San Mateo County Behavioral Health & Recovery Services
Quality Improvement Work Plan July 2017-June 2018 (Start July 2017)
Year End Review June 30, 2018

Requirement: Monitor Quality Improvement Activities (1-3)

Goal 1	Monitor staff satisfaction with QI activities & services.
Intervention	Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management department.
Measurement	Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%. Last Measurement Satisfaction Survey Responses Nov 2016 Are you satisfied with the help that you received from the Quality Management staff person? Baseline: Nov 2016- Yes 78%, Somewhat 16% = 94% Total responses 110.
Responsibility	Jeannine Mealey
Due Date	November 2017
Status	Met/Continued next year
Year End Review	Goal was met for the year. The survey was conducted in December 2017, the response rate was low due to several other surveys being sent to staff at the same time. Measurement Dec 2017- Yes 58%, Somewhat 36% = 94% Total responses 70 50% of responders requested that QM develop new Documentation Guides in 2018, the highest rated item was QM Online trainings. This was the item most people found helpful.

Goal 2	Create and update policies and procedures. This includes AOD/Organized Delivery System (ODS) Contract requirements.
Intervention	Update current policies and procedures for new managed care rules. Update policy Index. Collaborate with AOD management for integration and establishment of required AOD policies, identify and create policies. Maintain internal policy committee to address needed policies and procedures. Retire old/obsolete policies.
Measurement	Continue to amend and create policies as needed. QIC Survey Monkey for policy votes implemented in FY16-17.
Responsibility	Policy Committee: Jeannine Mealey Kathy Koeppen Marcy Fraser Holly Severson Claudia Tinoco

	Clara Boyden, AOD Manager Diana Hill, AOD Manager Sheryl Uyan, AOD Supervisor (WOC)
Due Date	June 2018
Status	Met/Continued next year
Year End Review	New policies created throughout FY 17-18 (and ongoing) This includes compliance policies and MH/AOD policies Old policies amended or obsoleted as needed Policy Index updated monthly QM Policy Committee continues to meet weekly via Skype to manage entire policy process that was begun in 12/2016. Detailed tracking spreadsheet (6/2017) continues to be used. Survey Monkey policy votes to QIC voting members as needed Policies written or revised, signed and completed include: 09-09 5150 Designated Facilities 94-19 Dispensing Policy-Registered Nurse 93-07 72 Hour Hold/5150 Policy and Procedure 93-08 Duty to Protect and Duty to Warn Potential Victims 93-11 Critical Incident Reporting 01-01 Cell Phone Usage 17-01 Security of Information (PI/PII/PHI) and Electronic Health Record (HER)< and Electronic Signatures & Terminations 17-02 Delegation oversight & Audit Program 17-03 Access to Services for Organized Delivery System (ODS) for Substance Use Disorder Services (SUD) 18-01 Cultural Humility, Equity, and Inclusion Framework; Implementation of CLAS Standards 18-02 Network Adequacy Standards for Mental Health(MHPs) and Drug Medical Organized Delivery System (DMC_ODS) Services 18-03 Utilization Management Program

Goal 3	Comply with QIC Policy and maintain voting membership that represents all parts BHRS
Intervention	1) Review/amend QIC Policy as necessary. 2) Maintain QIC voting membership of approx. 30 that represents BHRS system
Measurement	1) Ensure compliance with QIC Policy: communicate with QIC members as necessary. 3) Verify and document 30 QIC Voters that represents BHRS system by 6/2018 (continuous)
Responsibility	Jeannine Mealey Holly Severson
Due Date	June 2018
Status	Partially Met/Continued next year
Year End Review	QIC policy was reviewed and found to be current. QIC membership is currently at 26 members. At various points in time attendance has fluctuated. New BHRS Director and QM Manager are committed to diversifying and recruiting new members. Two new contractors, a clinician, and two new supervisor/managers joined. One client currently attends; our goal is to have three or more regular attendees with lived

	experience (family/clients).

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

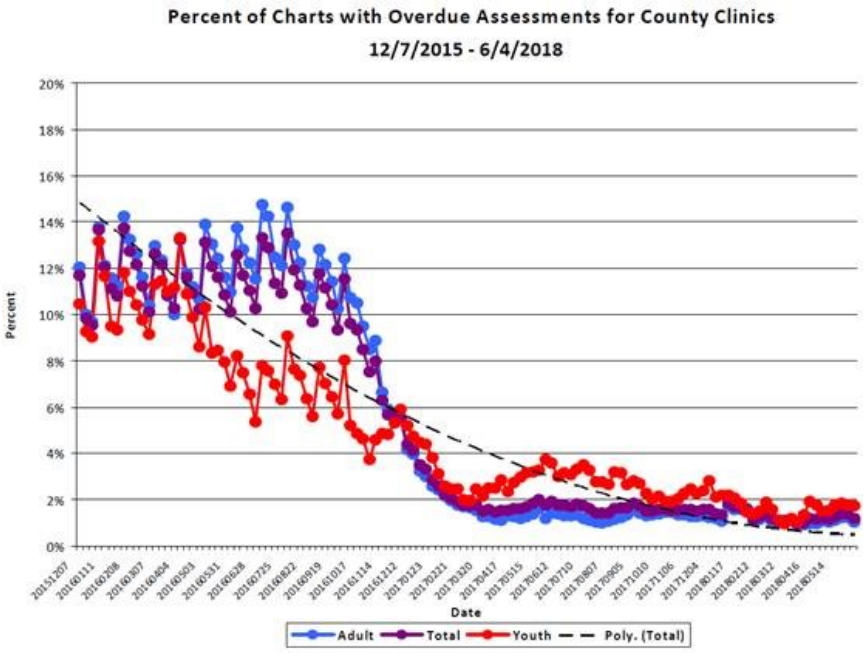
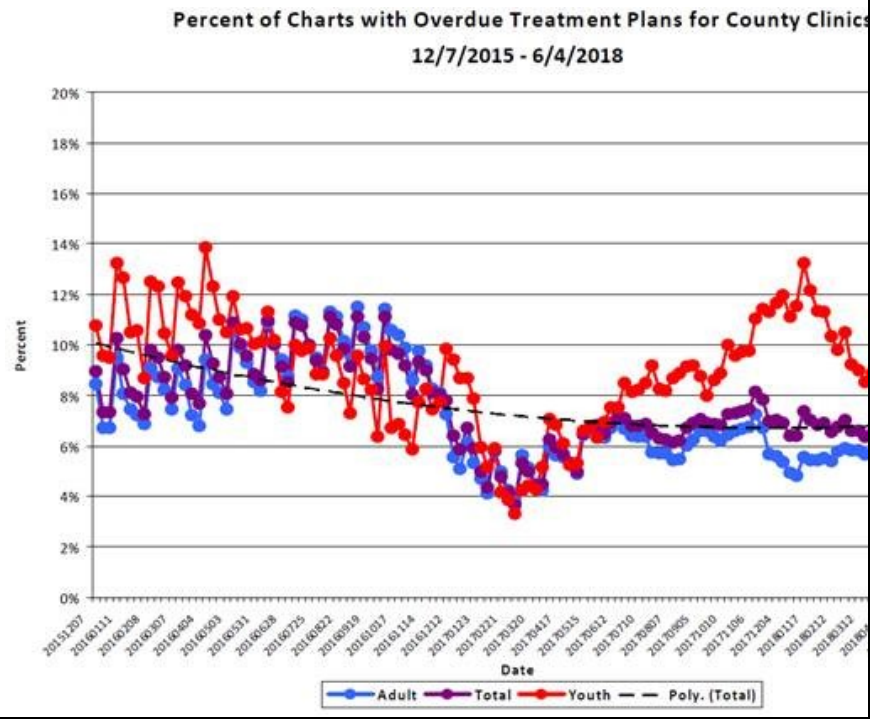
Goal 1	Improve compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.
Intervention	Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.
Measurement	Track training compliance, HIPAA, & FWA of new staff and current staff. Current staff: Goal = or > 90% for each training. New Staff: Goal = 100%. The assigned months for each training will be changed in FY17-18. Compliance -Nov 2017 FWA -Nov 2017 HIPAA -Aug 2017
Responsibility	Claudia Tinoco Nicola Freeman
Due Date	June 2018
Status	Partially Met/Continue next year
Year End Review	The status of the current staff trainings for Compliance, HIPAA & FWA are as follows: Compliance: **92.48%** of all staff completed it. HIPAA: **85.54%** of all staff completed it. FWA: **85.40%** of all staff completed it. 100% of all newly hired staff have completed all three trainings.

Goal 2	Improvement related to clinical practice. Improve basic documentation. Improve quality of care.
Intervention	Maintain clinical documentation training program for all current and new staff.
Measurement	Track compliance of new and current staff completing the training. New Staff: Goal = 100%. Current Staff: Goal= or > 90%
Responsibility	Clinical Documentation Workgroup Claudia Tinoco Amber Ortiz Nicola Freeman
Due Date	June 2018
Status	Partially Met/Continue next year
Year End Review	100% of all newly hired staff have completed these trainings. All new staff are required to take these trainings and will not be able to access our EMR system unless they complete all clinical and compliance

	trainings. The status of the current staff trainings for Compliance & FWA are as follows: Compliance: **92.48%** of all staff completed it. FWA: **85.40%** of all staff completed it.

Goal 3	Program staff to improve overall compliance with timelines and paperwork requirements.
Intervention	Maintain system-wide, yearly-audit program. Improve documentation tracking reports to encourage and monitor teams' compliance with requirements. Send monthly emails with documentation compliance rates to all county program managers and directors.
Measurement	Audit 10% Medi-Cal Charts Yearly.
Responsibility	Jeannine Mealey QM Audit Team
Due Date	June 2018
Status	Goal Met/Continue next year
Year End Review	10 % of CBO charts were audited. Four CBO agencies were issued plan of corrections and are being monitored for compliance. One provider was issued a POC requirement a second audit in FY 18-19 due to non-compliance over a two-year period. County program charts were audited ongoing as treatment plans were completed, approximately 100 emails were sent to different clinicians with specific feedback about their documentation and training material for any problem areas. Clinicians were informed of billing that required a void. In FY 2017-18 to date, upon audit, 2047 services were blocked from Medi-Cal billing due to the treatment plan not being complete.

Goal 4	Maintain disallowances to less than 5% of sample.
Intervention	Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System. Send progress reports to county programs.
Measurement	Decrease disallowances Target: Medi-Cal Audit: <5%
Responsibility	Jeannine Mealey QM Audit Team
Due Date	June 2018
Status	Goal Met/Continue next year
Year End Review	There was no DHCS Mental Health Medi-Cal audit this FY. Monthly documentation status reports were sent to BHRS programs monthly with details about treatment plan, assessment, and progress note compliance rates. Overdue assessment rates have significantly reduced

	and are being maintained under 3% late/97% in compliance. Treatment plan completion rates are continuing to vary and are currently 92% in compliance/ 8% overdue. The overall internal disallowance rate from audit is under 5%.  

Goal 6	Improve customer service and satisfaction for San Mateo County Access Call Center

Intervention	• Create scripts and procedures for administrative and clinical staff at Access Call Center • Develop standards for answering calls * Increase training for Optum call center staff on standards for answering calls.
Measurement	Test calls and call logs 90% test call rated as positive
Responsibility	Jeannine Mealey Kathy Koeppen Selma Mangrum Claudia Tinoco
Due Date	January 2018
Status	Partially Met/Continue next year
Year End Review	Scripts and procedures have been implemented to meet the minimum DHCS requirements for test calls, as well as developing a standard for staff when answering calls from clients. Goal is to increase client satisfaction. Based on 9 (as of 6/7/18) test calls for FY 17/18 about 89% of the callers' experiences were rated as positive. This is an improvement in previous FY test call results, our continued goal at least 90% of test calls will be rated as positive. To further this goal, we will continue to increase test calls, train current and incoming staff using our scripts and other tools. Optum call center staff was provided a refresher training on the script. Training session was also recorded for any staff unable to attend the training. Optum Supervisors were to discuss individually with each staff in their monthly 1:1 to ensure understanding of the material.

Goal 7	Tracking Incident Reports (IR) and Suicide Rates in SMC
Intervention	Collect data on known or suspected suicides reported to BHRS by Department IR Compare baseline statistics from BHRS population to County Coroner's office for method, demographics. Conducted review of cases identified in the highest impact population (older adults). Track rate of highest impact population over 2 years (majority people over 50) Provided community-wide training for older adult peer workers and professionals on assessing risk/signs in the population Report trends and current data to QIC and leadership Review information with Countywide Suicide Prevention Task Force
Measurement	Compare population specific suicide rates year to year with emphasis on older adults Track rates, methods and demographics for future outreach efforts to reduce rates of suicide Compare data from before and after community engagement training for increased awareness
Responsibility	Marcy Fraser
Due Date	June 2018
Status	Not met./ Continue next year
Year End Review	• We have not been able to meet this because we have discovered that there are data integrity issues

	• Due to staffing shortage report has not been made to QIC for FY17/18.

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.
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 prior to PIP rollout): 7 day measure: 25% of full sample, 26% Spanish subset. 90 day measure: 25% full sample, 17% Spanish subset.
Responsibility	Chad Kempel Scott Gruendl
Due Date	June 2018
Status	Not met/ Continue next year
Year End Review	For Fiscal year 2017-2018 45% of the full sample of clients met the criteria for initiation; 38% of the Spanish subset met the criteria.

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 percentage of clients receiving a second appointment within timeline compared to baseline.
Responsibility	Chad Kempel Scott Gruendl
Due Date	June 2018
Status	Met
Year End Review	90% of clients received a service within 7 days of their PES service.

Goal 3	24/7 Call Center will be able to successfully screen and refer AOD clients
Intervention	Develop Workflows for 24/7 to log requests for services; screen, and make appropriate AOD referrals Modify test call scripts to include inquiries about AOD services.
Measurement	90% of test callers report being successfully screened and referred for AOD services to 24/7 line 3 AOD test calls will be made per quarter 100% of AOD Test Call are logged
Responsibility	Selma Mangrum Claudia Tinoco
Due Date	March 2018
Status	Not met. Continued for next year
Year End Review	1 AOD test call was completed and logged for the fiscal year. This goal will be continued to next year in order to meet 3 AOD calls per quarter. To further this goal, we will increase test calls and recruitment of test callers.

Goal 4	Monitor access to afterhours care. 100% of calls will be answered. 100% of test callers will be provided information on how/where to obtain after hours services if needed.
Intervention	Make 4 test calls monthly to 24/7 toll-free number. Develop new Avatar Call Log Tracking System. Make 1 test call a month in another language.
Measurement	95 % or more calls answered 95 % or more test calls logged. 100% of requested interpreters provided
Responsibility	Claudia Tinoco
Due Date	June 2018
Status	Partially met/Continued into next year
Year End Review	Test calls answered: **83%** Test calls logged: **42%** Requested Interpreter provided: **100%:** For the 1st quarter there were 4 test calls, 2nd quarter there were 3 test calls, 3rd quarter there was 1 test call, and in the 4th quarter were two test calls. This goal will be continued to next year in order to improve the number of test calls per quarter As of 6/11/18 12 test calls were made: 10 calls were answered and 5 calls were logged. 1 test caller requested and interpreter and was given one in 3 minutes. 3 of our 12 test calls were completed in another language.

Requirement: Monitoring Beneficiary Satisfaction (4c)

Goal 1	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	Annual reports on grievances, appeals, and State Fair Hearings to QIC. Annual report with % of issues resolved to client/family member fully favorable or favorable. Annual report with % grievances/appeals resolved within 90/30 days.
Responsibility	GAT Team
Due Date	June 2018
Status	Met
Year End Review	All grievances and appeals were resolved within the required timeline. GAT continues to meet weekly to discuss and address all grievances and appeals with the involved staff and managers in order to ensure that all grievances are resolved with the required timeline.

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.
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 timely (baseline 50%)
Responsibility	GAT
Due Date	October 1 2017, January 1 2018, April 1 2018, July 1 2018
Status	Met
Year End Review	100 % of providers received the grievance resolution in a timely manner.

Goal 3	Ensure that grievances are in compliance with new regulations.
Intervention	GAT will review all relevant revisions to the 2017-2018 Grievance Protocol and make any changes required.
Measurement	Documentation in GAT Meeting.
Responsibility	GAT Members
Due Date	January 1, 2018
Status	Met
Year End Review	GAT team meets on a bi-monthly bias and reviewed all relevant revisions to the 17-18 grievance protocols. The completion and implementation of all revision were completed by 3-28-18.

Goal 4	Decision for client's requested Change of Provider within 2 weeks
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	Jeannine Mealey
Due Date	June 2018
Status	Not met. Continued to next year.
Year End Review	Notification was sent out to all BHRS providers and CBO agencies on July 6, 2017 and June 8, 2018 to remind them of the requirement to make a decision in all requests for a change of provider and to inform the client of the decision within 14 days. The overall number of change of provider requests being turned in the QI has decreased (however this may go up as people turn in forms late). We continue to struggle with unit chiefs making timely decisions. In FY 2017-18, 105 requests to change provider were received (122 were turned in last year). 76% of decisions were made within 14 days (84% were on time last year). In summary, 78 request were approved, 26 were resolved without a change of provider, and one request was denied due to clinical reasons. An executive summary of the reason or request, timeliness of decision, and decision was generated and sent to the BHRS executive team with recommendations on June 13, 2018.

Goal 5	Providers will be informed of results of the beneficiary/family satisfaction surveys bi-annually.
Intervention	Develop communication plan to inform providers/staff of the results of each survey within a specified timeline.
Measurement	Completion of notification twice a year. Presentation and notification of the results yearly.
Responsibility	Scott Gruendl David Williams

Due Date	Due January 1 2018, July 1, 2018
Status	Partially Met/ Continued
Year End Review	All county Medi-cal providers (management) were notified of their Survey results in FY17/18. All DMC ODS providers (management) were notified of their "Treatment Perceptions Survey (TPS) results in FY 17/18 (April 18, 2018)

Goal 6	Improve cultural and linguistic competence
Intervention	"Working Effectively with Interpreters in Behavioral Health "on-line refresher course training will be required for all direct service staff every 3 years.
Measurement	Of those staff who took the in-person "Working Effectively with Interpreters in Behavioral Health" training 3 or more years ago, 75% will take the on-line refresher course of "Working Effectively with Interpreters in Behavioral Health Refresher"
Responsibility	Ellie Dwyer, Doris Estremera and Jei Africa
Due Date	Due June 30, 2018
Status	Partially Met/continued next year
Year End Review	Only 17% of staff that took the in-person training over 3 years ago, took the on-line refresher course. This goal will be continue next year to improve the number of staff have taken the in-person "Working Effectively with Interpreters in Behavioral Health" training 3 or more years ago will complete the on-line refresher course.

Goal 7	Improve Linguistic Access for clients whose preferred language is other than English
Intervention	All staff with direct client contact will accurately report client's "Preferred Language" including American Sign Language or aids like braille or TTY/TDD using the drop down language option in Avatar progress notes. Trends will be determined and identified as "emerging languages"
Measurement	Via Avatar report, will identify emerging languages and the number of requests for ASL or aids like braille or TTY/TDD by tracking the increase in unduplicated client service requests for language(s) that are neither threshold nor prevalent languages in previous year(s).
Responsibility	Ellie Dwyer, Doris Estremera and Jei Africa
Due Date	Due June 30, 2018
Status	Partially Met. Continue next year
Year End Review	BHRS has shown improvement in providing services in the preferred language improving in FY 15/16 42.2% to 45, FY 16/17 45.9% to 65.7%, and FY17/18 67.6% to 68.7% We are not able to provide specific data at this time for ASL, Braille or TTY/TDD

Goal 8	Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.
Intervention	All staff will complete mandatory training on cultural humility
Measurement	75% of staff will attend the training and develop shared language

	related to self-reflection, humility, power and privilege, biases and the importance of multiculturalism in the work place
Responsibility	Ellie Dwyer, Doris Estremera and Jei Africa
Due Date	Due June 30, 2018
Status	Partially Met. Continue next year
Year End Review	28% of current employees have completed this training There has not been a formal email to ALL BHRS staff making them aware of this new training requirement. Similar to above, ODE does not have the capacity/resources to enforce this requirement. Exploration of managing this barrier is needed

Goal 9	Implement data collection guidelines regarding sexual orientation and gender identify (SOGI)
Intervention	All staff with direct client contact will appropriately ask client's sexual orientation and gender identity questions (SOGI)
Measurement	Staff with direct client contact will record SOGI data in Avatar for 80% of new clients in order to obtain baseline data
Responsibility	Ellie Dwyer, Doris Estremera and Jei Africa
Due Date	Due June 30, 2018
Status	Partially met. Continue next year
Year End Review	BHRS started going live with SOGI beginning 3/1/2018 with our Call Center ICI. Between 3/1/2018-6/30/2018 BHRS captured Gender Identity 27.82% of the time; Sexual Orientation 37.11% of the time; Preferred Pronoun 23.77% of the time. Beginning 4/2/2018 our AOD providers went live with the SOGI and since that time they have collected SOGI Information 51.35% Based on client who had an episode opening since 4/2/2018 BHRS System of Care began the collection of SOGI information after 6/30/2018

Requirement: ODS Implementation

Goal 1	Clinical Increase Capacity of ODS Residential treatment beds
Intervention	Increase in capacity (either N (number) or %) of co-occurring enhanced residential treatment beds.
Measurement	(N) or % of clients assessed as needing co-occurring enhanced residential treatment who received these services.
Responsibility	Clara Boyden
Due Date	Due June 30, 2018
Status	Partially Met/Continued
Year End Review	On October 31, 2017, the County Board of Supervisors approved an amendment to the Our Common Ground (OCG) contract to add a specialized wellness component to treat seriously mental ill (SMI) adults with a co-occurring substance use disorder. This wellness component is embedded within the existing residential and provided provide 24-

	hour supervision to support client stability within the residential program, a critical service that BHRS does not currently have. Up to eight beds in the OCG facility can now serve the SMI population. Since this, the program has seen reduced wait times for treatment and increases in treatment retention and completion. Preliminary data from April 2018 to the present shows 100% of SMI women who were evaluated as needing a 3.5 level of care were then admitted to a co-occurring enhanced residential treatment facility, either WRA or Hope House, while 75% of SMI men were subsequently admitted to OCG's 3.5 co-occurring enhanced facility. There has also been increased collaboration with mental health providers such as Caminar and Telecare, with regard to the coordination of the entry into these facilities and during the course of treatment. SMI clients are experiencing less denials from residential providers than before as we have not had a client denial in some time. High acuity and intensity of substance use continue to be barriers in evaluating and successfully getting these clients into residential care. For example, there have been 373 EMR/PES visits / episodes since July 2017 for our RTX caseload total and many of these visits are from SMI clients.

Goal 2	Clinical Increase Capacity of ODS Residential treatment beds
Intervention	Design implementation plan for County utilization management review of AOD services.
Measurement	Develop audit tool. Implementation of audit plan to review 10% of all related client charts by end of FY17-18
Responsibility	Diana Hill, QM Staff
Due Date	Due June 30, 2018
Status	Partially Met/ Continued into next year
Year End Review	A DMC ODS audit tool was developed by the AOD Manager who oversees the SUD Contract Performance Monitoring Team. We are using this tool in all treatment facilities. We did not review 10% of all client charts due to insufficient staff resources. We are meeting regularly with QM and are developing a plan to get closer to the 10% chart review target in 18/19 First year implementation reports for DMC ODS (2/1/2017 to 1/31/2018) showed run by BHRS MIS in Dimensions should 1106 unique clients with a DMC claim. Some claims have not been submitted due to challenges with the DHCS Master Provider File, so we believe more than 1106 beneficiaries were served. None the less, the first implementation year was used to establish the denominator to calculate the number of charts required for 10% review in in FY 17/18. This fiscal year, BHRS AOD staff completed site visits where 81 client charts were reviewed for compliance with documentation requirements and other federal and state regulations. Twenty-one (21) of these client charts were from Residential treatment programs, 52 were from Outpatient or Intensive Outpatient, 4 were from NRT, and 4 were from Detoxification programs.

	AOD Administrator is currently working with the QM Manager, Compliance Officer/Assistant Director, and Call Center Manager on expanding utilization review in compliance with managed care requirements for the upcoming year. Resources, staff assignments and training needs are still being identified /developed to ensure quality. 81 Number of Medi-Cal charts reviewed year to date for 17/18 1106 unique Medi-Cal beneficiaries with a submitted DMC claim 7.3% of Med-Cal client charts audited

Goal 3	New ODS Clinical Alternative Option:
Intervention	Expand access to Medication Assisted Treatment (MAT) including narcotic replacement therapy.
Measurement	% of clients with alcohol and/or opioids as drug of choice admitted to a clinic for MAT or Narcotic Replacement Therapy within 14 days.
Responsibility	Matt Boyle
Due Date	Due June 30, 2018
Status	Met/ 99% of clients requesting MAT admitted to clinic within 14 days
Year End Review	Access to MAT was expanded with the creation of the Integrated Medication Assisted Treatment (IMAT) team in 2015. This year the clinic began to operate 5 days a week. In the first eleven months of FY17-18 the IMAT team received 1590 referrals. Of these 1311 were for Alcohol and/or Opioids. There were 114 of these clients who requested linkage to Medication Assisted Treatment; 112 were admitted to the clinic within 14 days. The BAART clinic admitted 134 clients during this same period for NRT services. All of these admissions occurred within 14 days of referral. Total number of clients requesting MAT: 248 Total clients admitted to clinic within 14 days: 246 % of clients admitted within 14 days: 99%