YOLO COUNTY QUALITY MANAGEMENT

WORK PLAN

Fiscal Year 2022-2023

Evaluation Period: July 1, 2022 – June 30, 2023

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.	**Met: 1** **Partially Met: 2** **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 analyzed and presented the CP Survey results at the Quality Improvement Committee Meeting as well as the Behavioral Health All-Staff Meeting. The Plan had issues in receiving the results for the TP Surveys due to them being placed on the DHCS Secure Portal. Due to the delay and competing projects the Plan has not completed a thorough analysis of the results.		
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: 2, 3, 4** **Partially Met: 1** **Not Met:**
1) **Partially Met:** The Plan had 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. However, this PIP ended on December 31, 2022. The Plan has not initiated a new MH Clinical PIP at this time. 2) **Met:** The Plan has an active non-clinical MH PIP: Follow-Up After Emergency Department Visit for Mental Illness (FUM). 3) **Met:** The Plan had 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. This PIP ended on December 31, 2022. The Plan initiated a new active clinical DMC-ODS PIP: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). 4) **Met:** The Plan has an active non-clinical DMC-ODS PIP: Pharmacotherapy for Opioid Use Disorder (POD)		
3. Outcomes: Improve data collection and reporting to support decision making	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	**Met: 2a, 2b** **Partially Met: 1, 2c, 3, 4** **Not Met:**

	3) Use developed reports to aggregate and trend Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) data for QI purposes. 4) Use developed report(s) to aggregate and trend Level of Care Utilization System (LOCUS) data for QI purposes.	

1) **Partially Met:** The Plan maintains reports of key performance measures but, they are not heavily utilized for quality improvement efforts or contracting decisions.
2) **Met a & b, Partially Met c**
   a. The Plan has an established 24/7 Access Line for all Mental Health and Substance Use Disorder Screenings. In addition, The Plan has three residential Providers that offer 24/7 residential services. The Plan continues to expand our bed availability.
   b. The Plan has established a case manager for high utilizers who works in partnership with our Crisis Team to screen and assess for any needed intervention to reduce avoidable hospitalizations.
   c. Coordination of Care is an area that The Plan continues address and improve. The Plan assesses, monitors and creates solutions for increased care coordination.
3) **Partially Met:** The aggregate reports have been developed in The Plan's Electronic Health Record but the Plan is in process of developing a process for tracking and reporting the data.
4) **Partially Met:** The Plan trends LOCUS data as needed for forecasting and projects but, none that are specific for QI purposes.

4. Access: Improve responsiveness, quality, and utilization of the 24/7 BH Access Line	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 40% 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.	**Met: 1, 2, 4** **Partially Met:** **Not Met: 3**

1) **Met:** The Plan has updated the Test Call Process and has implanted a Staff rotation for call completion. Every two weeks, a Staff member is assigned to make at minimum of two call for that week.
2) **Met:** The Plan made a total of 20 Test Calls for the fiscal year and of those, 8 were made in a language other than English.
3) **Not Met:** None of the completed Test Calls were logged by the Access Line. The Plan will be reviewing business practices and will develop interventions to remedy the logging issues.
4) **Met:** The Plan continues to report Test Calls quarterly and reports any issues immediately for correction. This reporting is shared with Behavioral Health Leadership who relay the message to 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 to ensure the Plan is identifying and affirming cultural-related specific to support behavioral health recovery.	**Met: 1** **Partially Met:** **Not Met:**
1) **Met:** The Plan assists the Cultural Competency Coordinator with the Cultural Competency Plan by providing reports from audits, submissions and surveys for plan development.		
6. Timeliness to Services: Monitor and improve timely access to services	1) MHP: To Develop and Implement an Avatar Form to track: a) Timeliness of fist initial contact to first appointment b) Timeliness of Urgent Requests c) Timeliness of Psychiatry Requests 2) DMC-ODS: Develop and implement an Avatar form to track: a) Timeliness of first initial contact to 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: 1,2** **Not Met:**
1) **Partially Met:** The Plan's Enterprise Applications Team has successfully developed these timeliness forms in The Plan's Electronic Health Record. The Plan is currently in the test phase and determining user access and business process around the form. 2) **Partially Met:** The Plan's Enterprise Applications Team has successfully developed these timeliness forms in The Plan's Electronic Health Record. The Plan is currently in the test phase and determining user access and business process around the form.		
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 collaboration with the Plan's Cultural Competence workgroup, include an analysis of grievance trends based on beneficiary race / ethnicity. 3) Update Grievance policy and distribute to providers.	**Met: 3** **Partially Met: 1,2** **Not Met:**
1) **Partially Met:** In FY22/23, the MHP received 30 grievances. All were resolved within mandated timelines, and the grievance acknowledgement requirement was successfully met 97% of the time (29/30 were within timelines, one was one day late). One appeal was received for the MHP in FY22/23, but timelines were not met due to how it was received (hard copy mail). Internal USPS review process improvements initiated.		

In FY22/23, the DMC-ODS received 2 grievances. Both met acknowledgment and resolution mandated timelines. Additionally, one appeal was received for the DMC-ODS, and mandated timelines were not met (due to internal process regarding grievance vs. appeal requirements). An internal staff training was provided, and processes updated.

2) **Partially Met:** In FY22/23, four quarterly Quality Improvement Committee meetings (with MHP/DMC-ODS) were convened. Beneficiary protections data reports were prepared and presented at each, trends discussed, and process improvements explored. Analysis by race/ethnicity and collaboration with the Plan's Cultural Competence workgroup has not yet occurred.
3) **Met:** Grievance policy (HHSA 5-9-015) was updated and distributed to providers on 2/15/2023.

8. Clinical Documentation: Improve quality and regulatory compliance	1) Update training materials to align with finalized CalAIM documentation reform standards set forth by DHCS 2) DMC-ODS: Conduct at least one documentation training, which includes new CalAIM documentation standards, for each of the following service types: outpatient, residential and NTP. 3) MHP: Conduct at least one documentation training, which includes new CalAIM documentation standards, for mental health providers.	**Met: 3** **Partially Met: 1, 2** **Not Met:**

1) **Partially Met:** Training materials for the MHP were updated to align with finalized CalAIM documentation reform standards. Updates began on the DMC-ODS training materials but has not yet been finalized.
2) **Partially Met:** Full trainings were not provided for each of the service types. However, ad hoc trainings were provided to our residential treatment programs based on documentation needs. Documentation resources were provided to all service types and providers were required to take CalMHSA's documentation trainings which covered DMC-ODS CalAIM documentation requirements.
3) **Met:** Two documentation trainings were provided for mental health providers. One training was provided for internal HHSA staff (April 20th) and the other was provided for contracted providers (May 25th).

9. Access screening and Care coordination: Support provider implementation and compliance (MHP)	1) Develop policies for the new Screening and Transition Tools 2) Assist the IT department with ensuring the MHP EHR versions of the DHCS Screening and Transition Tools are compliant 3) Issue guidance on the new tools to the MHP network providers.	**Met: 1, 2, 3** **Partially Met:** **Not Met:**

1) **Met:** A policy was developed for the use of the new Screening Tool, an existing coordination of care policy was updated (to include the new Transition Tool), and both were distributed to all relevant providers.
2) **Met:** The Quality Management (QM) team worked closely with the IT department to ensure the screening and transition tools were built into the EHR and were compliant with DHCS requirements. EHR Desk guides were developed to assist providers with completing these forms based on DHCS instructions for use.

3) **Met:** The new and updated policies, along with the EHR desk guides were disseminated to internal staff and network providers. In addition, trainings were organized by the IT department to review these new forms in the EHR. The QM team attended these trainings and provided guidance related to regulation.

10. 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 submitted Network Adequacy Submissions for MHP and DMC-ODS. The Plan successful met all requirements for the MHP but had findings for DMC-ODS. The Plan has complied with all requirements and submissions for the DMC-ODS corrective action Plan.

11. 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 to bring forth project ideas to support ongoing QI needs and efforts. 2) Have consistent QM representation for the Avatar Clinical User Groups for vendors and external providers to support ongoing QI needs and efforts.	**Met: 1,2** **Partially Met:** **Not Met:**

1) **Met:** QM maintained consistent representation on the IT Avatar Steering Committee, with the QM Manager in attendance at these meetings, and was able to bring project ideas to this meeting for input.
2) **Met:** At least one clinical QM staff attended each of the Avatar Clinical User Groups for vendors and external providers in order to answer any questions that were outside of the scope of practice for the IT department (i.e., clinical questions).

12. 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 chart monitoring tools to reflect CalAIM changes	**Met: 2** **Partially Met: 1** **Not Met:**

1) **Partially Met:** The forms were created and implemented but when the report was retrieved for tracking and trending there was no data. Through troubleshooting it was determined that there needed to be an additional piece added from Fiscal. Unfortunately, due to payment reform, this topic had to be set to the side. The Plan will be relaunching this process in the coming months.
2) **Met:** Chart monitoring tools for both the MHP and DMC-ODS were updated to reflect CalAIM changes. Internal HHSA programs and contracted providers were monitored based on these updated tools.

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: 2**

1) **Met:** The QM team 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. The number of episodes that were erroneously left open has been reduced through this process.
2) **Not Met:** This item was not addressed during FY 22-23 due to other QI efforts that needed to be prioritized. However, it was added to the agenda for the first QM/SUD meeting as an item to discuss in FY 23-24.

14. Enhance the QIC committee through increased participation	1) Continue to recruit participants to ensure a diverse committee including vendors, stakeholders, beneficiaries and family members. 2) Combine SUD and MH QIC meetings in order to address quality improvement from an integrated behavioral health approach	**Met: 2** **Partially Met: 1** **Not Met:**

1) **Partially Met:** Vendor participation in QIC meetings was consistent. Recruitment options for beneficiaries/families were explored in QIC meetings, and vendor assistance with this recruitment was requested. Additional efforts, such as a recruitment announcement in the quarterly QM Newsletter, were implemented; however, no beneficiaries/family members were successfully recruited to the QIC this fiscal year.
2) **Met:** The 3rd and 4th quarter meetings during FY 22-23 were combined to include both SUD and MH in order to address quality improvement from an integrated behavioral health approach. SUD and MH providers were notified in advance that these meetings would be combined BH meetings.