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

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

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
Due Date	June 2018

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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