## 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 attend in person.

### Goal 3

<table>
<thead>
<tr>
<th>Create and update policies and procedures. This includes AOD/ODS Contract requirements.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>Update current policies and procedures. Work with leadership/managers to prioritize and modernize our policies. Update policy Index. Collaborate with AOD management &amp; 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.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
</tr>
<tr>
<td>Policy Committee: Jeannine Mealey Kathy Koeppen Marcy Fraser Holly Severson Betty Gallardo-Ortiz</td>
</tr>
<tr>
<td><strong>Status/Dates</strong></td>
</tr>
<tr>
<td>Ongoing</td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Improve compliance with HIPAA and Compliance training mandate.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>Staff will complete online HIPAA &amp; online Compliance Training at hire and annually.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
</tr>
<tr>
<td>Track training compliance of new staff and current staff. Current staff: Goal = or &gt; 90%. New Staff: Goal = or &gt; 100%.</td>
</tr>
</tbody>
</table>
| 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 |
| Year End Review      | Goal Met |
## Goal 4

**Maintain disallowances to less than 5% of sample.**

<table>
<thead>
<tr>
<th><strong>Intervention</strong></th>
<th>Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System. Implement Chart Audit Program.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measurement</strong></td>
<td>Audit 10% Medi-Cal Charts Yearly. Decrease disallowances Targets: Medi-Cal: &lt;5%</td>
</tr>
</tbody>
</table>
| **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. |
### 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.

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Decision regarding request of Change of Provider made within 2 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>Change of Provider Request forms will be sent to Quality Management for tracking. Obtain baseline/develop goal.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
<td>Annual review of requests for change of provider.</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Jeannine Mealey Kathy Koeppen</td>
</tr>
<tr>
<td><strong>Status/Dates</strong></td>
<td>In Progress</td>
</tr>
<tr>
<td><strong>Year End Review</strong></td>
<td>Partially met</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Providers will be informed of results of the beneficiary/family satisfaction surveys bi-annually.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>Develop communication plan to inform providers/staff of the results of each survey within a specified timeline.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
<td>Completion of notification twice a year. Presentation and notification of the results yearly.</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Scott Gruendl</td>
</tr>
<tr>
<td><strong>Status/Dates</strong></td>
<td>Goal in Progress</td>
</tr>
<tr>
<td><strong>Year End Review</strong></td>
<td>Partially met.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Goal 4</th>
<th>Streamline Clinical Work Flow to standardize the work across the system.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
<td>Use a specific question in QM Satisfaction Survey to identify training gaps for staff. Review of staff productivity around documentation</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Jeannine Mealey Hung-Ming Chu Kathy Koeppen Betty Ortiz-Gallardo Chad Kempel Bob Cabaj</td>
</tr>
<tr>
<td><strong>Status/Dates</strong></td>
<td>Partially Met</td>
</tr>
<tr>
<td><strong>Year End Review</strong></td>
<td>A workgroup have been developed and met 4 times to identify which workflow to streamline.</td>
</tr>
</tbody>
</table>