



Color Legend: MHP SUDS/AOD MHP/SUD

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### 1. Quality Improvement Activities

Goal 1	Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.
Intervention	Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.
Measurement	Track training compliance, HIPAA, & FWA of new staff and current staff.  Current staff: Goal = or > 90% for each training. New Staff: Goal = 100%.  <b><u>Annual Required Compliance Bundle: BHRS Staff Only:</u></b> The assigned months for each training will be November  <ul style="list-style-type: none"> <li>• Annual: BHRS Compliance Mandated Training – October 2022</li> <li>• Annual: BHRS Fraud, Waste, &amp; Abuse Training – October 2022</li> <li>• Annual: BHRS: Confidentiality &amp; HIPAA for Mental Health and AOD: All BHRSv3.3 – November 2022</li> <li>• BHRS Critical incident Tracking – November 2022</li> </ul>
Responsibility	Tracey Chan Jeannine Mealey
Due Date	June 2022

Goal 2	Improve clinical documentation and quality of care.
Intervention	Maintain clinical documentation training program for all current and new staff.
Measurement	Report on trainings provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.
Responsibility	Clinical Documentation Workgroup QM Manager Jeannine Mealey Claudia Tinoco Tracey Chan

Due Date	June 2022
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Goal 3	Program staff to improve overall compliance with timelines and paperwork requirements.
Intervention	<ul style="list-style-type: none"> <li>• Maintain system-wide, yearly-audit program.</li> <li>• Send monthly emails with documentation compliance rates to all county program managers and directors to monitor teams' compliance with requirements.</li> </ul>
Measurement	Reports sent to programs Monthly
Responsibility	Jeannine Mealey Tracey Chan A.B. Limin
Due Date	June 2022

Goal 4	Maintain disallowances to less than 5% of sample.
Intervention	<ul style="list-style-type: none"> <li>• Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System.</li> <li>• Send progress reports to county programs.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• Audit 10% of SDMC System of Care client charts annually</li> <li>• Decrease disallowances, Target: Medi-Cal Audit: &lt;5%</li> </ul>
Responsibility	Jeannine Mealey QM Audit Team
Due Date	June 2022

Goal 5	Monitor staff satisfaction with QI activities & services.
Intervention	<ul style="list-style-type: none"> <li>• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.</li> <li>• Determine Optimal timing for conducting survey</li> </ul>
Measurement	<p>Percentage of staff reporting satisfied/somewhat satisfied with QM support = or &gt; 90%.</p> <ul style="list-style-type: none"> <li>• Are you satisfied with the help that you received from the Quality Management staff person?</li> <li>• Baseline: Nov 2018- <ul style="list-style-type: none"> <li>○ Yes 75.47%, Somewhat 16.98% = 92.45%, No = 3.77% Total responses 61</li> <li>○ Yes 74.29%, Somewhat 18.57% = 92.86%, No = 7.14% Total</li> </ul> </li> </ul>
Responsibility	QM Manager
Due Date	June 2022

<b>Goal 6</b>	<b>Create and update policies and procedures in BHRS for Mental Health and SUD</b>
Intervention	<ul style="list-style-type: none"> <li>• Update current policies and procedures for new managed care rules.</li> <li>• Update policy Index.</li> <li>• Maintain internal policy committee to address needed policies and procedures.</li> <li>• Retire old/obsolete policies.</li> <li>• Create new, amend existing, and retire obsolete policies</li> </ul>
Measurement	# of Policies Created # of Policies Retired # of Policies Amended
Responsibility	Policy Committee QM Manager Annina Altomari Clara Boyden – AOD Deputy Director Diana Hill – AOD Health Services Manager Mary Taylor Fullerton – AOD Clinical Services Manager
Due Date	June 2022

<b>Goal 7</b>	<b>Comply with QIC Policy and maintain voting membership that represents all parts BHRS</b>
Intervention	<ul style="list-style-type: none"> <li>• Review/amend QIC Policy as necessary.</li> <li>• Maintain QIC voting membership that represents BHRS system</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• Ensure compliance with QIC Policy: communicate with QIC members as necessary.</li> <li>• Verify and document QIC Voters that represents BHRS system by 6/2021 (continuous)</li> </ul>
Responsibility	QM Manager Annina Altomari
Due Date	June 2022

<b>Goal 8</b>	<b>Tracking Incident Reports (IR)</b>
Intervention	<ul style="list-style-type: none"> <li>• Continue to monitor and track all Incident reports.</li> <li>• Present data to Executive Team</li> <li>• Report trends and current data to QIC and leadership</li> </ul>
Measurement	Annual Reports to Executive Team and QIC
Responsibility	Tracey Chan
Due Date	June 2022

<b>Goal 9</b>	<b>Develop protocol for eligibility screening for ICC and IHBS services for youth services</b>
Intervention	<ul style="list-style-type: none"> <li>• Develop Policy and Procedures for screening for ICC/IHBS services</li> <li>• Develop a universal screening form to be completed by direct service staff</li> <li>• Develop training for direct service staff.</li> </ul>
Measurement	Completed Policy and Procedure Sample Forms
Responsibility	QM Manager Regina Moreno Ziomara Ochoa Annina Altomari
Due Date	June 2022

Goal 10	Develop a process to identify and report on Health disparities for services by site, region and population served
Intervention	<ul style="list-style-type: none"> <li>Develop to analyze disparity in services by site, region and population serviced.</li> </ul>
Measurement	Completed Policy and Procedure Sample Forms
Responsibility	QM Manager Chad Kempel Maria Lorente-Foresti
Due Date	June 2022

**2. Performance Improvement Projects (PIP)**

Goal 1	BHRS will continue work on two on-going Performance Improvement Projects (PIP) for the MHP
Intervention	<ul style="list-style-type: none"> <li>Continue with second year of current clinical and non-clinical PIPs.</li> <li>Analyze data to measure progress on the clinical and non-clinical PIPs.</li> <li>Identify additional interventions to address the identified problem(s).</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>Development of 2 PIP's that are rated as active and meet EQRO standards</li> <li>Committee Minutes</li> </ul>
Responsibility	Eri Tsujii
Due Date	June 2022

Goal 2	Identify new or revised PIP interventions for the current fiscal year.
Intervention	<ul style="list-style-type: none"> <li>Review current PIPs in light of COVID-19 and assess viability for continuation.</li> <li>Review recent DMC ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas.</li> <li>Work with the DMC ODS QI subcommittee for input into direction and selection of clinical and administrative PIPs.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>Meeting Minutes</li> <li>Developed PIPs</li> </ul>
Responsibility	Clara Boyden Diana Hill Mary Fullerton QM Manager Eri Tsujii Eliseo Amezcua Desirae Miller
Due Date	June 2022

### 3. Utilization and Timeliness to Service Measures

Goal 3	Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client)
Intervention	<ul style="list-style-type: none"> <li>• Include data for BHRS and contract agencies serving SDMC clients.</li> <li>• Report to Executive Team and QIC, timeliness data annually.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• % of clients being offered or receiving an assessment appointment 10 days from request to first appointment.</li> <li>• % of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service.</li> <li>• Track Timeliness from assessment to first treatment appointment</li> <li>• Track Timeliness from request for Urgent appointment to actual encounter. (48 hrs for non-authorized service; 96 hrs for pre-authorized services)</li> </ul>
Responsibility	QM Manager Eri Tsujii Chad Kempel
Due Date	June 2022

Goal 4	Develop reporting capability for disaggregating data for Youth and Foster Care for tracking medication use. (SB1291)
Intervention	<p>Develop a process for capturing data for the following HEDIS measures</p> <ul style="list-style-type: none"> <li>○ Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)</li> <li>○ Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)</li> <li>○ Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)</li> <li>○ Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)</li> </ul> <p>Revise JV 220 oversight process to incorporate these measures Identify and update policies as needed</p>
Measurement	Creation of a protocol and process for oversight Updated policies
Responsibility	Quality Manager Eri Tsujii Chad Kempel
Due Date	June 2022

### 4. Access and Call Center

Goal 1	Improve customer service and satisfaction for San Mateo County Access Call Center
Intervention	<ul style="list-style-type: none"> <li>• Review and Revise, as needed, standards for answering calls</li> <li>• Provide training for Optum call center staff on standards for answering calls.</li> </ul>
Measurement	Test calls and call logs 90% test call rated as positive
Responsibility	Selma Mangrum Tracey Chan

	Claudia Tinoco
Due Date	June 2022

Goal 2	Monitor 24/7 access to care through Call Center and Optum. 100% of calls will be answered. 100% of test callers will be provided information on how/where to obtain services if needed.
Intervention	<ul style="list-style-type: none"> <li>• Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services.</li> <li>• Make 1 test call in another language and 1 for AOD services</li> <li>• QM will report to call center the outcome of test calls</li> </ul>
Measurement	<p>95 % or more calls answered  95 % or more test calls logged.  100% of requested interpreters provided  75% of call will be rated satisfactory (Caller indicated they were helped)</p>
Responsibility	Tracey Chan
Due Date	June 2022

**5. Monitoring Grievances, Notice of Adverse Benefits Determination and Appeals**

Goal 1 (required)	Grievances will be resolved within 90 days of receipt of grievance and appeals within 30-day timeframe, expedited appeals will be resolved within 72 hours after receipt of expedited appeal in 100% of cases filed.
Intervention	Grievance and appeals regularly addressed in Grievance and Appeal Team (GAT) Meeting.
Measurement	<ul style="list-style-type: none"> <li>• Annual reports on grievances, appeals, and State Fair Hearings to QIC.</li> <li>• Annual report with % of issues resolved to client/family member fully favorable or favorable.</li> <li>• Annual report with % grievances/appeals resolved within 90/30 days.</li> </ul>
Responsibility	GAT Team
Due Date	June 2022

Goal 2	Ensure that providers are informed of the resolution of all grievances and given a copy of the letter within 90 days of the grievance file date. This will have documented in the GAT file 100% of the time.
Intervention	Audit the grievance resolution folders quarterly to ensure that there is evidence that providers have been informed of the resolution.
Measurement	80% of providers will receive the grievance resolution at the time the client is informed. This will be documented in the GAT file. (baseline 50%)
Responsibility	GAT Team Annina Altomari Claudia Tinoco
Due Date	June 2022

Goal 3	Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.
Intervention	<ul style="list-style-type: none"> <li>• GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required.</li> </ul>

	<ul style="list-style-type: none"> <li>• Train BHRS staff and contractors on new grievance procedures</li> <li>• Track compliance with new Grievance and NOABD policy</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• # of successfully issued NOABDs</li> <li>• # of Appeals completed with outcome % for favorable outcomes for client</li> <li>• # of successfully completed Grievances</li> </ul>
Responsibility	Tracey Chan GAT Team
Due Date	June 2022

Goal 4	Decision for client's requested Change of Provider within 2 weeks
Intervention	<ul style="list-style-type: none"> <li>• Change of Provider Request forms will be sent to Quality Management for tracking.</li> <li>• Obtain baseline/develop goal.</li> </ul>
Measurement	Annual review of requests for change of provider.
Responsibility	Tracey Chan
Due Date	June 2022

**6. Client Satisfaction and Culturally Competent Services**

Goal 1	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.
Intervention	Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)
Measurement	<ul style="list-style-type: none"> <li>• Notify programs, according to MHP/ODS requirements, consumer survey results</li> <li>• Presentation and notification of the results yearly.</li> </ul>
Responsibility	QM Manager Scott Gruendl Diana Hill
Due Date	June 2022

Goal 2	Improve cultural and linguistic competence
Intervention	"Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.
Measurement	<ul style="list-style-type: none"> <li>• 100% of New staff will complete in-person "Working Effectively with Interpreters in Behavioral Health"</li> <li>• 75% of Existing staff who have taken the initial training will take the refresher training at lease every three years.</li> </ul>
Responsibility	Maria Lorente-Foresti Doris Estremera Claudia Tinoco
Due Date	June 2022

Goal 3	Improve Linguistic Access for clients whose preferred language is other than English
Intervention	Services will be provided in the clients preferred language
Measurement	% of clients with a preferred language other than English receiving a service in their preferred language

Responsibility	Doris Estremera Maria Lorente-Foresti Chad Kempel Claudia Tinoco
Due Date	June 2022

<b>Goal 4</b>	<b>Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.</b>
Intervention	All staff will complete mandatory training on cultural humility
Measurement	65% of staff will complete the Cultural Humility training.
Responsibility	Doris Estremera Erica Britton Desirae Miller Claudia Tinoco
Due Date	June 2022

**7. DMC-ODS Pilot**

<b>Goal 1</b>	<b>Develop and implement a Youth SUD Assessment tool.</b>
Intervention	Work with clinical consultants and youth SUD treatment providers to develop an ASAM-based SUD Assessment tool specific to youth ages 12-17 and 18-21. Train contracted providers on its usage and implement in Avatar EMR.
Measurement	<ul style="list-style-type: none"> <li>• The development of a youth SUD Assessment tool.</li> <li>• Import tool into Avatar.</li> <li>• Training and implementing with providers serving youth 17 and under, and with providers serving young people 18-21.</li> <li>• % of client charts audited with a completed Youth SUD Assessment tool.</li> </ul>
Responsibility	Diana Hill Christine O’Kelly Desirae Miller IT Manager Mary Taylor Fullerton Stephanie Coate Eliseo Amezcua
Due Date	June 2022

<b>Goal 2</b>	<b>Develop and Implement a Youth Health Screening Tool</b>
Intervention	Work with clinical consultants, youth SUD treatment providers, and medical directors to develop a youth health screening tool specific to youth ages 12-17 and 18-21.
Measurement	<ul style="list-style-type: none"> <li>• The development of a youth health screening tool.</li> <li>• Import into Avatar.</li> <li>• Training and implementing with providers serving youth 17 and under, and with providers serving young people 18-21.</li> <li>• % of client charts audited with a completed youth health screening tool.</li> </ul>
Responsibility	Diana Hill Christine O’Kelly Desirae Miller IT Manager



	Mary Taylor Fullerton Stephanie Coate Eliseo Amezcua
Due Date	June 2022

<b>Goal 3</b>	<b>Care Coordination:</b> Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.
Intervention	<ul style="list-style-type: none"> <li>ASAM evaluation and treatment referral completed prior to residential detox discharge.</li> <li>Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li># of Res Detox discharges</li> <li>% of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge</li> <li>% of clients re-admitted to detox within 30 days</li> </ul>
Responsibility	Eliseo Amezcua Giovanna Bonds Melina Cortez Mary Taylor Fullerton
Due Date	June 2022

<b>Goal 4</b>	<b>Monitor Service Delivery System:</b> Increase treatment provider compliance with DMC-ODS documentation regulations.
Intervention	<ul style="list-style-type: none"> <li>Design and implement a plan for County review of SUD treatment provider Medi-Cal beneficiary charts to allow remote monitoring for COVID-19 safety practices.</li> <li>Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts.</li> <li>Pilot Audit with each of the DMC-ODS providers</li> </ul>
Measurement	# of charts reviewed for each DMC-ODS providers
Responsibility	Diana Hill Desirae Miller Christine O'Kelly
Due Date	June 2022

<b>Goal 5</b>	<b>Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)</b>
Intervention	<ul style="list-style-type: none"> <li>Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement</li> <li>Develop of an annual Training Plan that incorporates Evidenced-Based Practices.</li> <li>Implement training plan</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>Copy of training plan protocol</li> <li># of trainings offered</li> </ul>
Responsibility	Diana Hill Mary Fullerton

	Christine O'Kelly
Due Date	June 2022

<b>Goal 6</b>	<b>80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs.</b>
Intervention	<ul style="list-style-type: none"> <li>• Implement Training Plan for provider clinicians, counseling and supervisory staff.</li> <li>• Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs.</li> <li>• Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs.</li> <li>• FY 18-19 performance is 28%</li> </ul>
Responsibility	Diana Hill Christine O'Kelly Erica Britton
Due Date	June 2022

<b>Goal 7</b>	<b>All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually.</b>
Intervention	Implement a Training Plan for provider clinicians.
Measurement	<ul style="list-style-type: none"> <li>• % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually.</li> <li>• FY 17/18 baseline is 35%.</li> <li>• FY 18/19 = 55%.</li> </ul>
Responsibility	Diana Hill Christine O'Kelly Mary Taylor Fullerton
Due Date	June 2022

<b>Goal 8</b>	<b>Monitor Service Delivery System:</b> Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards
Intervention	<ul style="list-style-type: none"> <li>• Implement Avatar SUD enhancements to collect data for measures.</li> <li>• Identified reports are created in Avatar</li> <li>• Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• List of reports developed that meet reporting requirement for DMC-ODS</li> </ul>
Responsibility	Clara Boyden Diana Hill Mary Fullerton Kim Pijma (contract monitor) Dave Williams
Due Date	June, 2022

<b>Goal 9</b>	<b>Timeliness of first contact to first appointment:</b> BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs.
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Intervention	<ul style="list-style-type: none"> <li>• Develop a process to analyze timeliness data quarterly for: <ul style="list-style-type: none"> <li>○ Outpatient SUD services (excluding Opioid Treatment Programs)</li> <li>○ Opioid Treatment Programs</li> </ul> </li> <li>• Share data for BHRS programs and contractor agencies serving DMC-ODS clients</li> <li>• NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment.</li> <li>• Report timeliness data annually with NACT Submission on April 1, 2022.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.</li> <li>• % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard)</li> <li>• % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment. (State measure/reference only; data not reported as County standard is more stringent).</li> </ul>
	Chad Kempel Diana Hill Mary Taylor Fullerton Matt Boyle Diana Campos Gomez
Due Date	June 2022

<b>Goal 10</b>	<b>Comply with SABG requirements for Pre-Award Risk Assessments</b>
Intervention	Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.
Measurement	% of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.
Responsibility	Diana Hill Christine O'Kelly Desirae Miller
Due Date	June 2022

<b>Goal 11</b>	<b>Care Coordination:</b> Care will be coordinated with physical health and mental health service providers.
Intervention	<ul style="list-style-type: none"> <li>• Implementing contract standard for physical health and mental health care coordination of services at the provider level</li> <li>• Audit charts to monitor compliance with standard</li> <li>• Develop system-wide coordination meeting with providers</li> <li>• Analyze TPS client survey data to monitor client satisfaction with care coordination</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• % of audited client charts which comply with DMC ODS physical health examination requirements.</li> <li>• % of MD reviewed physical health examinations with a subsequent referral to physical health services.</li> <li>• % of audited client charts with a completed ACOK screening</li> <li>• % of positive AC OK Screens with a subsequent referral to mental health services.</li> </ul>

Responsibility	Diana Hill Christine O'Kelly Desirae Miller Eliseo Amezcua Mary Fullerton
Due Date	June 2022

Goal 12	Assess client experience of SUD services through annual survey.
Intervention	<ul style="list-style-type: none"> <li>• Conduct annual TPS Survey with all provider/beneficiaries</li> <li>• Analyze TPS data and share findings with providers and stakeholders.</li> </ul>
Measurement	<ul style="list-style-type: none"> <li>• % percent of clients surveyed who indicate “staff were sensitive to my cultural background (race, religion, language, etc.)” on an annual treatment perceptions survey. <ul style="list-style-type: none"> <li>○ FY 19/20: 88.8 % (N=228) – baseline</li> </ul> </li> <li>• % of clients surveyed who indicated “I chose my treatment goals with my provider’s help” as determined by the annual SUD treatment perception survey. <ul style="list-style-type: none"> <li>○ FY 19/20: 90.8 % (N=228) – baseline</li> </ul> </li> <li>• % of clients surveyed who indicated, “As a direct result of the services I am receiving, I am better able to do the things that I want to do” as determined by the annual SUD treatment perception survey <ul style="list-style-type: none"> <li>○ FY 19/20: 90.8% (N=228) - baseline</li> </ul> </li> </ul>
Responsibility	Diana Hill Christine O'Kelly Desirae Miller Mary Fullerton
Due Date	June 2022