SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

# Quality Improvement Work Plan for SUDS and Mental Health July 2020-June 2021 (Start July 2020)

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.<br><br>Current staff: Goal = or > 90% for each training.<br>New Staff: Goal = 100%.<br><br>**<u>Annual Required Compliance Bundle: BHRS Staff Only:</u>**<br>The assigned months for each training will be November<br><br>• Annual: BHRS Compliance Mandated Training – October 2020<br>• Annual: BHRS Fraud, Waste, & Abuse Training – October 2020<br>• Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD: All BHRSv3.3 – November 2020 |
| Responsibility | Tracey Chan<br>Jeannine Mealey |
| Due Date | June 2021 |

| Goal 2 | Improve clinical documentation and quality of care. |
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| 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. |

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| Responsibility | Clinical Documentation Workgroup<br>Amber Ortiz<br>Ingall Bull<br>Claudia Tinoco<br>Tracey Chan |
| Due Date | June 2020 |

| Goal 3 | Program staff to improve overall compliance with timelines and paperwork requirements. |
|---|---|
| Intervention | • Maintain system-wide, yearly-audit program.<br>• Send monthly emails with documentation compliance rates to all county program managers and directors to monitor teams' compliance with requirements. |
| Measurement | Reports sent to programs Monthly |
| Responsibility | Jeannine Mealey<br>Tracey Chan<br>A.B. Limin |
| Due Date | June 2021 |

| Goal 4 | Maintain disallowances to less than 5% of sample. |
|---|---|
| Intervention | • Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System.<br>• Send progress reports to county programs. |
| Measurement | • Audit 10% of SDMC System of Care client charts annually<br>• Decrease disallowances, Target: Medi-Cal Audit: <5% |
| Responsibility | Jeannine Mealey<br>QM Audit Team |
| Due Date | June 2021 |

| Goal 5 | 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.<br>• Determine Optimal timing for conducting survey |
| Measurement | Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%.<br>• Are you satisfied with the help that you received from the Quality Management staff person?<br>• Baseline: Nov 2018-<br>o Yes 75.47%, Somewhat 16.98% = 92.45%, No = 3.77%Total responses 61 |
| Responsibility | Ingall Bull |
| Due Date | June 2021 |

| Goal 6 | Create and update policies and procedures in BHRS for Mental Health and SUD |
|---|---|
| Intervention | • Update current policies and procedures for new managed care rules. Update policy Index.<br>• Maintain internal policy committee to address needed policies and procedures.<br>• Retire old/obsolete policies.<br>• Create new, amend existing, and retire obsolete policies |
| Measurement | # of Policies Created<br># of Policies Retired<br># of Policies Amended |
| Responsibility | Policy Committee:<br>Ingall Bull<br>Claudia Tinoco<br>Jeannine Mealey<br>Holly Severson<br>Eri Tsujii<br>Annina Altomari<br>Tracey Chan<br>Clara Boyden – AOD Deputy Director<br>Diana Hill – AOD Health Services Manager<br>Mary Taylor Fullerton – AOD Clinical Services Manager |
| Due Date | June 2021 |

| Goal 7 | Comply with QIC Policy and maintain voting membership that represents all parts BHRS |
|---|---|
| Intervention | • Review/amend QIC Policy as necessary.<br>• Maintain QIC voting membership that represents BHRS system |
| Measurement | • Ensure compliance with QIC Policy: communicate with QIC members as necessary.<br>• Verify and document QIC Voters that represents BHRS system by 6/2021 (continuous) |
| Responsibility | Ingall Bull<br>Annina Altomari |
| Due Date | June 2021 |

| Goal 9 | Tracking Incident Reports (IR) |
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| Intervention | • Continue to monitor and track all Incident reports.<br>• Present data to Executive Team<br>• Report trends and current data to QIC and leadership<br>• Enter deaths and major incident in to System to See |
| Measurement | Annual Reports to Executive Team and QIC |
| Responsibility | Tracey Chan |
| Due Date | June 2021 |

## 2. Performance Improvement Projects (PIP)

| Goal 1 | BHRS will develop two on going Performance Improvement Projects (PIP) for the MHP |
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| Intervention | • Gather baseline data from BHRS sources to identify improvement areas.<br>• Form a PIP committee to select improvement areas to focus on for a clinical PIP and a non-clinical PIP based on data gathered.<br>• Identify interventions to address the identified problem(s).<br>• Identify a population (Adult and/or Youth) for the PIP. |
| Measurement | • Development of 2 PIP's that are rated as active and meet EQRO standards<br>• Committee Minutes |
| Responsibility | Eri Tsujii |
| Due Date | June 2021 |

| Goal 2 | Identify new or revised PIP interventions for the current fiscal year. |
|---|---|
| Intervention | • Review current PIPs in light of COVID-19 and assess viability for continuation.<br>• Review recent DMC ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas.<br>• Work with the DMC ODS QI subcommittee for input into direction and selection of clinical and administrative PIPs. |
| Measurement | • Meeting Minutes<br>• Developed PIPs |
| Responsibility | Clara Boyden<br>Diana Hill<br>Mary Fullerton<br>Ingall Bull<br>Eri Tsujii<br>Eliseo Amezcua<br>Desirae Miller |
| Due Date | Target Implementation Date: 6/30/2021 |

## 3. Utilization and Timeliness to Service Measures

| Goal 2 | Track time from first request to first assessment and treatment appointment for BHRS and contractor programs for new SDMC Mental Health, Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client) |
|---|---|
| Intervention | **New Client is a beneficiary who has Medi-cal and is not currently open to SDMC services*<br>• Maintain workgroup focused on determining how to track and implementing timeliness measures<br>• Continue to refine the process for capturing data and tracking timeliness information from initial request to encounter for the following areas:<br>o Offered assessment and treatment appointments<br>o Time to first kept assessment and/or 1st kept treatment appointment.<br>o Time to first psychiatric service<br>o Time from request for *Urgent* appointment to actual encounter |

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|---|---|
| | o Time to appointment for post-psychiatric inpatient discharge<br>o Inpatient readmission rates with 30 days of discharge<br>o Mental Health Service (incl. Targeted Case Management, Medication Support, and Crisis intervention)<br>• Develop a plan and push Tracking mechanisms out to the BHRS Programs and Contractors.<br>• Include data for BHRS and contract agencies serving SDMC clients.<br>• Report to Executive Team and QIC, timeliness data annually. |
| Measurement | • % of clients receiving a mental health service within 10 days from request to first appointment.<br>• % of new clients receiving Psychiatry Services within 15 days from request to first service.<br>• Average time from first request for service to first assessment appointment.<br>• Average time from assessment to first treatment appointment<br>• Average time from request for Urgent appointment to actual encounter. |
| Responsibility | Ingall Bull<br>Eri Tsujii |
| Due Date | June 2021 |

| Goal 3 | Develop reporting capability for disaggregating data for Youth and Foster Care for tracking medication use. (SB1291) |
|---|---|
| Intervention | Develop a process for capturing data for the following HEDIS measures<br>o Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)<br>o Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)<br>o Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)<br>o Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)<br>Revise JV 220 oversight process to incorporate these measures<br>Identify and update policies as needed |
| Measurement | Creation of a protocol and process for oversite<br>Updated policies |
| Responsibility | QM Workgroup<br>Ingall Bull<br>Eri Tsujii |
| Due Date | June 2021 |

## 4. Access and Call Center

| Goal 1 | Improve customer service and satisfaction for San Mateo County Access Call Center |
|---|---|
| Intervention | • Review and Revise, as needed, standards for answering calls<br>• Provide training for Optum call center staff on standards for answering calls. |
| Measurement | Test calls and call logs 90% test call rated as positive |

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| Responsibility | Selma Mangrum<br>Tracey Chan<br>Ingall Bull<br>Claudia Tinoco |
| Due Date | June 2021 |

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| 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 | • Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services.<br>• Make 1 test call in another language and 1 for AOD services<br>• QM will report to call center the outcome of test calls |
| Measurement | 95 % or more calls answered<br>95 % or more test calls logged.<br>100% of requested interpreters provided<br>75% of call will be rated satisfactory (Caller indicated they were helped) |
| Responsibility | Tracey Chan |
| Due Date | June 2021 |

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

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| 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 | • Annual reports on grievances, appeals, and State Fair Hearings to QIC.<br>• Annual report with % of issues resolved to client/family member fully favorable or favorable.<br>• Annual report with % grievances/appeals resolved within 90/30 days. |
| Responsibility | GAT Team |
| Due Date | June 2021 |

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| 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.<br>(baseline 50%) |
| Responsibility | GAT Team<br>Annina Altomari |
| Due Date | June 2021 |

| Goal 3 | Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances. |
|---|---|
| Intervention | • GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required.<br>• Train BHRS staff and contractors on new grievance procedures<br>• Track compliance with new Grievance and NOABD policy |
| Measurement | • # of successfully issued NOABDs<br>• # of Appeals completed with outcome % for favorable outcomes for client<br>• # of successfully completed Grievances |
| Responsibility | Ingall Bull<br>GAT Team |
| Due Date | June 2021 |

| 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.<br>• Obtain baseline/develop goal. |
| Measurement | Annual review of requests for change of provider. |
| Responsibility | Tracey Chan |
| Due Date | June 2021 |

## 6. Client Satisfaction and Culturally Competent Services

| Goal 1 | Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually. |
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| Intervention | Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year) |
| Measurement | • Notify programs, according to MHP/ODS requirements, consumer survey results<br>• Presentation and notification of the results yearly. |
| Responsibility | Ingall Bull<br>Scott Gruendl<br>David Williams<br>Diana Hill |
| Due Date | June 2021 |

| 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 | • 100% of New staff will complete in-person "Working Effectively with Interpreters in Behavioral Health"<br>• 75% of Existing staff who have taken the initial training will take the refresher training at lease every three years. |
| Responsibility | Claudia Tinoco<br>Maria Lorente-Foresti<br>Doris Estremera |
| Due Date | June 2021 |

| Goal 4 | 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 | Claudia Tinoco<br>Doris Estremera<br>Maria Lorente-Foresti<br>Chad Kempel |
| Due Date | June 2021 |

| Goal 5 | Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations. |
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| Intervention | All staff will complete mandatory training on cultural humility |
| Measurement | 65% of staff will complete the Cultural Humility training. |
| Responsibility | Claudia Tinoco<br>Doris Estremera<br>Erica Britton<br>Desirae Miller |
| Due Date | June 2021 |

## 7. DMC-ODS Pilot

| Goal 1 | Enhance the EMR system (Avatar) to include expanded SUD client health information |
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| Intervention | • Enhance Avatar for SUD to include required DMC ODS data collection and reporting components and clinical components.<br>• Train county and provider SUD staff on how to use the new system.<br>• Implement SUDS EMR with identified programs.<br>• Develop a post implementation survey for collecting user feedback.<br>• Implement improvements to fix system bugs and improve user experience based on user feedback |
| Measurement | • Go live date<br>• Post implementation survey results for user acceptance and feedback |
| Responsibility | Kim Pijma<br>QM Team<br>Diana Hill |
| Due Date | June 2021 |

| Goal 2 | **Care Coordination:**<br>Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care. |
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| Intervention | • ASAM evaluation and treatment referral completed prior to residential detox discharge.<br>• Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care. |
| Measurement | • # of Res Detox discharges |

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| | • % of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge<br>• % of clients re-admitted to detox within 30 days |
| Responsibility | Eliseo Amezcua<br>Giovanna Bonds<br>Melina Cortez<br>Mary Taylor Fullerton |
| Due Date | June 2021 |

| Goal 3 | **Monitor Service Delivery System:**<br>Increase treatment provider compliance with DMC-ODS documentation regulations. |
|---|---|
| Intervention | • 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.<br>• Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts.<br>• Pilot Audit with each of the DMC-ODS providers |
| Measurement | # of charts reviewed for each DMC-ODS providers |
| Responsibility | Diana Hill<br>Desirae Miller<br>Christine O'Kelly |
| Due Date | June 2021 |

| Goal 4 | Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.) |
|---|---|
| Intervention | • Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement<br>• Develop of an annual Training Plan that incorporates Evidenced-Based Practices.<br>• Implement training plan |
| Measurement | • Copy of training plan protocol<br>• # of trainings offered |
| Responsibility | Diana Hill<br>Mary Fullerton<br>Christine O'Kelly |
| Due Date | June 2021 |

| Goal 5 | 80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs. |
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| Intervention | • Implement Training Plan for provider clinicians, counseling and supervisory staff.<br>• Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs.<br>• Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements. |
| Measurement | • % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs.<br>• FY 18-19 performance is 28% |
| Responsibility | Diana Hill<br>Christine O'Kelly<br>Kathy Reyes<br>Erica Britton |
| Due Date | June 2021 |

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| Goal 6 | All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually. |
| Intervention | Implement a Training Plan for provider clinicians. |
| Measurement | • % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually.<br>• FY 17/18 baseline is 35%.<br>• FY 18/19 = 55%. |
| Responsibility | Diana Hill<br>Christine O'Kelly<br>Mary Taylor Fullerton |
| Due Date | June 2021 |

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| Goal 7 | Monitor Service Delivery System:<br>Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards |
| Intervention | • Implement Avatar SUD enhancements to collect data for measures.<br>• Identified reports are created in Avatar<br>• Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system. |
| Measurement | • List of reports developed that meet reporting requirement for DMC-ODS |
| Responsibility | Clara Boyden<br>Diana Hill<br>Mary Fullerton<br>Kim Pijma (contract monitor)<br>Dave Williams |
| Due Date | June, 2021 |

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| Goal 8 | **Timeliness of first contact to first appointment:**<br>BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs. |
| Intervention | • Develop a process to analyze timeliness data quarterly for: |

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| | o Outpatient SUD services (excluding Opioid Treatment Programs)<br>o Opioid Treatment Programs<br>• Share data for BHRS programs and contractor agencies serving DMC-ODS clients<br>• NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment.<br>• Report timeliness data annually with NACT Submission on April 1, 2021. |
| Measurement | • % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.<br>• % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard)<br>• % 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). |
| | Chad Kempel<br>Diana Hill<br>Mary Taylor Fullerton<br>Matt Boyle<br>Diana Campos Gomez |
| Due Date | June 2021 |

| Goal 9 | BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs. |
|---|---|
| Intervention | • Develop a Process to capture and analyze timeliness data for:<br>o Outpatient SUD services (excl. Opioid Treatment Programs)<br>o Opioid Treatment Programs<br>• Include data for BHRS programs and contractor agencies serving DMC-ODS clients<br>• Analyze and report timeliness data annually with NACT Submission on April 1, 2020. |
| Measurement | • % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.<br>• % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment. |
| Responsibility | Chad Kempel<br>Clara Boyden |
| Due Date | 06/30/2020 |

| Goal 10 | **Care Coordination:**<br>Care will be coordinated with physical health and mental health service providers. |
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| Intervention | • Implementing contract standard for physical health and mental health care coordination of services at the provider level<br>• Audit charts to monitor compliance with standard<br>• Develop system-wide coordination meeting with providers |

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| | • Analyze TPS client survey data to monitor client satisfaction with care coordination |
| Measurement | • % of audited client charts which comply with DMC ODS physical health examination requirements.<br>• % of MD reviewed physical health examinations with a subsequent referral to physical health services.<br>• % of audited client charts with a completed ACOK screening<br>• % of positive AC OK Screens with a subsequent referral to mental health services. |
| Responsibility | Diana Hill<br>Christine O'Kelly<br>Desirae Miller<br>Eliseo Amezcua<br>Mary Fullerton |
| Due Date | June 2021 |

| Goal 11 | Assess client experience of SUD services through annual survey. |
|---|---|
| Intervention | • Conduct annual TPS Survey with all provider/beneficiaries<br>• Analyze TPS data and share findings with providers and stakeholders. |
| Measurement | • % percent of clients surveyed who indicate "staff were sensitive to my cultural background (race, religion, language, etc.)" on an annual treatment perceptions survey.<br>o FY 19/20: 88.8 % (N=228) – baseline<br>• % of clients surveyed who indicated "I chose my treatment goals with my provider's help" as determined by the annual SUD treatment perception survey.<br>o FY 19/20: 90.8 % (N=228) – baseline<br>• % 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<br>o FY 19/20: 90.8% (N=228) - baseline |
| Responsibility | Diana Hill<br>Christine O'Kelly<br>Desirae Miller<br>Mary Fullerton |
| Due Date | June 2021 |