San Mateo County Behavioral Health & Recovery Services
Yearend review of Quality Improvement Work Plan July 2015-June 2016

END of Year Review
June 30 2016

Requirement: Monitor Quality Improvement Activities (1-3)

Goal 1	**Monitor staff satisfaction with QI activities.**
Intervention	Perform Annual Staff Satisfaction Survey with Quality Management.
Measurement	Goal-Percentage of staff reporting Satisfied/Somewhat Satisfied with QM support = or > 90%.
Responsibility	Jeannine Mealey
Status/Dates	Goal Met for FY15-16 Next due Oct 2016
Year End Review	The survey was sent to all BHRS staff 11/15/2015 **Satisfaction Survey Responses Nov 2015** **Are you satisfied with the help that you received from the Quality Management staff person?** Yes (71%) and Somewhat (24%) = 95% Oct 2016 Total responses 125. **QM Team was supportive and tried to help me**. Always (64%) Most of the Time (20%) Sometime (12%) No (4%) **QM Team responded in a timely fashion**. Always (53%) Most of the time (31%) Sometime % (10) No % (7) **QM Team was clear and provided useful help**. Always (54%), Most of the Time (22%), Sometime (19%), No % (5%)

Goal 2	**Maintain attendance and active participation in QIC.**
Intervention	Invite specific constituents, including under-represented groups, families and clients with lived experience. Analyze attendance patterns. Develop schedule of presentations/topics. Includes all parts of BHRS and contractors.
Measurement	Participants to include members from all groups: Clients, Families, OCFA, Management, Line staff and Supervisors from Programs - Youth, Adult, Senior, Contractors, Medical Director, Training Committee, Cultural Committee, AOD.
Responsibility	Jeannine Mealey Holly Severson
Status/Dates	Met. Continued to sustain membership increases observed in FY14-15, and added representatives of more stakeholder groups. Attendance from .past several meetings: July 2015- 23; September 2015 - 20; November 2015 – 29; March 2016 – 26; May 2016 – 18; July 2016 - 26.

Year End Review	Attendance has stayed high in 2016 due to sustained efforts to recruit and retain. Continuing to recruit in various BHRS venues. Recruitment effort at the San Mateo Mental Health & Substance Abuse Recovery Commission was especially successful: we now have 3 clients and 2 family members that attend most meetings as full participants. We also have a female Transitional Age Youth client who attends some meetings and we hope to increase that. We are adding representatives from throughout BHRS, with assistance from managers. We are still 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 by phone if they are not able to be attend in person.

Goal 3	**Create and update policies and procedures. This includes AOD/ODS Contract requirements.**
Intervention	Update current policies and procedures. Work with leadership/managers to prioritize and modernize our policies. Update policy Index. Collaborate with AOD management & staff for integration and establishment of required AOD policies. Identify and create policies for iMAT. Maintain internal policy committee to review needed policies and procedures. Retire old/obsolete policies.
Measurement	QIC Survey Monkey for policy votes implemented in FY15-16.Excel file kept with outcomes of policy votes including 4 options: Pass, Pass with suggested edits, Abstain or No.
Responsibility	Policy Committee: Jeannine Mealey Kathy Koeppen Marcy Fraser Holly Severson Betty Gallardo-Ortiz
Status/Dates	Ongoing
Year End Review	Quality Management and QIC have continued to review, amend and develop 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, with new ones developed as needed. At every QIC we present policies recently reviewed and introduce new ones coming due for QIC online Survey Monkey Voting. For members without email, we mail materials and allow their approval in person or by US mail at member's preference.

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

Goal 1	**Improve compliance with HIPAA and Compliance training mandate.**
Intervention	Staff will complete online HIPAA & online Compliance Training at hire and annually.
Measurement	Track training compliance of new staff and current staff. Current staff: Goal = or > 90%. New Staff: Goal = or > 100%.

Responsibility	Betty Ortiz-Gallardo Nicola Freeman Amber Ortiz
Status/Dates	Compliance training was assigned in 2015- 98% completed. HIPAA training was assigned in 2015- 95% completed. New staff for FY15-16- 100% compliance for both trainings.
Year End Review	Met for FY15-16

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. Current staff: Goal = or > 90%. New Staff: Goal = or > 100%.
Responsibility	Clinical Documentation Workgroup Kathy Koeppen Jeannine Mealey Betty Ortiz-Gallardo
Status/Dates	FY15-16- 70% of current staff completed all of required trainings, 30% had at least one training to complete. 100% all new staff in FY15-16 completed all required documentation training.
Year End Review	Partially Met: Current staff: Goal = or > 90%. Current progress 70% completed all trainings. Goal Met: New Staff: Goal = or > 100%.

Goal 3	**Program staff to improve overall compliance with timelines and paperwork requirements.**
Intervention	Implement system-wide, yearly-audit program. Improve documentation tracking reports to encourage and monitor teams' compliance with requirements. Reports to improve: Doc at a Glance, Coming Due/Over Due Assessment & Tx Plan Reports, Days to Document Progress Notes Report.
Measurement	Audit 10% Medi-Cal Charts Yearly.
Responsibility	Jeannine Mealey QM Audit Team eCC Team
Status/Dates	In FY15-16 Quality Management audited 1093 Medi-Cal charts.
Year End Review	Goal Met

Goal 4	Maintain disallowances to less than 5% of sample.
Intervention	Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System. Implement Chart Audit Program.
Measurement	Audit 10% Medi-Cal Charts Yearly. Decrease disallowances Targets: Medi-Cal: <5%
Responsibility	Jeannine Mealey QM Audit Team
Status/Dates	Goal Met in FY15-16
Year End Review	There was no Medi-Cal Audit in FY15-16

Goal 5	Reduce number of days between adult client admission to BHRS Regional Adult Clinics and first medication service.
Intervention	Clinical Performance Improvement Project (PIP). • Document baseline wait time in days for 1st medication service at five Regional Clinics Adult teams individually and for BHRS system average (mean) • Investigate/study existing procedures at each clinic to assess best method(s) to reduce wait times • Develop specific interventions targeting causes of delays • Use Plan-Do-Study-Act (PDSA) cycles to address problem areas • Implement procedures to consistently reduce wait times • Re-evaluate and make changes needed for sustained improvement
Measurement	Service code billing data from AVATAR (EMR System); Survey of Unit Chiefs & Med Chiefs at Clinics; Assess current work flows. Measure baseline wait times at each clinic for three Fiscal Years prior to rollout of planned improvement. Measure wait times quarterly for each clinic and calculates regional average (mean). Measure annual change when data is complete.
Responsibility	Bob Cabaj Hung-Ming Chu Scott Gruendl Jeannine Mealey Kathy Koeppen Holly Severson Marcy Fraser Chad Kempel
Status/Dates	In progress Planning stage: Established baseline data, investigating current clinical procedures to help inform interventions needed.

Yearend Review	**In progress.**

Goal 6	**Improve customer service and satisfaction for San Mateo County Access Call Center**
Intervention	System Performance Improvement Project (PIP). • Create a telephone routing system (telephone tree) for callers to indicate their reason for their call. • Test Callers using the Caller Rating Scale • NEW intervention is to provide the Access Call Center staff with customer service training.
Measurement	The measurements we are looking at are caller abandonment rate, answered call rate and the caller satisfaction at the end of the call from our test call data.
Responsibility	Jeannine Mealey Kathy Koeppen Betty Ortiz-Gallardo Selma Mangrum Rosamaria Oceguera
Status/Dates	Begun March 2015 and still in progress.
Year End Review	The current numbers have indicated that we have met our goals, but we experienced a decline in improvement rates, which is why we will continue to work on this PIP and implement a new intervention with the aim it will sustain caller satisfaction.

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
Status/Dates	In Progress
Year End Review	Not Met

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
Status/Dates	Not Met
Year End Review	BHRS is in the process of creating a report to monitor this indicator. This goal will be continued to next year.

Goal 3	**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 3 test calls monthly to 24/7 toll-free number.
Measurement	% of calls answered % of test calls logged. % of interpreter used June-December 2015- Calls Answered/Total Calls Made: 11 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

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 addressed in 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 30 days. Baseline FY 15-16: 27 of 38 favorable or fully favorable = 71 %.
Responsibility	GAT Team Kathy Koeppen Betty Gallardo Jeannine Mealey OCFA Staff
Status/Dates	Met
Year End Review	Goal Met. 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	**Decision regarding request of Change of Provider made 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 Kathy Koeppen
Status/Dates	In Progress
Year End Review	Partially met In April 2016 emails were sent to the system to remind all of the requirements. All Managers were trained on the requirements in April 2016.

Goal 3	**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
Status/Dates	Goal in Progress
Year End Review	Partially met.

Goal 4	**Streamline Clinical Work Flow to standardize the work across the system.**
Intervention	Develop plan to restructure work flow of clinical documentation practices. Facilitate collaborative processes in order to reduce unnecessary steps and improve workflow of clinical paperwork.
Measurement	Use a specific question in QM Satisfaction Survey to identify training gaps for staff. Review of staff productivity around documentation
Responsibility	Jeannine Mealey Hung-Ming Chu Kathy Koeppen Betty Ortiz-Gallardo Chad Kempel Bob Cabaj
Status/Dates	Partially Met
Year End Review	A workgroup have been developed and met 4 times to identify which workflow to streamline.