

Marin County Drug/Medi-Cal Organized Delivery System (DMC-ODS) Quality Improvement Plan April 1, 2017 – June 30, 2018



Quality Management Program Description

The Marin Drug/Medi-Cal Organized Delivery System (DMC-ODS) Quality Management (QM) program is responsible for monitoring the DMC-ODS' effectiveness and for providing support to all areas of DMC-ODS operations by conducting performance monitoring activities which include, but are not limited to: utilization management, utilization review, provider appeals, credentialing and monitoring, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes.

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 22 and Title 9, and the DMC-ODS' Intergovernmental Agreement with the State Department of Health Care Services (DHCS).

Activities in the QM program are performed by the DMC-ODS Administrative team, which consists of the County Alcohol and Drug Administrator, Program Manager, two Department Analysts, two Senior Program Coordinators and one Administrative Services Associate, as well as partners—and integrates many functions with—the Behavioral Health and Recovery Services Quality Management team, one of whom is a licensed clinician dedicated to performing Utilization Reviews for the DMC-ODS. QM staff carries out their job responsibilities as defined by their individual professional disciplines and scope of practice.

The Utilization Management (UM) program is a component of the QM program. The UM program assures that beneficiaries have appropriate access to DMC-ODS services. Program activities include: the evaluation of medical necessity determinations, the appropriateness and efficiency of services, as well as the access to capacity and geographical distribution of services provided to Marin County Medi-Cal beneficiaries. The different programs and committees within the QM Department provide structure for the quality improvement and oversight responsibilities of the organization.

The **Admin Compliance Committee** is formed by the QM Department, Fiscal, Children Services, and DMC-ODS representatives. The HHS/BHRS Compliance Officer, Office Services Supervisors, Billing Manager, IT staff and administrative lead staff members also comprise the committee. During these meeting, stakeholders identify and discuss issues across the BHRS system that relate to the Electronic Health Record (EHR) system, the practice management system, policies and procedures, documentation processing, and other administrative tasks that are essential to providing quality services to consumers and family members.

Quality Improvement Program: The Quality Improvement program monitors the overall service delivery system with the aim of improving processes of care provision and increasing consumer and family member satisfaction and outcomes.

The Quality Improvement Committee (QIC) is a combined MH and SU services committee, and is comprised of a diverse group of stakeholders, including representatives from DMC-ODS and MHP administration and clinical programs, peers/family members, the patient rights advocate, and

contractors/community partners. QM staff is responsible for facilitating a quarterly QIC meeting to review findings from a range of compliance and quality improvement activities, including specified DMC-ODS data elements, and to obtain input into these and other areas for improvement.

BHRS has an active **Cultural Competency Advisory Board (CCAB)** which is comprised of BHRS management, BHRS line staff, contract agency providers, consumer advocates, consumers, community leaders from ethnic communities and an administrative aide to one of the county's Supervisors. There are three existing working committees within the Board: Training, Policy, and Access. The 21-member board is tasked to analyze data, review existing improvement plans, examine practice approaches and make recommendations related to policy, service delivery, staffing and training needs, and system improvements. QM staff provides data for the CCAB, and there is shared participation in both the QIC and CCAB on the management, staff and consumer level.

BHRS convenes a monthly **DMC-ODS Contractors** meeting which is comprised of management staff from the contracted provider network, County DMC-ODS staff, BHRS QM staff and Recovery Coach/Care Managers. The DMC-ODS also convenes a monthly **Clinical Provider** meeting which is facilitated by the BHRS QM Utilization Review Specialist and includes clinical line staff from County-operated and contracted provider staff.

Quality Improvement Work Plan: The intent of the Quality Improvement (QI) Work Plan is to create systems whereby data relevant to the performance of the DMC-ODS is available in an easily interpretable and actionable form. This year's plan represents the first year in the DMC-ODS and is largely focused on developing the infrastructure to track and report on metrics related to access, timeliness, quality and outcomes. The QI Work Plan will be evaluated and updated at least annually. The elements of this QI Work Plan are informed by the quality improvement requirements of the DMC-ODS performance contract.

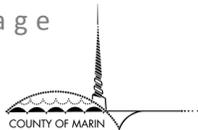
Note that some activities occurred prior to the QI Work Plan start date of April 1, 2017, though are referenced as they directly relate to issues critical to Marin's DMC-ODS implementation. These activities include: 1) Integrating the Quality Improvement Committee; 2) Integrating the 24/7 Access Line; 3) Piloting the Residential Authorization process so that the Access Line had the training and capacity to successfully authorize services by April 1, 2017; and 4) Developing updated contract language to ensure that DMC-ODS providers had contracts in place that reflected applicable requirements.

DMC-ODS QI Work Plan (April 1, 2017 – June 30, 2018)

Category	Goal	Planned Activities
Timeliness – Access to Services	By December 31, 2017, establish a baseline and system to collect, maintain and evaluate accessibility to care and waiting list information. At a minimum, timely access measures will include number of days to first DMC-ODS service at an appropriate level of care following initial request or referral, timeliness of services of the first dose of NTP services, and frequency of follow-up appointments in accordance with individualized treatment plans.	<ul style="list-style-type: none"> • Engage stakeholders and review DMC-ODS STCs to identify measures [e.g. first contact to service initiation, first dose of NTP, etc.] • Review existing data collection systems to identify any needed revisions and update accordingly [e.g. PES/Access Log, WITS] • For measures with existing data being collected, analyze to determine the baseline • Review baseline data and industry standards for timely access to care to establish performance targets • Document and distribute to DMC-ODS providers access to care performance targets. • Train relevant staff to collect and report data • Prepare language on standards and performance targets for FY 2016-17 DMC-ODS contracts
Timeliness – Authorization for Services	By April 1, 2017, there will be a system in place to review and respond to prior authorization requests for residential treatment within 24 hours of the request.	<ul style="list-style-type: none"> • Engage BHRS Access and Residential treatment provider staff to identify potential processes for submitting and reviewing authorization requests for Residential treatment • Develop the necessary forms (e.g. Treatment Authorization Request), procedures for submitting to and responding to requests (e.g. submit via secure e-fax) and update the BHRS Access Policy and Procedure to incorporate language on Residential authorization. • Update data collection systems, as needed, to track Residential treatment authorization reviews and results • Train Residential providers on the Authorization process • Pilot the Residential authorization process in Summer 2016, and incorporate any adjustments, as needed, prior to DMC-ODS Implementation.

<p>Access – 24/7 Beneficiary Access Line</p>	<p>By April 1, 2017, there will be a 24/7 beneficiary access line that provides screening, assessment and referral services in English and the prevalent non-English languages.</p>	<ul style="list-style-type: none"> • Engage in planning to transition substance use access and assessment functions provided through a contracted provider to the Mental Health Beneficiary Access Line. Specific tasks include: establishing timelines, communicating the change to stakeholders and referring partners, updating the contract agreement with the existing substance use access provider, hiring an Access Line Supervisor, creating referral forms, etc.] • Launch the Integrated BHRS Access Line in October 2015 • Provide training to BHRS Access staff, such as training in the ASAM Criteria, substance use screening and assessment, available resources/services, etc. • Update the BHRS Access Policy and Procedure and related documentation [e.g. referral forms, screening/assessment summary reports, etc.] • Continue BHRS Access staff training, as needed, and educating stakeholders and referring partners on the Integrated BHRS Access Line
<p>Access – Access Line Quality</p>	<p>By June 30, 2018, there will be a system to track and report that at least 75% of substance use treatment referrals from the Access Line were to the appropriate ASAM Level of Care.</p>	<ul style="list-style-type: none"> • Provide BHRS Access staff training and follow-up consultation on the ASAM Criteria • Update data collection systems to record referrals and recommended ASAM Level of Care • Develop procedures for: 1) reviewing a sample of DMC-ODS provider charts to compare the BHRS Access recommended ASAM Level of Care to Admitted ASAM Level of Care; 2) communicating the results to BHRS Access; and 3) engaging BHRS Access and DMC-ODS providers to identify strategies for improving accurate referrals, if needed.

<p>Access – Access Line Responsiveness</p>	<p>By December 31, 2017, establish quality and performance standards and a system to track and report on the responsiveness of the Access Line.</p>	<ul style="list-style-type: none"> • Engage stakeholders and review DMC-ODS STCs to identify measures [e.g. services provided in language of preference] • Identify performance targets and methods of measurement • Review existing data collection systems to identify any needed revisions and update accordingly [e.g. Test Call protocol, PES/Access Log, WITS] • Explore the feasibility of updating the BHRS Access Line programming to enable additional data collection [e.g. call abandonment, hold times, etc.] • Explore the feasibility of implementing a beneficiary satisfaction survey for BHRS Access
<p>Access – Afterhours Services</p>	<p>By December 31, 2017, 100% of County-operated and contracted DMC-ODS providers will have procedures in place to link beneficiaries with afterhours care.</p>	<ul style="list-style-type: none"> • Establish a 24/7 Beneficiary Access Line • Provide substance use resource and referral information to Psychiatric Emergency Service staff, as they handle afterhours calls to the BHRS Access Line • Review current procedures at contracted provider sites for linking beneficiaries with afterhours care • Develop contract language that require posting of afterhours information at sites and in admission agreements • Update the Provider Self-Audit tool to incorporate review of procedures for linking beneficiaries to afterhours care into the annual monitoring process
<p>Access –Penetration Rates</p>	<p>By March 31, 2018, establish baseline penetration rates and targets for beneficiaries for all threshold languages.</p>	<ul style="list-style-type: none"> • Partner with HHS Epidemiology to analyze and map MEDS data • Analyze MEDS data and data for beneficiaries in substance use treatment to establish baseline penetration rates • Review local beneficiary data and statewide/national penetration rates to establish penetration targets for age group, race/ethnicity and preferred language



<p>Access – Network Adequacy</p>	<p>By March 31, 2018, establish baseline measures and a system to track and report on utilization of services, and expected number, types and location of providers to meet the needs of beneficiaries.</p>	<ul style="list-style-type: none"> • Analyze beneficiary and capacity data to establish a baseline of utilization of services. • Analyze MEDS data and data for beneficiaries in substance use treatment to project sufficient network capacity needs • Identify/develop systems to track utilization of services [e.g. Interim Services list in WITS, DATAR, etc.] and train DMC-ODS providers to utilize • Develop a protocol to monitor accurate and timely submission of utilization data, and to utilize the information to adjust system capacity, as needed
<p>Access – Network Adequacy</p>	<p>By April 1, 2017, there will be all ASAM levels of care required in the DMC-ODS Waiver available to Marin Medi-Cal beneficiaries (18+).</p>	<ul style="list-style-type: none"> • Analyze MEDS and data for beneficiaries in substance use treatment to project the types and location of services needed • Review listing of Drug/Medi-Cal certified sites and identify gaps • Provide technical assistance to prospective providers to submit Drug/Medi-Cal applications • Outreach to out-of-county partners and programs to explore the feasibility of accessing services not yet available in Marin County • Identify additional service gaps and strategies for ensuring all ASAM levels of care are available for beneficiaries (18+)
<p>Quality – Workforce Development</p>	<p>By December 31, 2017, 100% of BHRS Access staff and Drug/Medi-Cal certified providers will participate in at least two trainings relevant to meeting the needs of the Medi-Cal population, such as ASAM criteria, cultural competence and/or diagnosing and serving individuals with complex needs.</p>	<ul style="list-style-type: none"> • Engage stakeholders and review the DMC-ODS STCs to identify workforce development and training needs • Develop a training plan, including topics, trainers, timeframe and required/optional participants • Provide trainings and track attendance and outcomes • Provide trainings and track attending and outcomes • Identify methods for assessing training effectiveness and ongoing workforce development and training needs • Develop language for FY 2016-17 contracts related to participating in mandatory trainings

Quality – Contracts	By July 1, 2017, BHRS will have developed contract language for use in DMC-ODS contracts requiring: 1) implementation of at least two Evidence Based Practices referenced in the DMC-ODS STCs; 2) provision of culturally competent services with access to oral interpreter services in the prevalent non-English language; and 3) access to or linkage with Medication Assisted Treatment, as clinically indicated.	<ul style="list-style-type: none"> • Review DMC-ODS STCs, State-County Intergovernmental Agreement and BHRS Policies and Procedures for language to be included in/added to contracts • Engage BHRS Compliance and County Counsel to draft updated contract language • Update any Policies and Procedures, as applicable • Distribute contract language to DMC-ODS providers
Quality – Clinical Documentation	By March 31, 2018, establish a utilization management program that monitors Drug/Medi-Cal Title 22, DMC-ODS STCs, Title 9 and applicable 42 CFR 438 requirements, including establishing medical necessity, ensuring the beneficiary is at the appropriate ASAM level of care, and the interventions are appropriate for the diagnosis and level of care.	<ul style="list-style-type: none"> • Identify functions and procedures that shall be part of the utilization management program • Identify functions and procedures that can be integrated with the existing BHRS Quality Improvement Program, and develop a work plan and timeline to integrate utilization management, as appropriate • Develop/update procedures and related documentation to monitor Title 22, Title 9, DMC-ODS and 42 CFR 438 requirements • Provide relevant training/technical assistance to DMC-ODS providers • Seek approval to hire a new licensed clinician position to support utilization management/quality improvement responsibilities

<p>Quality – Primary Care Coordination</p>	<p>By June 30, 2018, develop a system to track and report that at least 85% of clients engaged in outpatient or residential treatment will have a primary care provider at discharge.</p>	<ul style="list-style-type: none"> • Engage DMC-ODS providers to identify current and proposed practices for identifying and linking a beneficiary to primary care • Develop contract language for DMC-ODS providers for identifying and tracking whether a beneficiary has a primary care provider and if not, linking them to primary care • Update Marin WITS, as needed, to include a field(s) for recording whether a beneficiary has a primary care provider and efforts to link beneficiaries with care • Update documentation, as needed (e.g. Contractor Manual, Marin WITS training materials, Policies & Procedures, etc.) • Train DMC-ODS providers to in updated procedures and data collection requirements
<p>Quality – Mental Health Care Coordination</p>	<p>By March 31, 2018, develop a baseline, performance target and method to track the percentage of clients with a mental health diagnosis who are provided appropriate services directly or via referral.</p>	<ul style="list-style-type: none"> • Develop a methodology for determining the percentage of clients with a mental health diagnosis who are provided services (e.g. chart review of a percentage of files) • Using the determined methodology, develop any needed data collection tools/process and determine the baseline • Engage stakeholders to review the baseline data and best practices and establish an initial performance target
<p>Quality – Complaints, Grievances and Appeals</p>	<p>By June 30, 2017, develop and implement policies and procedures for addressing complaints, grievances and appeals. At a minimum, policies and procedures shall include procedures for submitting a grievance, appeal and request for state fair hearing, the timeframe for resolution of appeals and expedited appeals, the content of appeal resolution, record keeping, continuation of benefits, and requirements of state fair hearings.</p>	<ul style="list-style-type: none"> • Review existing Policies and Procedures and update accordingly to incorporate requirements from the DMC-ODS STCs and 42 CFR 438 • Develop updated forms in at least English and Spanish • Develop a system to log and address complaints, grievances and appeals • Review DMC-ODS provider policies, procedures and forms for complaints, grievances and appeals and provide technical assistance, as needed

Quality – Beneficiary Satisfaction	By December 31, 2017, establish a survey tool and process for assessing beneficiary experience.	<ul style="list-style-type: none"> • Select/develop a beneficiary satisfaction survey tool • Engage BHRS Quality Improvement and other stakeholders (e.g. UCLA Evaluators, providers) to determine the process for implementing the survey, including the frequency and location of administration • Identify the process for utilizing the beneficiary satisfaction survey data to inform continuous quality improvement efforts
Quality – Avoidable Hospitalizations	By June 30, 2018, develop a baseline, performance target and method to track the number of avoidable hospitalizations for beneficiaries engaged in DMC-ODS services.	<ul style="list-style-type: none"> • Perform a literature review to identify industry standard definitions for avoidable hospitalizations • Identify methods to track avoidable hospitalizations • Analyze FY 2015-16 or CY 2016 data to establish a baseline and establish performance targets
Quality – Outcomes	By March 31, 2018, determine baseline outcomes by modality in domains including reductions in substance use, improvements in mental and physical health, gainful employment/educational attainment, reductions in justice involvement, attaining stable housing, and improved family/social support.	<ul style="list-style-type: none"> • Analyze FY 2015/16 and/or CY 2016 CalOMS data to establish baseline beneficiary [note: field is self-report Medi-Cal beneficiary] outcomes by modality • Partner with relevant stakeholders, such as the UCLA evaluators, Quality Improvement Committee and DMC-ODS providers to identify additional key measures of interest • Identify the timeline and format for reporting beneficiary outcomes