San Mateo County Behavioral Health & Recovery Services
Quality Improvement Work Plan July 2014-June 2015

END of Year Review
June 30 2015

Requirement: Monitor Quality Improvement Activities (1-3)

Goal 1	**Monitor staff satisfaction with QI activities.**
Intervention	Perform Annual Staff Satisfaction Survey with Quality.
Measurement	Goal-Percentage of staff reporting Satisfied/Somewhat Satisfied with QM support = or > 90%.
Responsibility	Jeannine Mealey
Status/Dates	Goal Met for FY14-15 Next due Nov 2015
Year End Review	There was improvement in overall satisfaction from last survey for 73% Satisfied/ 23% Somewhat Satisfied in Jan 2014, to 83% Satisfied/ 16% Somewhat Satisfied in Dec 2014. As in the past few years, the Satisfaction Survey for Quality has been very successful in the number of participants who have answered the survey and the positive upswing in the rating of the question regarding satisfaction with Quality Management support over this time frame. We will continue to use the Satisfaction Survey in the years to come. **Satisfaction Survey Responses Dec 2014** **Are you satisfied with the help that you received from the Quality Management staff person?** Yes 83%(62) (14% Improvement), Somewhat 16%(12) Dec 2014 –Total responses 104. **QM Team was supportive and tried to help me**. Always 69%(49) Most of the Time 21%(15) Sometime 6%(4) No 4% (3) **QM Team responded in a timely fashion**. Always 59%(44) Most of the time 28%(21) Sometime 11% (8) No 3% (2) **QM Team was clear and provided useful help**. Always 64%(47),Most of the Time 19%(14), Sometime 15% (11), No 1% (1)

Goal 2	**Improve attendance and active participation in QIC.**
Intervention	Continue same, ongoing. Specific constituents recruited: Added one family member and one client with Lived Experience, PES Manager, and Health Plan of San Mateo QI/UR staff (last ended d/t turnover, will recruit new HPSM staff). Several AOD staff now attend, including supervisors, analysts and members of New Medication-Assisted Treatment team. Analyze attendance patterns. QM liaises with various committees and others to schedule reports on an annual basis.
Measurement	Created Excel file to track attendance. We record roles of all participants. These include members of all groups: Client, Family, OCFA, Management, Programs - Youth, Adult, Senior, Contractors, Medical Director, Training Committee, Cultural Committee, AOD, Co-Occurring Steering Committee.

	Through this we have identified underrepresented constituencies and have targeted recruitment. Have begun scanning Sign-in Sheets to make attendance easier to document.
Responsibility	Jeannine Mealey Holly Severson Keith Clausen
Status/Dates	In progress – Partially met. Increased attendees in past several meetings: Jan 2015- 23; March 2015 - 21; May 2015 – 28. Recruiting additional members. Continue to recruit in bimonthly newsletter (Wellness Matters) on internet; also recruiting within BHRS, with assistance of managers.
Year End Review	Attendance is up quite significantly in 2015, due to sustained efforts to recruit. This includes a 2nd client who attends every meeting, and a 2nd family member. There are still constituencies we'd like to have better representation of and we will continue our efforts in FY15-16 (for instance: line staff, contractors and another consumer/client especially a Transitional Age Youth). In previous reviews, we have worked to invite more participants from county teams to present and it has been fairly successful. We are working to improve communication with BHRS initiatives teams to provide periodic check-ins. We also solicit outside agency presentations. We continue to offer telecommunications options for individuals who wish to join us if they are not able to be in attendance in person.

Goal 3	**Update policies and procedures as needed**
Intervention	Develop new policies and procedures, amend existing policies, includes the integration and addition of AOD policies. New process in FY 15-16 will be to vote online in Survey Monkey to more easily record votes.
Measurement	*Evaluate existing HIPAA and chart related policies and procedures and update for AOD implementation to account for 42 CFR, Part 2.* All policy changes and introduction of new policies are recorded in QIC Minutes and are updated in the BHRS Policy Index.
Responsibility	Jeannine Mealey Holly Severson Keith Clausen Youth & Adult Policy Committees
Status/Dates	Ongoing Three (3) new policies and 1 procedure were developed in FY14-15 and several more policies amended/revised: 14-01 Implementation of Cultural Competency Standards NEW 7/9/14 14-02 Family Inclusion Policy NEW 7/9/14 14-03 Selection of Evidence Based and Community Defined Practices NEW (email vote) 7/9/14 09-01 Animal Assisted Therapy and Animal Assisted Activities, AMENDED 1/14/15 93-06 Psychiatry Residency Program Procedures for Resolving Performance and Conduct Problems, AMENDED 1/14/15 00-05 Electroconvulsive Therapy, AMENDED 1/14/15 ADHD Protocol for Adults Seeking BHRS Services REPORTED AT QIC 1/14/15 (Per Medical Director) 97-10 Nurse Practitioner Policy Attachment AMENDED (email vote) 5/22/15 99-08 Referral Procedures for Non-SMMC Inpatient Psychiatric Care AMENDED (email vote) 6/26/15
Year End	Quality Management and QIC have continued to review, amend and develop

Review	new policies as needed to keep up with changing demands and regulations. Our current protocol to review and update policies on a regular basis continues. AOD policies are being integrated into existing BHRS policies. In coming QIC's and email votes we will be presenting these policies for review and approval.

Requirement: **Monitoring the MHP's Service Delivery System (4a)**

Goal 1	**Improvement related to clinical practice.** **Improve treatment plan compliance rates.** **Reduce Audit Disallowance to less than 5%**
Intervention	Develop online and live compliance training. Develop and implement documentation and compliance plan training for all Staff. Send monthly reports to management team to inform of treatment and assessment compliance rates.
Measurement	Medi-Cal Audit 2014 results approx. 86% disallowance. 90% Staff will complete compliance training yearly. 100% new staff will complete training before using EMR.
Responsibility	Pat Miles Paul Sorbo Kacy Carr Keith Clausen Jeannine Mealey Doreen Avery
Status/Dates	Goal Met in 2014- Compliance Training was developed. Goal Met 2015 - Compliance training was required for all BHRS staff in Aug 2014- 93% of staff completed this requirement.
Year End Review	**Goal met:** Quality Management developed and implemented an online compliance training.

Goal 2	**Improve compliance with HIPAA training mandate.**
Intervention	Staff will complete online HIPAA Training at hire and yearly.
Measurement	Track compliance to have 100% of new staff take HIPAA before receiving access to EMR and track yearly requirement. 90% staff to complete the HIPAA update training yearly. Due Oct 2015.
Responsibility	Lilian Montalvo
Status/Dates	Met FY14-15- Yearly HIPAA Training update was assigned to all BHRS staff in Oct 2014, 98% completed.
Year End Review	**Goal Met:** 98% of staff completed yearly HIPAA training in 2014.

Goal 3	**Improvement related to clinical practice.** **Improve basic documentation. Improve quality of care.**
Intervention	Develop and implement clinical documentation training program for all current staff and new staff. Implement Self-Audit Check List.
Measurement	Track compliance with goal of 100% of all current staff complete training program by Oct 2014. All new staff complete training program before getting Avatar Access.
Responsibility	Clinical Documentation Workgroup Holly Severson Lilian Montalvo Jeannine Mealey Keith Clausen
Status/Dates	Goal Met in 2013-2014- Documentation Training Requirement Implemented. The management team agreed to assign all clinical staff- anyone that bills- to a series of online training. This new requirement has been implemented as of May 2014. In Progress- Current Staff completing the series of five documentation trainings- 68% of current staff met this requirement.
Year End Review	In November 2014, the QM supervisor sent reminders to supervisors for staff that have not completed the required trainings. This goal is still in progress and will be continued in FY15-16.

Goal 4	**Standardize audit review process across system of care utilizing the Documentation at a Glance Report and other reports by program staff to improve overall compliance with timelines and paperwork requirements.**
Intervention	QM to attend Unit Chief meetings to train supervisors on auditing. QM to hold supervisor training in August 2014. Implement self-audit program
Measurement	Will establish audit frequency and the number of charts to be audited quarterly.
Responsibility	Jeannine Mealey Keith Clausen QM Team eCC Team
Status/Dates	Goal Met in FY14-15
Year End Review	BHRS successfully implemented an internal audit program in 2014. 10% of all charts were audited. Supervisors were trained in auditing charts, are conducting chart audits monthly, and are utilizing Documentation at a Glance reports weekly to improve compliance with standards. The management team is monitoring process and sending reports to unit chiefs weekly with feedback about progress on up-to-date documentation. This was implemented however errors have been found in the reports coming out of our Avatar System. IT was informed of these errors. Update Jan 2015: Due to the inconsistences in the program supervisors ability

	to audit charts it was determined by the BHRS Executive team that external auditors would be utilized. In February three auditors were identified and trained. They have been assigned 10% of County Charts to audit. As of June 30, 2015 approximately 2% of charts were audited; no summary report is available at the time of this report.

Goal 5	**Maintain disallowances to less than 5% of sample.**
Intervention	Monitor adherence to documentation standards/completion thru AVATAR System. Implement Chart Audit Program.
Measurement	Will establish audit frequency and number of charts to be audited quarterly. Decrease disallowances to: EPSDT: <5%, Medi-Cal: <5% Percentage of charts audited = 10%
Responsibility	Kacy Carr Paul Sorbo Keith Clausen QM Team
Status/Dates	Conducted system-wide Chart Audit Program in FY14/15.
Year End Review	Goal Met BHRS has successfully implemented an internal audit program in 2014. 10% of all charts will be audited yearly. Supervisors were trained in auditing charts. In 2014, 244 charts were audited by San Mateo County- 113 resulted in self-disallowances. The management team is monitoring the process and sending reports to unit chiefs weekly with feedback about progress on up-to-date documentation.

Goal 6	**PIP 1**
Intervention	Clinical Performance Improvement Project. Long-acting Injectable (LAI) Naltrexone for Participants with Alcohol Use Disorders Pilot is addressing BHRS clients with problematic alcohol abuse and/or dependence, severe mental illness and multiple ER/PES/Detox visits in which most conventional treatments have failed. Objectives include: reduction of the participants' number of ER/PES/Detox visits, the number of standard drinks per day and their urge to drink.
Measurement	Performance Indicators are the Number or ER/PES/Detox visits, standard measure of the alcohol cravings and the number of drinks per day, pre and post intervention.
Responsibility	Lilian Montalvo Keith Clausen Jeannine Mealey Bob Cabaj ARM Team

Status/Dates	Reported to QIC April 2015 Presented to EQRO in February 2015. PIP was passed by EQRO.
Year End Review	Goal Met We created a workgroup to focus on developing the PIP: We met on: 8/15/14, 9/12/14 and 10/10/14- The attendees were: Bob Cabaj (Medical Director), Barbara Liang Pharmacy Manager), Clara Boyden (AOD Manager), Cynthia Chatterjee- MD Interface, Hung-Ming Chu (Dept. Medical Director), Jeannine Mealey & Lilian Montalvo (QM), Melinda Parker (ARM), Rukhsana Siddiqi (pharmacy contractor)

Goal 7	**PIP 2**
Intervention	System Performance Improvement Project. Same Day Assistance process rolled out to Adult Services at County Regional Clinics. Central Assessment team dispersed to regional clinics, new & returning adults calling for services get brief phone assessment and those that may qualify for clinic-delivered services are advised to drop in that day or the next to local clinic for further assessment/treatment. Broad goals are to improve timeliness of service delivery in order to improve client satisfaction and client outcomes. Target objectives measured are: 50% increase in adult clients receiving 1st service within 7 days and 50% decrease in adult clients receiving no service within 90 days of calling. Focus on all adult clients referred for regional services and, as a subset, Spanish speaking population.
Measurement	Baseline (year before PIP rollout): 7 day measure: 25% of full sample, 26% Spanish subset. 90 day measure: 25% full sample, 17% Spanish subset. See year-end review below for post-intervention results.
Responsibility	Holly Severson Keith Clausen Jeannine Mealey Patrick Miles Dave Williams and Associates (Database/Statisticians)
Status/Dates	Goal for 7 day measures met, in fact, greatly exceeded. Goals for 90 day measure not fully met.
Year End Review	Goal Met BHRS has made significant improvement in FY14-15 and FY13-14 for timeliness to first appointment for all clients and Spanish speaking ones. 65% of adult clients had their first appointment within 7 days of calling the ACCESS call center. This is a 168% improvement over baseline of 25%. 66% of adult Spanish-Speaking clients had their first appointment within 7 days of calling the ACCESS call center. This is a154% improvement over baseline of 26%. For 90 day measure, 15.05% of all adult clients had no service within 90 days. This was a 39.8% improvement. For 90 day measure, 16.3% of adult Spanish speaking clients had no service within 90 days. This was a 4.1% improvement.

Requirement: **Monitoring the Accessibility of Services (4b)**

Goal 1	**Timeliness of routine mental health appointments.** **Client will have a second appointment within 14 days of their first (initiation).**
Intervention	Program staff will review their initiation rate and develop plans to meet the goal of 65% Initiation (2nd appointment within 14 days, of 1st).
Measurement	Baseline (year before PIP rollout): 7 day measure: 25% of full sample, 26% Spanish subset. 90 day measure: 25% full sample, 17% Spanish subset. Baseline initiation date is for 12/1/2012 to 11/30/2013 is 54% of client met the goal of a receiving a second service within 14 days if the 1st visit.
Responsibility	Pat Miles Dave Williams
Status/Dates	In Progress
Year End Review	Not Met In March 2015 a report was created to allow BHRS to measure initiation rate. The management team reviewed the report finding. They have not yet determined how to effectively utilize this data. This goal will be extended to next year.

Goal 2	**Timeliness of services for urgent conditions.** **Client will be seen within 7 days of discharge from PES.**
Intervention	90% or more of clients referred to outpatient services will receive an appointment within 7 days of leaving PES.
Measurement	Review of percentage of clients receiving a second appointment within timeline compared to baseline.
Responsibility	Pat Miles Dave Williams
Status/Dates	Not Met
Year End Review	BHRS is in the process of creating a report to monitor this indicator. This report has not yet been created. This goal will be continued to next year.

Goal 3	**Monitor access to after-hours care. 100% of calls will be answered. 100% of test calls to provide information on how/where to obtain after hours services.**
Intervention	Make 3 test calls monthly to 24/7 toll-free number. Develop new Avatar Call Log Tracking System.
Measurement	% of calls answered % of test calls logged. % of interpreter used, if needed. Baseline- Date Range: June- December 2013 Calls Answered/Total Calls Made: 21/24 Calls Logged/ Calls Answered: 9/21 Interpreter Used/Total Non-English Calls: 5/7
Responsibility	QM Staff OCFA- Client/Family Members
Status/Dates	Ongoing

Year End Review	In Progress Great improvements were made in this measure in 2014. BHRS has developed a report in Avatar to allow for the call log to be generated automatically from the EMR. In the past this was on paper. In the last set of test calls, all calls were logged.

Requirement: **Monitoring Beneficiary Satisfaction (4c)**

Goal 1	**Complete resolution of grievances/appeals within 30/45 day timeframes in 100% of cases filed, with 80% fully favorable or favorable.**
Intervention	Grievance and appeals will be addressed in GAT Meeting.
Measurement	Annual reports on grievances, appeals, and State Fair Hearing to QIC. Annual report with % of issues resolved for client/family member fully favorable or favorable. Baseline FY 13-14 (July-Dec):29 of 30 favorable or fully favorable = 97%. Annual report with % grievances/appeals resolved within 29/30 days.
Responsibility	OCFA staff
Status/Dates	Met in 2014/2015
Year End Review	Goal Met. All grievances were resolved within the required timeline.

Goal 2	**Increase staff, client and family understanding of Patients' Rights issues.**
Intervention	Continue same, ongoing: Deliver reports to QIC from Patients' Rights Office. Provide educational outreach throughout the system.
Measurement	Annual reports to QIC about Patients' Rights issues. Conduct four educational sessions for families, clients and staff. Conduct one routine monitoring per quarter for each of three designated facilities and provide educational sessions for treatment staff in response to issues identified by routine monitoring or as requested.
Responsibility	Marshall Gonzalo (Patients' Rights Advocate), Holly Severson
Status/Dates	In Progress
Year End Review	Not Met

Goal 3	**Request of Change of Provider occurs within 30 days.**
Intervention	Change of Provider Request forms will be sent to quality management for tracking. Obtain baseline/develop goal.
Measurement	Annual review of requests for change of provider.
Responsibility	Keith Clausen Jeannine Mealey
Status/Dates	Goal in Progress
Year End Review	Partially met.

	A database was created to track change of provider requests. This goal will continue next year.

Goal 4	**Providers will be informed of the results of the beneficiary/family satisfaction surveys bi-annually.**
Intervention	Develop communication plan to inform providers/staff of the results of each survey in a timely fashion.
Measurement	Completion of notification twice a year.
Responsibility	Pat Miles Dave Williams
Status/Dates	In Progress
Year End Review	Partially Met BHRS conducted the satisfaction survey two times in 2014. The summary is being developed to send to providers.

Goal 5	**90% of clients will be provided services in preferred languages as evidenced in progress notes.**
Intervention	For all non-English speaking clients, at least one service will be provided in the client's preferred language as indicated in progress notes. 95% of clients will have a preferred language indicated in their chart. Report to be developed and sent to programs with current rates and goals. Make progress note language field required in Avatar in May 2014.
Measurement	% clients who have a preferred language indicated in their chart. % of progress notes where the language is indicated. Baseline 62% non-English speaking clients had at least one service in their preferred language as indicated in progress notes time period - 4/1/11 thru 3/31/12.
Responsibility	Pat Miles Dave Williams Jeannine Mealey Keith Clausen
Status/Dates	In Progress
Year End Review	Not Met. We have developed an improved electronic progress note in the EMR that requires staff to answer this question for every service. Due to a technical problem in our EMR we have not implemented the new progress note yet but plan to in 2015.