plan will update these materials. This goal will be revisited in FY 22/23.

2) Met
QM conducted both an Outpatient and Residential Clinical Documentation training for providers in November 2021. Additionally, guidance was issued to providers on CalAIM documentation reform, including information on accessing CalMHSA’s Documentation Trainings in June of 2022.

3) Met
Medical necessity policies and procedures were updated by April 1, 2022 based on CalAIM information notices and submitted to DHCS for approval.</td></tr>
<tr><td>9. Maintain and monitor a network of providers that is sufficient to provide</td><td>1) Complete annual MHP and DMC-ODS Network Adequacy submissions and Corrective Action Plans according to DHCS schedule.</td><td>Met:
Partially Met:
Not Met:</td></tr>
</table>

adequate access to services		
1) Met The Plan successfully completed the Network Adequacy Submissions by the required due date which fell in the new fiscal year. The Plan was able to resolve corrective action plans surrounding the MHP continuum of care and are awaiting the results of the recent submission. For the DMC-ODS Network, the plan has an Alternative Access in place and has received technical assistance from DHCS. This past year the Plan has placed a high emphasis on developing the youth continuum and have several potential providers in contracting discussions.		
10. Avatar: Continue to improve Avatar usability to promote efficiency and support service delivery	1) Have consistent QM representation on the new IT Avatar Steering Committee, once developed, to bring forth project ideas to support ongoing QI needs and efforts.	**Met:** **Partially Met:** **Not Met:**
1) Met The QM Deputy and Manger actively participate in the IT Avatar Steering Committee and support QI needs and efforts. In addition, all other QM staff participate in the IT Avatar User Groups which are for The Plan's staff and for contracted providers. QM provides guidance and support during all meetings.		
11. Develop a more robust BH Monitoring Program	1) MHP: Work with HHSA CYF branch and IT Department to develop a medication monitoring review format that captures the requirements of SB 1291 to track / trend results over time to inform QI efforts on identified system-related issues. 2) DMC-ODS: Utilize contract provider feedback and process improvement lessons learned from prior FY monitoring to update the monitoring tools to improve clarity and usability by providers and QM staff.	**Met:** **Partially Met: 1, 2** **Not Met:**
1) **Partially Met** Avatar has been updated to track the requirements of SB 1291. However, the report needs to be created in order to review/ trend results over time to inform QI efforts. 2) **Partially Met** Provider feedback was gathered regarding monitoring. The Plan is in conversation on what changes to make to improve clarity and usability by providers and QM staff. Finalizing monitoring tools which have incorporated this feedback is pending due to additional monitoring changes based on implementation of CalAIM documentation reform.		
12. Use data to track and improve DMC-ODS residential authorization timeliness metrics as well as compliance with Yolo County	1) Calculate timeliness for provider residential authorization submissions and County residential authorization processing for the previous fiscal year. 2) Share the data above with residential providers and provide individualized technical assistance (TA) to improve timeliness / compliance.	**Met: 1, 2, 3** **Partially Met:** **Not Met:**

authorization policies and DHCS requirements	3) Provide ongoing TA to residential providers as needed throughout the fiscal year to improve processes and compliance.	
1, 2, 3) Met Timeliness for provider residential authorization submission and County residential authorization processing for the previous fiscal year was calculated. PowerPoint presentations based on the data were created and shared with each residential provider in (one in December 2021 & the other in February 2022) to discuss individual needs and provide TA. After this data was shared, ongoing TA occurred throughout the fiscal year to assist with improved processes and compliance.		
13. Improve accuracy of treatment episode data to increase reliability and utility for QI efforts as well as compliance with DHCS data tracking requirements	1) Generate monthly episode management data reports for providers to ensure Avatar episodes are being discharged in a timely manner once a client is no longer receiving services. 2) Review and update guidance for HHSA staff and providers around episode admission and discharge dates to ensure consistency in definitions for data entry and episode management.	**Met: 1** **Partially Met:** **Not Met:**
1) Met An episode management data report was generated by QM each month and sent to the AOD Program Coordinator for distribution to providers. Providers have been using this report to get Avatar up to date with discharges and to help ensure discharges are completed within a timely manner. **2) Not met** Due to competing priorities with the implementation of CalAIM documentation reform and staffing turnover/shortages, guidance was not issued around episode admission and discharge dates. This goal will be revisited in FY 22/23.		