San Mateo County Behavioral Health & Recovery Services
Quality Improvement Work Plan July 2015-June 2016 (Start July 2015)

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 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
Responsibility	Jeannine Mealey
Due Date	November 2015

Goal 2	Maintain attendance and active participation in QIC.
Intervention	Invite specific constituents, including under-represented groups, families and individuals 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: Client, Family, Office of Consumer and Family Affairs, Management, Programs - Youth, Adult, Senior, Contractors, Medical Director, Training Committee, Cultural Committee, Alcohol and Other Drugs (AOD).
Responsibility	Jeannine Mealey Holly Severson

Goal 3	Create and update policies and procedures. This includes AOD/OSD Contract requirements.
Intervention	Update current policies and procedures. Update policy Index. Collaborate with AOD management for integration and establishment of required AOD policies, identify and create policies for iMAT. 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 FY15-16.
Responsibility	Policy Committee: Jeannine Mealey Kathy Koeppen Marcy Fraser Holly Severson

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 = 100%. The assigned months for each training will be changed in FY15-16. Compliance Nov 2015 HIPAA July 2016
Responsibility	Betty Gallardo

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 = 100%.
Responsibility	Clinical Documentation Workgroup Kathy Koeppen Jeannine Mealey Betty Ortiz-Gallardo

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 track and monitor teams' compliance with requirements. Reports to improve: Document 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

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

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 med services 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 calculate 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.

Goal 6	Improve customer service and satisfaction for San Mateo County Access Call Center
Intervention	System Performance Improvement Project (PIP). • Create scripts and procedures for administrative and clinical staff at Access Call Center • Develop/Implement standards for answering calls • Streamline calls by utilizing a phone tree with appropriate languages options for callers • Utilize LEAN Quality Improvement processes
Measurement	Customer surveys, test calls and call logs.
Responsibility	Jeannine Mealey Kathy Koeppen Lilian Montalvo Selma Mangrum Rosamaria Oceguera Betty Ortiz-Gallardo
Status/Dates	Begun March 2015, currently in work progress.

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

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

Goal 3	**Monitor access to after hours 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. Develop new Avatar Call Log Tracking System.
Measurement	% of calls answered. Goal 100% % of test calls logged. 75% % of interpreter used. 90% Baseline- Date Range: June- December 2013 Calls Answered/Total Calls Made: 21/24 = 88% Calls Logged/ Calls Answered: 9/21 = 43% Interpreter Used/Total Non-English Calls: 5/7 = 71%
Responsibility	QM Staff OCFA- Client/Family Members

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 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. Post to the Health System public web site. Annual report with % grievances/appeals resolved within 30 days.
Responsibility	GAT Team

Goal 2	**Decision is made for request of 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 Kathy Koeppen

Goal 3	**Providers will be informed of results of the beneficiary/family satisfaction surveys bi-annually.**
Intervention	Post results on public website.
Measurement	Completion of notification twice a year. Presentation and notification of the results yearly.
Responsibility	Scott Gruendl

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