SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

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

Status	**Met Goal in FY20-21** Goal to be repeated in FY21-22. Due 12/31/22.
Summary	

Required Annual Compliance Training	Completed	Not Completed	Total # Staff	% Staff Completing Required Training
Annual BHRS Compliance Training FY20-21	439	12	451	**97%**
Annual BHRS Confidentiality Training FY20-21	436	16	452	**96%**
Annual BHRS FWA Training FY20-21	441	11	452	**98%**

Training For New Staff	Completed	No Completed	% Completed Mandatory Training
Confidentially	38	**0**	**100%**
Compliance	38	**0**	**100%**
FWA	38	**0**	**100%**
Total # New Staff FY20-21	38	**0**	**100%**

Goal 2	Improve clinical documentation and quality of care.
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.
Responsibility	Clinical Documentation Workgroup Amber Ortiz Ingall Bull Claudia Tinoco Tracey Chan
Due Date	June 2021
Status	**Met Goal in FY20-21** Goal to be repeated in FY21-22. Due 12/31/22.
Summary	QM provided an array of Live trainings and on OnDemand trainings in FY20-21 that were widely attended by BHRS staff and CBO staff.

Training Title Live WEBINAR Provided FY20-21	Training Date	Total Attended
QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR	7/15/2020	76
MH Treatment Plans	7/28/2020	50
MH Treatment Plans	7/30/2020	34

QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR	8/12/2020	37
BHRS Mental Health Coding for Progress Notes & Documenting Your Services: WEBINAR	8/25/2020	39
BHRS Mental Health Coding for Progress Notes & Documenting Your Services: WEBINAR	8/27/2020	29
ASK QM Clinical Documentation Webinar	9/9/2020	54
Community-Focused Services: Guidelines Regarding Coding, Billing & Documenting	9/22/2020	52
Community-Focused Services: Guidelines Regarding Coding, Billing & Documenting	9/24/2020	32
BHRS Mental Health Coding & Billing for Meeting with Other Professionals, CFT, Case Conference, and Collaborating	10/27/2020	41
ASK QM Clinical Documentation Webinar	10/21/2020	63
BHRS Mental Health Coding & Billing for Meeting with Other Professionals, CFT, Case Conference, and Collaborating	10/29/2020	33
ASK QM Clinical Documentation Webinar- Special Topic - DHCS Medi-Cal Mental Health AUDIT RESULTS	11/18/2020	76
ASK QM Clinical Documentation WEBINAR	12/16/2020	51
ASK QM Clinical Documentation WEBINAR	1/20/2021	44
BHRS Avatar Clinical Forms	1/27/2021	44
ASK QM Clinical Documentation WEBINAR	2/17/2021	41
BHRS Incident Reports WEBINAR	2/24/2021	67
BHRS NOAS & Timely Access WEBINAR	3/24/2021	88
New Avatar Forms Consents: WEBINAR	4/28/2021	134
ASK QM Clinical Documentation WEBINAR	5/19/2021	50
		1135

There was a total of 3955 unique completed session of QM LMS OnDemand content in FY20-21	
BHRS Compliance Mandated Training	807
BHRS: Confidentiality & HIPAA for Mental Health and AOD	980
Fraud, Waste, & Abuse Training for BHRS	809
Critical Incident Management for BHRS	705
Introduction to the BHRS Avatar Electronic Medical Record: All New Avatar Users	162
Progress Notes for BHRS: Part 1, Writing progress notes 2020	62
Progress Notes for BHRS: Part 2, Group progress notes 2020	68
Progress Notes for BHRS: Part 3, Billing for progress notes 2020	47
Avatar Progress Note Demonstration for BHRS	36
Client Treatment & Recovery Plan for BHRS Mental Health: Clinical Staff	44
Avatar Treatment Plan Demonstration for BHRS	33
Assessments for BHRS Mental Health: Clinical Staff v7.16.19	15
Avatar Discharges and Transfers for BHRS	9
Avatar Mental Health Assessment Demonstration for BHRS: Clinical Staff	35
Avatar OrderConnect for BHRS: Medical Staff 2020	18
LOCUS Training for BHRS: Adult Program Clinical Staff 2020	42
Mental Health Assessments for BHRS v2020.9.29v3	21

	BHRS QM Webinar Recording: Ask QM Special Topics	62
	Grand Total Competed Sessions	**3955**

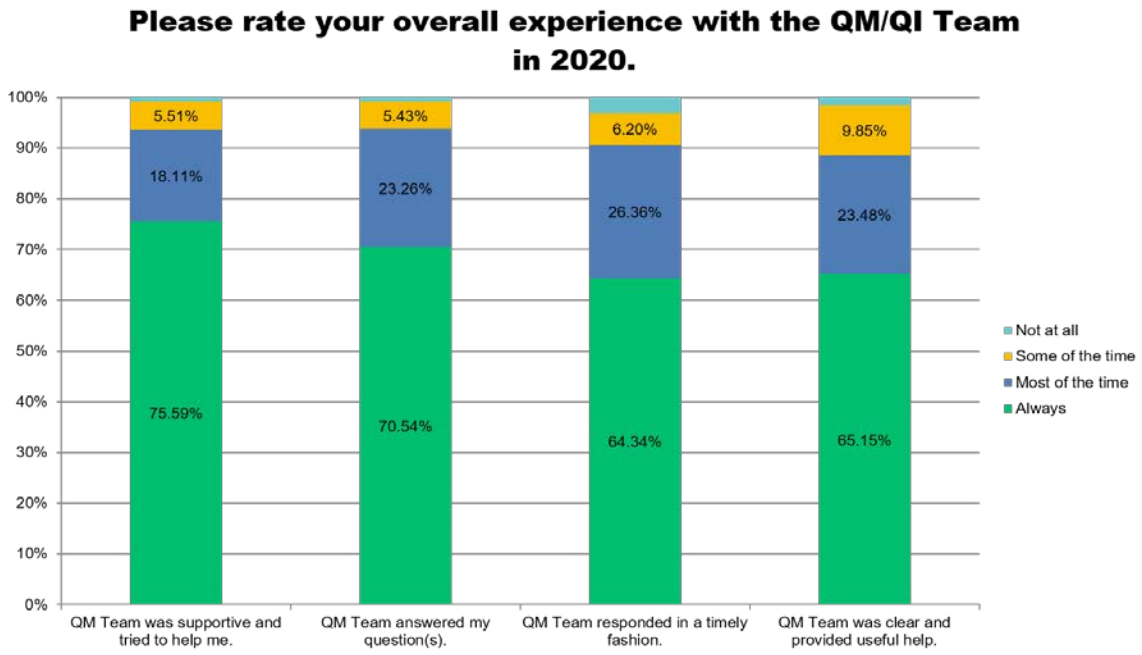
Goal 3	Program staff to improve overall compliance with timelines and paperwork requirements.
Intervention	• Maintain system-wide, yearly-audit program. • Send monthly emails with documentation compliance rates to all county program managers and directors to monitor teams' compliance with requirements.
Measurement	Reports sent to programs Monthly
Responsibility	Jeannine Mealey Tracey Chan A.B. Limin
Due Date	June 2021
Status	**Met**
Summary	The following monthly reports were continuously sent to all SDMC programs and contractors with the following explanation of each each report. Hello Supervisor/Manager: ****Please address your questions/ concerns to: [redacted] QM appreciates the quality care your team continues to provide for our clients during this challenging time. QM would like to support you and help you navigate changes in the documentation of services in these times. Please send us your questions. **The full assessment and treatment plan may be completed over the phone or by telehealth (video).** Attached you will find the following reports: **Assessment Overdue Status Report** Do the best that you can to complete the different areas of the assessment. For areas that you are unable to assess, you will state in that area of the assessment "Unable to assess due to assessment being completed over the phone." **You may finalize the assessment even if you have areas in the assessment that you were not able to assess. Do NOT leave the assessment in draft.** If you later find out additional information that is relevant for the areas in the assessment that you were previously unable to assess, you would do an assessment addendum to add that information to the client's record. **Treatment Plan Overdue and Coming Due Status Report** **Please do your best to complete treatment plans and note the participation with your client on the treatment plan and in the progress note.** If your treatment plan is late, this will not cause a disallowance in an audit, Avatar automatically blocks billing, but we are NOT able to bill Medi-Cal for these clients. Please continue to using the appropriate services codes (DO NOT CODE EVERYTHING 55). Complete a treatment plan when you can, and do NOT back date the start dates once you complete them- the start date is the date that they are completed. **You may finalize the treatment plan without the client's signature.** **Days to Document (Summary)** We have included this report for your review. Please note that this report only reflects completed notes. Any notes still in draft status are not shown on this report. If you have a clinician

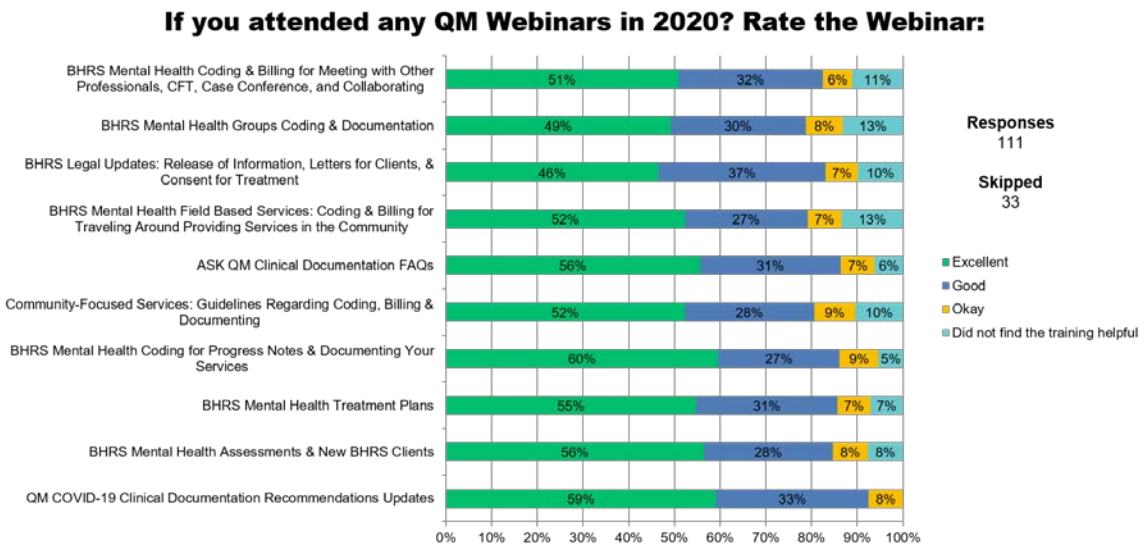
	that you would like more specifics on their documentation, you can run the report called Days to Document (Single). Select the name of the clinician and it will let you know more specifics about their documentation and timelines. **This is run for one month.** **If the number of progress notes is less than the number of services that staff person provided, that staff person is not documenting all of their services.** Thank you to you and your team, for your valuable contribution to BHRS Mental Health and for your attention to our feedback. Your dedication in this difficult time is deeply appreciated. There is no need to respond to this email but please feel free to email [redacted] anytime with any questions or concerns or email **HS_BHRS_ASK_QM@smcgov.org**

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	• Audit 10% of SDMC System of Care client charts annually • Decrease disallowances, Target: Medi-Cal Audit: <5%
Responsibility	Jeannine Mealey QM Audit Team
Due Date	June 2021
Status	Partially Met
Summary	There was not an external Medi-Cal audit this FY. QM audited county SDMC programs. There was a disruption to the audit program due to COVID-19. Not all CBO were audited due to COVID-19. There was a total of 22 County BHRS programs and selected CBO agencies audited in FY20-21, summary below. services rated to be disallowed were voided. The self-identified disallowance rate was over the goal of 5%.

Charts Audited	Services Audited	Services Disallowed	Dollars Audited	Disallowance	% Disallowed Services	$ Disallowance Rate
313	4538	836	$ 1,215,818.52	$ 187,190.49	18%	15%

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

Status	Met, Continue for next year
Summary	BHRS QM showed improvement with staff's satisfaction with QM services. QM showed an improvement in all of our scores over this past year. The Satisfaction Survey is run in December and was extended a week to allow more staff to participate. **Areas that Staff found QM resources helpful** • Specific feedback from chart audits • Online trainings are very popular • Clinical Care consultation • ASK QM email box **Areas for continued Development/Improvement** • New Documentation Guides/Templates • Development of New Online Trainings 



Milestones

- COVID-19 Response to service delivery changing landscape
- QM Continues to Develop and Update Training Materials
- LMS Access for contractors
- Triennial Audit resulted in lowest disallowance rate
- Online Trainings and Guides have been significantly revised
- QM and BHRS-IT are continuing to work together to improve Avatar usability

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. • Maintain internal policy committee to address needed policies and procedures. • Retire old/obsolete policies. • Create new, amend existing, and retire obsolete policies
Measurement	# of Policies Created # of Policies Retired # of Policies Amended
Responsibility	Policy Committee: Ingall Bull Claudia Tinoco Jeannine Mealey Holly Severson Eri Tsujii Annina Altomari Tracey Chan Clara Boyden – AOD Deputy Director Diana Hill – AOD Health Services Manager Mary Taylor Fullerton – AOD Clinical Services Manager
Due Date	June 2021
Status	Met
Summary	QM continued to update, amend, and create policies throughout the pandemic. Many updates were focused on making existing processes more compatible with the new realities of remote work due to COVID-19. QM had created or updated a large number of policies last in

	FY19/20, so there were fewer policy revisions this year. DUE to the continued public health emergency, Management staff were redirected to other priorities which also contributed to fewer new policies. Policies can be found at https://www.smchealth.org/behavioral-health-staff-forms-policies **Policies Created** 20-11 COVID-19 Testing Policy **Policies Amended/Updated** 18-02 Network Adequacy Standards 94-04 Psychiatry Residency Training Program_ Moonlighting 20-05 "Utilization Management Program and Authorization of Specialty Mental Health Services: SMHS" 20-06 Utilization Management of Inpatient Psychiatric Services 05-01 Translation of Written Materials 19-05 Medical Necessity for SMHS 04-07 Advanced Directives 16-12 Psychiatric Medication Consent 01-01 Cell Phone Agreement 98-01 Change of Provider 03-02 Notice of Privacy Practices 03-01 Confidentiality/Privacy of PHI 20-05 UM Program and Auth of SMHS 03-06 "Disclosures of Protected Health Information (PHI) with Client Authorization" 19-08 Credentialing and Re- Credentialing Providers 99-01 Services to Clients in Primary or Preferred Languages 20-04 Authorization of Youth SMHS 19-01 Consumer Problem Resolution & NOABD

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

Goal 9	Tracking Incident Reports (IR)
Intervention	• Continue to monitor and track all Incident reports. • Present data to Executive Team • Report trends and current data to QIC and leadership • 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
Status	
Summary	QM continues to manage the incident reporting process. Each incident report is sent to the Executive Team for their review. System to See was retired at the end of the previous fiscal year and was replaced by

Type of Incident	% of Total	Count
5150	19.15%	167
Abuse	4.07%	35
Arrest	1.30%	14
Assault by Client	1.02%	13
Assault to Client	1.93%	18
Assault to Staff	0.04%	2
AWOL	9.64%	93
Car Accident	0.24%	4
Confidentiality Breach	1.70%	16
Death	4.77%	70
Facility Safety/Maintenance	0.87%	32
Fall or Injury	3.41%	39
General Staff Concern	0.65%	9
High Risk Behavior (drug use, sexual)	5.69%	64
Medical Problem	30.05%	358
Medication Error	1.59%	28
Pharmacy Error	0.12%	3
Self-Harm	1.32%	9
Suicide Attempt-Survived	0.68%	6
Symptom Related	10.73%	100
Theft/Loss	0.17%	1
Threat	0.87%	9
Grand Total	**100.00%**	**1090**

2. Performance Improvement Projects (PIP)

Goal 1	BHRS will develop two on going Performance Improvement Projects (PIP) for the MHP
Intervention	• Gather baseline data from BHRS sources to identify improvement areas. • Form a PIP committee to select improvement areas to focus on for a clinical PIP and a non-clinical PIP based on data gathered. • Identify interventions to address the identified problem(s). • 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 • Committee Minutes
Responsibility	Eri Tsujii
Due Date	June 2021
Status	Met

Summary	Clinical PIP: “Increasing youth engagement in remote services” PIP aims to assess whether the use of a clinical toolkit that provides interactive activities to use during remote services results in a 10 percent increase in the average total service minutes provided to youth clients ages 0-12. This PIP was rated as “Active and Ongoing” by EQRO. PIP intervention was implemented in April 2021. Currently in process of collecting and analyzing data for first quarter of data. Non-Clinical PIP: “Increase client’s ability to utilize telehealth services” PIP aims to assess if providing technical support to clients to help them understand how to use remote service technology will increase the proportion of remote services provided by telehealth from 21 percent to 30 percent. This PIP was rated as “Active and Ongoing” by EQRO. PIP intervention was implemented in April 2021. Currently in process of collecting and analyzing data for first quarter of data.

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. • Review recent DMC ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas. • Work with the DMC ODS QI subcommittee for input into direction and selection of clinical and administrative PIPs.
Measurement	• Meeting Minutes • Developed PIPs
Responsibility	Clara Boyden Diana Hill Mary Fullerton Ingall Bull Eri Tsujii Eliseo Amezcua Desirae Miller
Due Date	Target Implementation Date: 6/30/2021
Status	Met
Summary	Clinical PIP: “Increasing youth engagement in remote services” PIP aims to assess whether the use of a clinical toolkit that provides interactive activities to use during remote services results in a 10 percent increase in the average total service minutes provided to youth clients ages 0-12. This PIP was rated as “Active and Ongoing” by EQRO. PIP intervention was implemented in April 2021. Currently in process of collecting and analyzing data for first quarter of data. Non-Clinical PIP: “Increase client’s ability to utilize telehealth services” PIP aims to assess if providing technical support to clients to help them understand how to use remote service technology will increase the proportion of remote services provided by telehealth from 21 percent to 30 percent. This PIP was rated as “Active and Ongoing” by EQRO. PIP intervention was implemented in April 2021. Currently in process of collecting and analyzing data for first quarter of data.

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* • Maintain workgroup focused on determining how to track and implementing timeliness measures • Continue to refine the process for capturing data and tracking timeliness information from initial request to encounter for the following areas: o Offered assessment and treatment appointments o Time to first kept assessment and/or 1st kept treatment appointment. o Time to first psychiatric service o Time from request for *Urgent* appointment to actual encounter o Time to appointment for post-psychiatric inpatient discharge o Inpatient readmission rates with 30 days of discharge o Mental Health Service (incl. Targeted Case Management, Medication Support, and Crisis intervention) • Develop a plan and push Tracking mechanisms out to the BHRS Programs and Contractors. • Include data for BHRS and contract agencies serving SDMC clients. • 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. • % of new clients receiving Psychiatry Services within 15 days from request to first service. • Average time from first request for service to first assessment appointment. • Average time from assessment to first treatment appointment • Average time from request for Urgent appointment to actual encounter.
Responsibility	Ingall Bull Eri Tsujii
Due Date	June 2021
Status	Met
Summary	We are currently tracking data from first request to first offered, accepted, and attended appointment; however, we are still working on parsing out the data to differentiate non-psychiatry, psychiatry, and urgent appointments. Overall, per DHCS review of our NACT Timeliness data in April 2021, 78% of new requests were provided appointments within 10 days, with the average time to first assessment appointment being 7.24 days.

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 o Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) o Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH) o Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) o Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) Revise JV 220 oversight process to incorporate these measures Identify and update policies as needed
Measurement	Creation of a protocol and process for oversite Updated policies

Responsibility	QM Workgroup Ingall Bull Eri Tsujii
Due Date	June 2021
Status	Not Met
Summary	Due to demands from COVID-related projects, the development of a tracking system for these measures could not be developed.

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 • Provide training for Optum call center staff on standards for answering calls.
Measurement	Test calls and call logs 90% test call rated as positive
Responsibility	Selma Mangrum Tracey Chan Ingall Bull Claudia Tinoco
Due Date	June 2021
Status	Met/Continue for next year
Summary	Scripts and procedures have been implemented to meet the minimum DHCS requirements for test calls. There is also a developed standard for staff when answering calls from clients. Goal is to increase client satisfaction. Based on 13 test calls for FY 20/21 about 92% of the callers' experiences were rated as positive. This is an increase in the previous FY test call results of 76% from 17 test calls, our continued goal is at least 90% of test calls will be rated as positive. To maintain this goal, we will continue to increase test calls, train current and incoming staff using our scripts and other tools.

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. • Make 1 test call in another language and 1 for AOD services • QM will report to call center the outcome of test calls
Measurement	95 % or more calls answered 95 % or more test calls logged. 100% of requested interpreters provided 75% of call will be rated satisfactory (Caller indicated they were helped)
Responsibility	Tracey Chan
Due Date	June 2021
Status	Partially Met/Continue for next year
Summary	Test calls answered: 100% Test calls logged: 69% Requested Interpreter provided: N/A Call rated satisfactory: 84% For the 1st quarter there were 5 test calls, 2nd quarter there were 2 test calls, 3rd quarter there were 3 test calls, and in the 4th quarter were 3 test calls. This goal will be

	continued to next year in order to improve the number of test calls per quarter, in total there were 13 test calls made: all 13 calls were answered, and 9 calls were completely logged. 0 test callers requested an interpreter. 1 of out 13 test calls were completed in another language.

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

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. • 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 2021
Status	Met
Summary	• FY 19/20: Grievance report presented at QIC on October 14, 2020 • FY 20/21: Favorable: 58.6%, Partially Favorable: 34.4%, Unfavorable: 6.9% · FY 20/21: Grievances: 83.9% resolved within 30 days. 100% of grievances resolved within 90 days. • FY 20/21: 3 Appeals All resolved within 30 days 2 Upheld 1 Overturned

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. (baseline 50%)
Responsibility	GAT Team Annina Altomari
Due Date	June 2021
Status	Met
Summary	• All providers received a copy of the Resolution letters within 90 days. • 94% of Providers copy Resolution letters were sent the same day as the Resolution letter was sent to the clients. 3.5% of letters were sent within three days after the Resolution letter to the client was sent. 2.4% of letters were sent before the resolution letter to the client was sent.

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. • Train BHRS staff and contractors on new grievance procedures • Track compliance with new Grievance and NOABD policy
Measurement	• # of successfully issued NOABDs • # of Appeals completed with outcome % for favorable outcomes for client • # of successfully completed Grievances
Responsibility	Ingall Bull

	GAT Team
Due Date	June 2021
Status	Met
Summary	• The Grievance and Appeals team handled 90 grievances in FY 20/21 • QM held a series of Webinars dedicated to instructing staff on the Grievance and appeals process. • With the COVID-19 Pandemic much of this work was delayed and resumed in March 2022. o **BHRS NOAS & Timely Access WEBINAR** – Presenter: Jeannine Mealey, LMFT. This training will address timelines (timely access) for new clients to BHRS. We will also discuss the required documentation needed if timelines are not met (**March 2021)** o **New Avatar Forms: WEBINAR** – Presenter Jeannine Mealey, LMFT. We will answer your questions about the new Avatar Consent Forms, Medication Consent Forms, and introduce the new Avatar NOA form. **(April 2021)** o **New Avatar NOABD (Notices of Adverse Benefit Determination) Form:** Avatar Demonstration & NOABD Q&A Intended for all mental health staff and their supervisor that use Avatar receive requests for service and/or provide assessment for medical necessity or treatment. Any BHRS staff that completes NOABD and/or authorization services. **(July 2021)** • In addition to the trainings. QM Staff have been meeting with individual team to assist them in developing workflows and processes to manage timeliness and the NOABD Process**.**

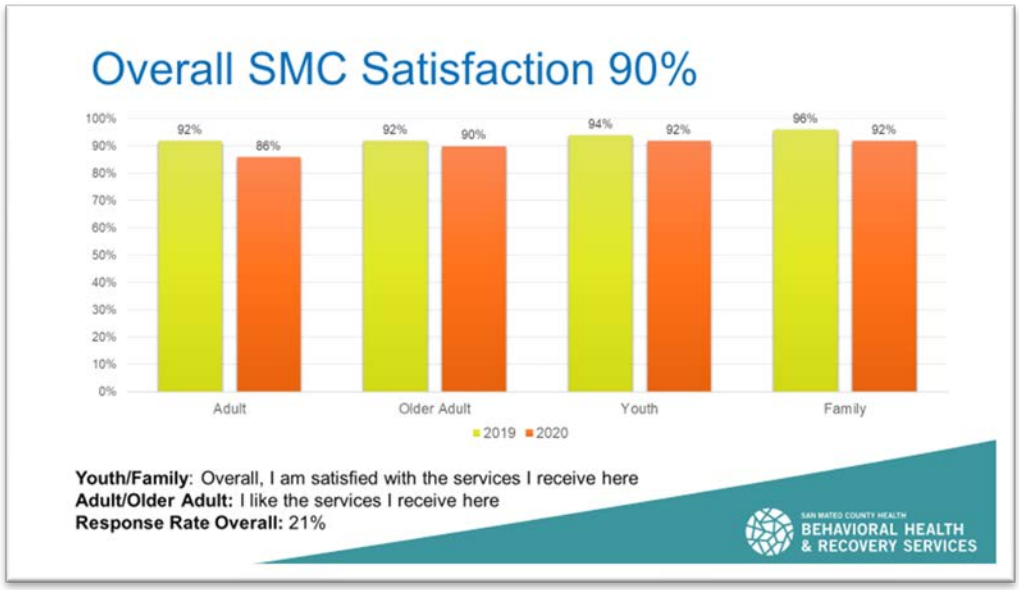
REASON FOR NOA	**# of NOABD**	**% of Total**
ABD overturned	1	1.43%
ABD Upheld	1	1.43%
Authorization delay	9	12.86%
Denial of Service	18	25.71%
Denial of Services	7	10.00%
Modification of Services	5	7.14%
Notice of Appeal Resolution-upheld	1	1.43%
Payment Denial	4	5.71%
Termination of Services	23	32.86%
Timely Access	1	1.43%
Grand Total	**70**	**100.00%**

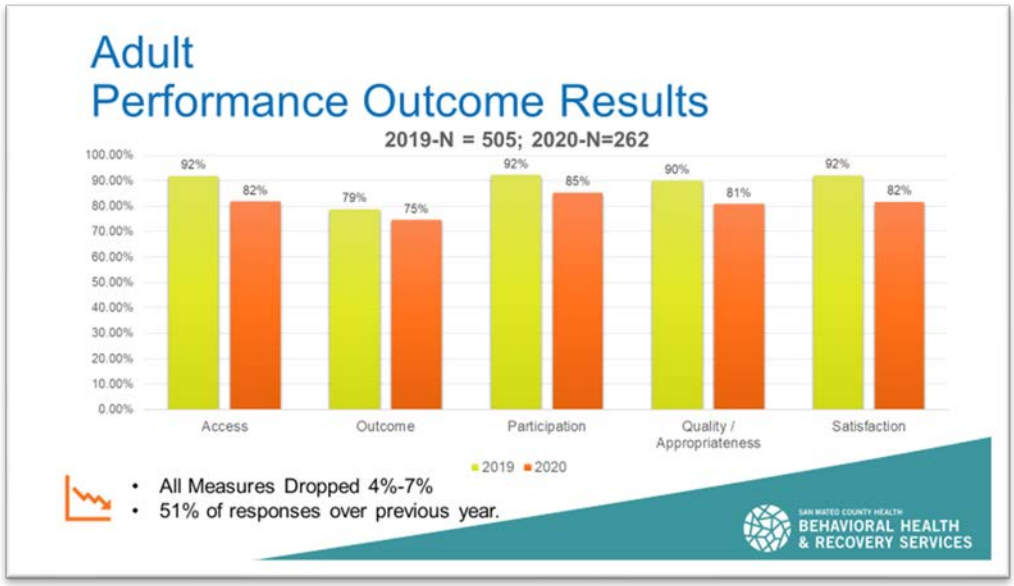
Goal 4	Decision for client's requested Change of Provider within 2 weeks
Intervention	• Change of Provider Request forms will be sent to Quality Management for tracking. • Obtain baseline/develop goal.
Measurement	Annual review of requests for change of provider.
Responsibility	Tracey Chan
Due Date	June 2021
Status	Continued for next year
Summary	In FY 2020-2021, 47 requests to change provider were received. Below is totals for previous fiscal years.

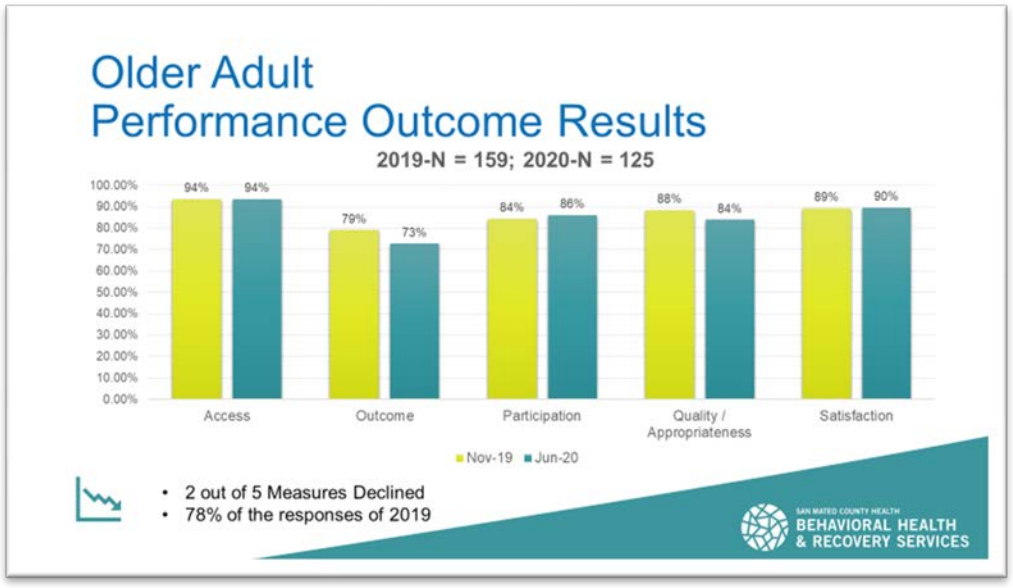
	• 62 requests in FY 19-20 • 69 requests in FY 18-19 • 105 requests in FY 17-18 87% of decisions were made within 14 days. Below are percentages from previous fiscal years. • 82% for FY19-20 • 73% for FY18-19 • 76% for FY17-18 In summary, 43 requests were approved and 4 were resolved without a change of provider.

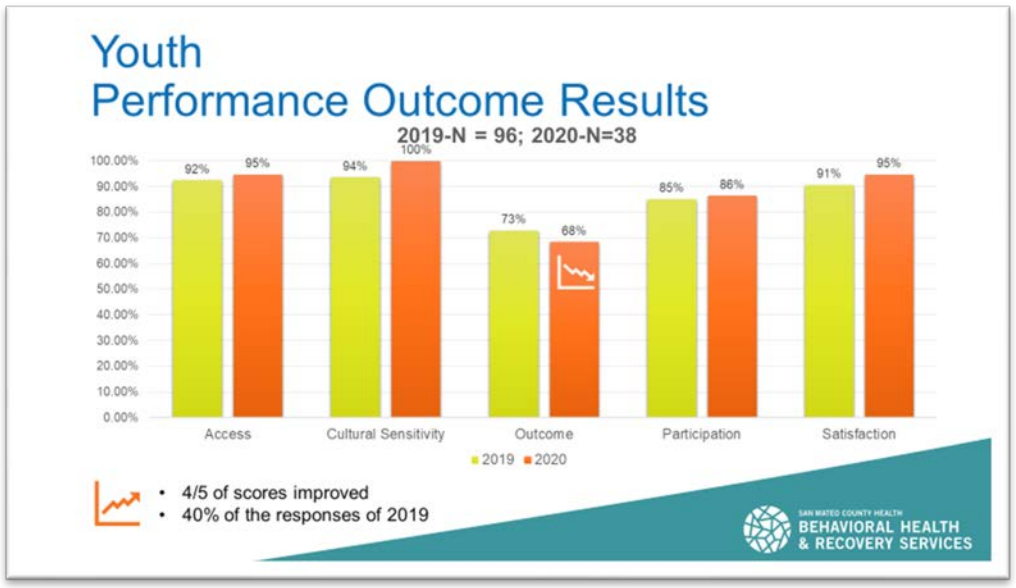
6. Client Satisfaction and Culturally Competent Services

Goal 1	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.
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 • Presentation and notification of the results yearly.
Responsibility	Ingall Bull Scott Gruendl David Williams Diana Hill
Due Date	June 2021
Status	Met but partially implemented due to COVID
Summary	• Due to COVID-19 Emergency Health Orders, DHCS cancelled the Fall 2020 Client Satisfaction Survey and delayed the May 2020 and 2021 survey until the third week of June in in 2020 and 2021. Information presented below is from the June 2020 Survey. • As a result of the shutdown in the beginning of the Pandemic satisfaction ratings declined due to the pivot to phone and telehealth services. However Overall Satisfaction was 90%. • Total number of number of surveys sent out dropped by 45% due to the pivot to remote services and difficulty in getting surveys to clients. • Overall Adult and Older Adult appeared to be affected most by the impact of COVID-19 Public Health Emergency.


Overall SMC Satisfaction 90%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
92%
86%
92%
90%
94%
92%
96%
92%
Adult
Older Adult
Youth
Family
2019 2020
Youth/Family: Overall, I am satisfied with the services I receive here
Adult/Older Adult: I like the services I receive here
Response Rate Overall: 21%
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES


Adult
Performance Outcome Results
2019-N = 505; 2020-N=262
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
92%
82%
79%
75%
92%
85%
90%
81%
92%
82%
Access
Outcome
Participation
Quality / Appropriateness
Satisfaction
2019 2020
All Measures Dropped 4%-7%
51% of responses over previous year.
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES





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" • 75% of Existing staff who have taken the initial training will take the refresher training at lease every three years.
Responsibility	Claudia Tinoco Maria Lorente-Foresti Doris Estremera
Due Date	June 2021
Status	Met (Ongoing)

Summary	The goal is ongoing. BHRS New Staff participate in multiple orientations. Orientation participants are informed of the requirement to attend the Working with Interpreters in a Behavioral Health Setting. The New Hire Orientation and the BHRS Internship Orientation, which are separate from the Onboarding Orientation provided by the BHRS Payroll/HR also informs participants about the requirement. Supervisors are asked to inform their new hires during their team orientation process. Lastly, new hires are given access to BHRS policy documents. Generally, two in-person Working with Interpreters in a Behavioral Health Setting are provided annually (April and October). This Fiscal year 2019-2020 BHRS had a total of 75 new hires including regular, extra-hire, relief, and interns. Forty-eight (48) of the new hires are still active and 60% (26) have taken at least one of the Working with Interpreters in Behavioral Health Settings training that were available during this fiscal year. Nineteen (19) of the new hires who are still active and were eligible to take one of the sessions offered this fiscal year have not taken it. Ninety (90) percent of existing staff who have taken the course in 2017 or before have taken either a refresher course or an in-person course. There are some barriers impacting this ongoing goal. Staff are hired over the course of the fiscal year. The course has been offered, primarily, in-person. However, the largest attendance was during the Shelter-in-place related to the COVID-19 pandemic. So, some staff have difficulty attending with a full caseload. The BHRS New Hire Orientation (provided by the Workforce Education and Training Team) is only offered once a year due to its labor-intensive organization (3 Sessions) and insufficient staffing. However, changes have been implemented during this fiscal year. Specifically, the training was assigned via the BHRS LMS and the session was virtual.

Goal 3	Expand Translation of BHRS Consumer Documents to meet Threshold Languages (Spanish, Tagalog, Chinese)
Intervention	Update BHRS Consumer facing communications to be in our threshold languages Update Policies to include threshold languages
Measurement	Completion of translation identified communication Posted on Website Printed Materials distributed to Clinics and Contractors
Responsibility	Tracey Chan Maria Lorente-Foresti Doris Estremera
Due Date	June 2020
Status	Met (Ongoing)
Summary	

Document FY 19-20	English	Spanish	Chinese	Tagalog	Russian	Samoan	Tongan
Survey Cover Letter	X	X	X				
BHRS Wallet Card instructions	X	X	X	X			
UPDATE BHRS COVID resources	X	X	X	X	X		

	New client flyer	X	X	X	X	X		
	Stakeholder Handout	X	X	X	X	X	X	X
	2020 CPP MHSA 3 Year Plan Flyer	X	X	X	X	X	X	X
	Consent to Treatment	X	X	X	X			
	BHRS Brochure	X	X	X	X	X		
	Disclosure Form	X	X					
	Beneficiary Handbook	X	X		X			
	Immigration Resources	X	X					

- Documents are also vetted by BHRS staff before publication to ensure cultural appropriateness.
- Translation of Documents to threshold languages is ongoing and work is done interdepartmentally to ensure that materials at least meet Goal 3.

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 Doris Estremera Maria Lorente-Foresti Chad Kempel
Due Date	June 2021
Status	Met (Ongoing)
Summary	Data from the first half of Fiscal year 2019-2020 indicate that on average approximately 84% of clients whose preferred language is other than English were provided services in their preferred language. It is likely that COVID-19 had an impact however, the data are not currently available. We also do not have data on clients who refuse interpreter services either due to symptomatology, preferred interpreter not being available, etc.

Goal 5	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	65% of staff will complete the Cultural Humility training.
Responsibility	Claudia Tinoco Doris Estremera Erica Britton Desirae Miller
Due Date	June 2021
Status	Partially Met (Ongoing)
Summary	To date BHRS has offered 27 foundational Cultural Humility courses from a variety of trainers including Dr. Melanie Tervalon and BHRS Staff and Partners who participate as part of the training cohort. Currently, there are 507 active BHRS Staff in LMS. As of June 26th, 2020, 176 BHRS staff or 34% had taken a foundational Cultural Humility course. This number does not include BHRS Staff who may have taken Cultural Humility related course (eg Becoming Visible: Using Cultural Humility in Asking SOGI questions). There are some barriers impacting this ongoing goal. Due to the content, the course in offered primarily in person and the course is limited to 40 people. The course has been offered, primarily, in-person. For this fiscal year, the Shelter-in-place related to the COVID-19 pandemic severely impacted the delivery of this course. Due to the content of the course, it has not been offered virtually and did not have an established virtual curriculum. Additionally, the number of Cultural Humility Cohort trainers has greatly diminished due to BHRS turnover. However, changes have been implemented during this fiscal year. Specifically, the Cohort has consulted with Dr. Tervalon regarding creating and standardizing a virtual version of the training. Several new BHRS staff have been trained in the delivery of the model.

7. DMC-ODS Pilot

Goal 1	Enhance the EMR system (Avatar) to include expanded SUD client health information
Intervention	• Enhance Avatar for SUD to include required DMC ODS data collection and reporting components and clinical components. • Train county and provider SUD staff on how to use the new system. • Implement SUDS EMR with identified programs. • Develop a post implementation survey for collecting user feedback. • Implement improvements to fix system bugs and improve user experience based on user feedback
Measurement	• Go live date • Post implementation survey results for user acceptance and feedback
Responsibility	Kim Pijma QM Team Diana Hill
Due Date	June 2021
Status	Met (discontinue)
Summary	All SUD contracted providers have been trained on the enhanced Avatar data collection forms and processes as of June 2021. We are currently working on fixing system issues to improve user experience, which is an ongoing practice as issues arise.

Goal 2	**Care Coordination:** Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.

Intervention	• ASAM evaluation and treatment referral completed prior to residential detox discharge. • Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.
Measurement	• # of Res Detox discharges • % of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge • % of clients re-admitted to detox within 30 days
Responsibility	Eliseo Amezcua Giovanna Bonds Melina Cortez Mary Taylor Fullerton
Due Date	June 2021
Status	Not Met (Continue)
Summary	Palm Ave detox, our residential detox program, closed unexpectedly in March 2021. Prior to their closure, they had just implemented enhanced Avatar EMR processes from Goal #1, so that we could start tracking the measurements for this goal. As we are amid a pandemic, the focus of Palm Ave and other contractor staff was developing and implementing COVID-19 response and safety protocols. We are currently in the process of working with contractors to re-establish Palm Ave and open additional residential detox programs within the county, and this goal will need to be implemented with the newly contracted programs, including the establishment of program expectations and the creation of tracking reports

Goal 3	**Monitor Service Delivery System:** 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. • Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts. • Pilot Audit with each of the DMC-ODS providers
Measurement	# of charts reviewed for each DMC-ODS providers
Responsibility	Diana Hill Desirae Miller Christine O'Kelly
Due Date	June 2021
Status	Met
Summary	We designed and implemented a client chart audit tool for remote chart audits of all SUD contracted providers. In FY 20-21, we audited 99 DMC-ODS beneficiary charts.

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 • Develop of an annual Training Plan that incorporates Evidenced-Based Practices. • Implement training plan
Measurement	• Copy of training plan protocol • # of trainings offered
Responsibility	Diana Hill Mary Fullerton Christine O'Kelly
Due Date	June 2021
Status	Partially Met

Summary	In FY 20-21, workforce training efforts were largely focused on the COVID-19 pandemic and implementing safety protocols for clients and staff. Additional barriers included a hiring freeze and a vacant analyst position tasked with coordinating training protocols. However, contracted consultants Dr. Brian Greenberg and Dr. Lea Goldstein offered SUD treatment providers training, including but not limited to those listed as Evidenced-Based Practices in the STCs, and those listed as standard practices in the BHRS SOC.

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.
Intervention	• Implement Training Plan for provider clinicians, counseling and supervisory staff. • Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs. • 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. • FY 18-19 performance is 28%
Responsibility	Diana Hill Christine O'Kelly Kathy Reyes Erica Britton
Due Date	June 2021
Status	Partially Met (Continue)
Summary	In FY 20-21, workforce training efforts were largely focused on the COVID-19 pandemic and implementing safety protocols for clients and staff. Additional barriers included a hiring freeze and a vacant analyst position tasked with coordinating training protocols. Training on EBP's were offered ad hoc, as requested by each contracted provider. Personnel file reviews showed that 64% of counseling and LPHA staff had attended training in at least two EBPs, representing 129% increase over FY 18-19.

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. • FY 17/18 baseline is 35%. • FY 18/19 = 55%.
Responsibility	Diana Hill Christine O'Kelly Mary Taylor Fullerton
Due Date	June 2021
Status	Met
Summary	In FY 20-21, workforce training efforts were largely focused on the COVID-19 pandemic and implementing safety protocols for clients and staff. Additional barriers included a hiring freeze and a vacant analyst position tasked with coordinating training protocols. Training on EBP's were offered ad hoc, as requested by each contracted provider. Personnel file reviews showed that 100% of LPHA staff received at least 5 hours of addiction medicine training in FY 20-21.

Goal 7	**Monitor Service Delivery System:** 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. • Identified reports are created in Avatar • 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 Diana Hill Mary Fullerton Kim Pijma (contract monitor) Dave Williams
Due Date	June, 2021
Status	Not Met
Summary	The COVID-19 pandemic necessitated the diversion of resources. As a result, this goal was not addressed. As programs have all implemented the new enhanced Avatar, reports can now be developed for monitoring compliance with DMC ODS requirements, and for monitoring system quality and performance.

Goal 8	**Timeliness of first contact to first appointment:** 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: o Outpatient SUD services (excluding Opioid Treatment Programs) o Opioid Treatment Programs • Share data for BHRS programs and contractor agencies serving DMC-ODS clients • NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment. • 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. • % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard) • % 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 Diana Hill Mary Taylor Fullerton Matt Boyle Diana Campos Gomez
Due Date	June 2021
Status	Partially Met
Summary	Avatar is now able to track timeliness data from time of first request to first face-to-face appointment, and all programs have been trained and implemented this process. The next step is to develop reports on the timeliness data. Providers' internal tracking indicates that 85% of outpatient SUD clients receive a first appointment within 10 days of first request, and that 100% of OPT clients receive a first appointment within 3 days of first request. When the Avatar reports are created, we can confirm this data.

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: o Outpatient SUD services (excl. Opioid Treatment Programs) o Opioid Treatment Programs • Include data for BHRS programs and contractor agencies serving DMC-ODS clients • 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. • % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment.
Responsibility	Chad Kempel Clara Boyden
Due Date	06/30/2020
Status	Met (Discontinue/Combine with previous goal)
Summary	NACT data was submitted on time.

Goal 10	**Care Coordination:** Care will be coordinated with physical health and mental health service providers.
Intervention	• Implementing contract standard for physical health and mental health care coordination of services at the provider level • Audit charts to monitor compliance with standard • Develop system-wide coordination meeting with providers • 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. • % of MD reviewed physical health examinations with a subsequent referral to physical health services. • % of audited client charts with a completed ACOK screening • % of positive AC OK Screens with a subsequent referral to mental health services.
Responsibility	Diana Hill Christine O'Kelly Desirae Miller Eliseo Amezcua Mary Fullerton
Due Date	June 2021
Status	Partially Met
Summary	In FY 20-21, 85.2% of clients surveyed agreed or strongly agreed with the statement: "Staff here work with my physical health care providers to support my wellness." In FY 20-21, 88.3% of clients surveyed agreed or strongly agreed with the statement: "Staff here work with my mental health care providers to support my wellness." As the Avatar EMR was not fully implemented until June 2021, client chart audits were completed manually. The data records regarding percentages of physical health examination requirements, referrals to physical health services, ACOK screenings and

	referrals to mental health services were not available. It is anticipated that in FY 21-22, this data will be more accessible in Avatar,

Goal 11	Assess client experience of SUD services through annual survey.
Intervention	• Conduct annual TPS Survey with all provider/beneficiaries • 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. o FY 19/20: 88.8 % (N=228) – baseline • % of clients surveyed who indicated "I chose my treatment goals with my provider's help" as determined by the annual SUD treatment perception survey. o FY 19/20: 90.8 % (N=228) – baseline • % 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 o FY 19/20: 90.8% (N=228) - baseline
Responsibility	Diana Hill Christine O'Kelly Desirae Miller Mary Fullerton
Due Date	June 2021
Status	Met
Summary	• % percent of clients surveyed who indicate "staff were sensitive to my cultural background (race, religion, language, etc.)" on an annual treatment perceptions survey. o FY 19/20: 88.8 % (N=228) – baseline o FY 20/21: 92.9% (N=175) • % of clients surveyed who indicated "I chose my treatment goals with my provider's help" as determined by the annual SUD treatment perception survey. o FY 19/20: 90.8 % (N=228) – baseline o FY 20/21: 93.5% (N=175) • % 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 o FY 19/20: 90.8% (N=228) – baseline o FY 20/21: 89.4% (N=175) Keep goal with a new due date of June 2022.