YOLO COUNTY QUALITY MANAGEMENT

WORK PLAN

Fiscal Year 2023-2024

Evaluation Period: July 1, 2023 – June 30, 2024

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.

Category	Goals	Annual Evaluation
1. Outcomes: Beneficiary and Family Satisfaction with Services	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. 3) Report out results annually to BH managers, contracted providers, and stakeholders to identify areas for improvement.	**Met: 1** **Partially Met: 2, 3** **Not Met:**
1) Met: The Plan administered the CP surveys in the Summer and the TP Surveys in the Fall. 2) Partially Met: The Plan reviewed and analyzed the results of the TP Survey. The Plan did not review the data to determine if responses reflect a diverse representation of clients served. 3) Partially Met: The Plan presented the results from the analysis on the TP Surveys at the Behavioral Health Quality Improvement Committee and the Behavioral Health All-Staff Meeting. The CP Survey analysis was not completed during the fiscal year, so the results have not yet been reported out.		
2. Outcomes: Continuous quality and performance improvement	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	**Met:** **Partially Met: 2, 3, 4** **Not Met: 1**
1) Not Met: The Plan began discussing potential clinical PIP ideas for the Mental Health system of care but has not yet initiated a PIP. 2) Partially Met: This PIP was in the planning phase, but upon analysis of the data, it was determined that the data did not support that the identified problem was an issue for our system of care. The Plan will be working towards identifying a new area of focus for this PIP. 3) Partially Met: This PIP was in the planning phase, but upon analysis of the data, it was determined that the data did not support that the identified problem was an issue for our system of care. The Plan will be working towards identifying a new area of focus for this PIP. 4) Partially Met: This PIP was in the planning phase, but upon analysis of the data, it was determined that the data did not support that the identified problem was an issue for our system of care. The Plan will be working towards identifying a new area of focus for this PIP.		
3. Outcomes: Improve data collection and reporting to support decision making	1) MHP: Identify strategies to monitor quality, timeliness, and access to care. 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; and c) Coordination of physical and mental health services	**Met:** **Partially Met: 1, 2** **Not Met:**
1) Partially Met: The Plan is still working towards implementing timeliness forms for the purpose of		

tracking data that will allow us to work towards better monitoring of timeliness and access to care. Chart reviews were completed to review the quality of care provided to our beneficiaries.

2) Partially Met: The Plan monitored for coordination of physical and mental health services through our annual chart reviews of all SUD providers. Corrective action plans were utilized to improve coordination efforts as needed. The plan was unable to address access to after-hours care and avoidable hospitalizations. The plan is working on improving data collection efforts in order to monitor/improve accessibility for access to after-hours care and reduce avoidable hospitalization.

4. Access: Improve responsiveness, quality, and utilization of the 24/7 BH Access Line	1) Maintain current process to ensure test calls are conducted routinely, including maintaining a schedule of trained HHSA staff who will be assigned to conduct calls on a regular basis. 2) Conduct at least two (2) test calls in prevalent non-English languages per quarter. 3) Conduct at least two (2) test calls during after-hours (AH) per quarter. 4) Increase the percentage of test calls logged during business (BH) and AH to a minimum of 80% 5) For quality and performance improvement purposes, report out on test call results quarterly to BH leadership and Access Line vendor, unless more prompt reporting is indicated.	**Met: 1, 5** **Partially Met: 2, 3** **Not Met: 4**

1) Met: The Plan continues to have a staffing schedule for completing Test Calls. Calls are completed consistently each month.
2) Partially Met: The Plan successfully completed non-English test calls in each of the quarters. During the second quarter, only one (1) non-English test call was completed.
3) Partially Met: The Plan completed after hours calls in all of the quarters except for the second quarter.
4) Not Met: The Plan's Access Line did not log any calls for the evaluation period. The Plan has recently contracted with a new vendor for Access Line Services and is working with the new vendor to provide training and guidance to ensure that calls are being logged appropriately.
5) Met: The Plan compiles quarterly summaries and reports for all Access Line Test Calls completed. These reports and summaries are shared with Behavioral Health Leadership and detail successes and areas for improvement. The manager that oversees the contract for this vendor shares the findings of these calls with them.

5. Quality & Appropriateness of Care: Cultural and Linguistic Competency and Capacity	1) Assist with the Cultural Competence Plan annual update process in collaboration with the HHSA Community Health Branch. 2) Monitor internal and external providers to ensure culturally and linguistically competent services are being delivered.	**Met: 1, 2** **Partially Met:** **Not Met:**

1) Met: The Plan assisted the Cultural Competency Team with the Cultural Competency Plan by providing reports from audits, submissions and surveys for plan development.
2) Met: The Plan monitored all SUD providers during the annual monitoring for compliance with the National Culturally and Linguistically Appropriate Services (CLAS) Standards. Mental Health providers were monitored to CLAS standards during the site certification process. Onsite monitoring during mental health site certification and SUD annual monitoring included a review

	of posted informing materials to ensure availability in Yolo County's threshold languages. Mental Health chart monitoring also included review of documentation ensuring that members whose primary language is not English received informing materials in their primary language.	
6. Timeliness to Services: Monitor and improve timely access to services	1) MHP: Implement the Avatar Timeliness Form to track: a) Timeliness of fist initial contact to first routine appointment b) Timeliness of Urgent Requests c) Timeliness of Psychiatry Requests 2) DMC-ODS: Implement the Avatar timeliness form to track: a) Timeliness of first initial contact to first appointment b) Timeliness of services for urgent conditions c) Timeliness of first dose of NTP services 3) DMC-ODS: Begin tracking frequency of follow-up appointments, including after residential treatment.	**Met:** **Partially Met:** **Not Met: 1, 2, 3**
1) Not Met: The Plan did not implement the MHP Timeliness forms. The Plan will be prioritizing this project and plans to pilot the forms with one of our existing providers. 2) Not Met: The Plan did not implement the DMC-ODS Timeliness forms. The Plan will be prioritizing this project and plans to pilot the forms with one of our existing providers. 3) Not Met: The Plan did not begin tracking frequency of follow-up appointments but intends to increase data analysis efforts.		
7. Beneficiary Protection and Informing Materials	1) Continue to ensure grievances, appeals, and state fair hearings are processed within mandated timeframes 2) Continue to track and trend Beneficiary Protection data to identify QI opportunities and share results in quarterly QIC meetings. 3) Update Change of Provider policy and distribute to providers.	**Met: 2, 3** **Partially Met: 1** **Not Met:**
1) Partially Met: There were no state fair hearings or appeals for either MHP or DMC-ODS in FY23-24. All resolutions for Grievances in FY23-24 were within timelines. We had 35 non-exempt grievances total between MHP and ODS and all but 3 received timely acknowledgements (approx. 91% of our acknowledgements happened timely). 2) Met: Beneficiary Protection data was tracked and trended regularly and presented at quarterly QIC meetings. Review of this data led to the creation of a QIC workgroup and discussion of process improvements for certain protections. 3) Met: The Change of Provider policy was updated and distributed in August 2023.		
8. Clinical Documentation: Improve quality and regulatory compliance	1) Update training materials to include payment reform standards set forth by DHCS 2) DMC-ODS: Conduct at least one documentation training, which includes new CalAIM standards, for each of the following service types: outpatient, residential and NTP.	**Met: 1, 2, 3, 4** **Partially Met:** **Not Met:**

	3) MHP: Conduct at least two documentation trainings, which includes new CalAIM standards, for mental health providers (one for internal teams and one for contracted providers). 4) Update telehealth policy and consent forms to align with BHIN 22-019.	
1) Met: Training materials were updated to include payment reform changes and trainings were conducted as described below. 2) Met: Documentation trainings were provided for outpatient, residential and NTP providers from October to November 2023. 3) Met: Updated documentation trainings were provided for internal and contracted SMHS providers from July 2023 – April 2024. 4) Met: The telehealth policy and consent forms were updated and distributed to providers in July 2023.		
9. 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 and Corrective Action Plans according to DHCS schedule.	**Met: 1** **Partially Met:** **Not Met:**
1) Met: The Plan successfully completed the Network Adequacy Submissions as well as the additional requests. In addition, the Plan also completed a reassessment per DHCS' request.		
10. Avatar: Continue to improve Avatar usability to promote efficiency and support service delivery	1) Have QM representation at 90% of the IT Avatar Steering Committee meetings to bring forth project ideas to support ongoing QI needs and efforts. 2) Have at least one QM representative attend each Avatar Clinical User Groups for vendors and external providers to support ongoing QI needs and efforts. 3) Update Avatar progress note form and desk guide to align with payment reform.	**Met: 1,2, 3** **Partially Met:** **Not Met:**
1) Met: The current QM Manager attended all Steering Committee meetings that QM was invited to attend. 2) Met: At least one QM representative attended each Avatar Clinical User Group held during the fiscal year. 3) Met: The Plan updated the Avatar progress note form and desk guide to align with payment reform. The updated desk guide was distributed to all providers that document in Avatar on July 11, 2023.		
11. Develop a more robust BH Monitoring Program	1) MHP: Work with HHSA CYF branch and IT Department to track / trend results of medication monitoring over time to inform QI efforts on identified system-related issues. 2) Update the following areas of the contracted provider and internal program monitoring to reflect CalAIM changes. a) Chart (Clinical Record Review)	**Met: 2, 3** **Partially Met: 1** **Not Met:**

	b) System (Personnel Records & Policies and Procedures) c) On-Site 3) Implement revised service verification policy and process based on provider feedback.	
1) Partially Met: HHSA CYF and IT collaborated to create Special Population Tracking and Medication Management forms, which were tested and implemented in the live system of Avatar. Data entry has begun, and the IT team is working on creating reports. 2) Met: All portions of the monitoring tools were updated to reflect CalAIM changes. 3) Met: The Plan used provider feedback to update the service verification policy and procedure. The new policy and forms were implemented July 1, 2023. Feedback received from providers after the implementation of the new policy and forms was positive.		
12. 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, 2** **Partially Met:** **Not Met:**
1) Met: The Plan generated monthly episode management data and sent this to the SUD Program Coordinator. The SUD program coordinator sent these to our providers, asking that they review the discharges and close any episodes as needed. 2) Met: The Plan developed guidance for HHSA staff and SUD providers defining Admission and Discharge Dates. This guidance was issued via email on August 10, 2023 and was shared during the SUD Provider meeting held that same day.		
13. Enhance the QIC committee through increased participation	1) Recruit beneficiaries and family member participants to ensure a diverse committee. 2) Continue to encourage providers to attend QIC meetings through regular reminders in order to increase provider representation across both mental health and substance use disorder systems of care.	**Met: 2** **Partially Met: 1** **Not Met:**
1) Partially Met: A beneficiary/family member communication was developed through input of QIC. Implementation of the communication is slated for Q2 of FY24-25. 2) Met: Regular emails are sent to providers to elicit agenda items and remind of QIC dates/times. These emails include links for virtual participation. Additionally, reminders are included in each quarterly edition of the HHSA BH-QM Newsletter that encourage provider participation.		
14. Use data to track and improve DMC-ODS residential authorization timeliness metrics as well as compliance with Yolo County authorization policies and DHCS requirements.	1) Track the number, percentage of denied, and timeliness of requests for authorization for residential DMC-ODS services. 2) Share the data above with residential providers and provide individualized technical assistance (TA) to improve timeliness / compliance.	**Met:** **Partially Met: 1** **Not Met: 2**

1) Partially Met: The Plan tracked the number of denied authorizations but was unable to analyze the data to determine the percentage of denied authorizations and the timeliness of authorization submissions. The Plan hopes to work with our IT department to make the analysis of this data more manageable in order to meet this goal during the next FY. 2) Not Met: As the Plan was unable to analyze this data, there was no information to share with our providers regarding timeliness/compliance.		
15. Implement CalAIM Behavioral Health Payment Reform	1) Collaborate with providers to establish rates and update contracts to reflect payment reform changes 2) Develop resources for providers to assist with the implementation of payment reform and to identify appropriate billing codes for services provided 3) Update Avatar to include new payment reform codes and billing rates.	**Met: 1, 2, 3** **Partially Met:** **Not Met:**
1) Met: Contract monitors collaborated with providers to establish rates and update contracts to include payment reform changes. 2) Met: HHSA BH-QM developed multiple tip sheets and FAQ documents on the topic of CalAIM payment reform and appropriate billing code usage. These were shared directly with providers through regular notification processes. Additionally, all resources were posted to the HHSA BH-QM webpage for provider access ongoing. 3) Met: HHSA BH-QM, Fiscal, and IT teams collaborated to update Avatar include new payment reform codes and billing rates.		