SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Quality Improvement Work Plan for SUDS and Mental Health July 2019-June 2020 (Start July 2019)

Color Legend: MHP SUDS/AOD MHP/SUD

Table of Contents

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%. The assigned months for each training will be Compliance -Nov 2019 FWA -Nov 2019 HIPAA -Aug 2019
Responsibility	Tracey Chan Jeannine Mealey
Due Date	June 2020
Status	Met
Summary	Annual 2019: BHRS Staff Compliance Bundle — Completed 445 In Progress / Past Due 53 Annual 2019: BHRS Staff Compliance Bundle Total 498 ***% Completed Training as of 6.17.2020 89.36%*** New Staff Completed 100%

Goal 2	Improve clinical documentation and quality of care.
Intervention	Maintain clinical documentation training program for all current and new staff.

<table>
<tr><td>Measurement</td><td>Track compliance of new staff completing the training. New Staff: Goal = 100%.</td></tr>
<tr><td>Responsibility</td><td>Clinical Documentation Workgroup
Amber Ortiz
Ingall Bull
Claudia Tinoco
Tracey Chan</td></tr>
<tr><td>Due Date</td><td>June 2020</td></tr>
<tr><td>Status</td><td>Met</td></tr>
<tr><td>Summary</td><td>Training summary 2020 (Jan-May) BHRS Quality Management
Report Date 6.16.20

QM Training efforts in 2020 as of May 31, 2020.
1. ASK QM, with an QM OD for the day to answer questions with 24 hours (if possible). Many questions are received and answered daily. Most questions are related to clinical care, clinical documentation, and billing.
2. Staff's charts are audited ongoing. Very specific feedback is sent directly to the staff person and their supervisor.
3. Weekly very detailed informational emails were send to all staff related to clinical documentation and billing with special attention to COVOD-19 and telehealth/phone services.
4. A series of live webinars were held related to clinical documentation and billing.
5. A series of ONLINE documentation trainings are accessible to all staff and contractors at any time. BHRS Trainings are located at www.smcgov.org/LMS

Live WEBINAR Provided in 2020 Jan-May 31, 2020
<table><tr><th>Training Title</th><th>Training Start Date</th><th>Total Attended</th></tr><tr><td>QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR</td><td>April 1- 1 to 2 pm</td><td>124</td></tr><tr><td>QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR</td><td>April 8- 1 to 2 pm</td><td>99</td></tr><tr><td>QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR</td><td>April 15- 1 to 2 pm</td><td>75</td></tr><tr><td>QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR</td><td>April 22- 1 to 2 pm</td><td>88</td></tr><tr><td>BHRS Mental Health Groups Coding & Documentation WEBINAR</td><td>April 28th – Tuesday 9:30am to 11:00am</td><td>18</td></tr><tr><td>QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR</td><td>April 29th – Wednesday 1pm to 2pm</td><td>76</td></tr><tr><td>QM COVID-19 Clinical Documentation Recommendations Updates WEBINAR</td><td>May 13th – Wednesday 1:00pm to 2:00pm</td><td>72</td></tr><tr><td>BHRS Legal Updates: Release of Information, Letters for Clients, & Consent for Treatment WEBINAR</td><td>May 26th – Tuesday 9:30am to 11:00am</td><td>15</td></tr><tr><td>BHRS Legal Updates: Release of Information, Letters for Clients, & Consent for Treatment WEBINAR</td><td>May 28th – Thursday 2:30pm to 4:00pm</td><td>99</td></tr><tr><td>Grand Total</td><td>9 Live Sessions</td><td>666</td></tr></table>
QM webinars:
• The Webinar Trainings are LIVE.</td></tr>
</table>

- Participates are actively engaged during the training.
- There are live Polls throughout the training that participants answer.
- Participates ask many questions and we answer all questions during the training. We do not end the training until all questions are answered. Any additional questions are welcomed in our Ask QM email box.
- The feedback that we are getting is very positive overall! Staff and supervisors state they like and appreciate these trainings.
- What people like most: being able to ask questions, the Q&A portion, the Polls, specific examples and scenarios.
- Staff appreciate that a recording of the webinars are posted and that helpful resources are provided.
- Current Online Training Available to all Staff and BHRS Contractors:

Training Title: Total Number of People completing the Training Jan-May 31, 2020	
Annual 2019: BHRS Compliance Mandated Training	176
Annual 2019: BHRS Fraud, Waste, & Abuse Training	178
Annual 2019: BHRS: Confidentiality & HIPAA for Mental Health and AOD: All BHRSv3.3	173
Assessments for BHRS Mental Health: Clinical Staff v7.16.19	13
Avatar Assessment Demonstration for BHRS: Clinical Staff v7.16.19	12
Avatar Discharges and Transfers for BHRS: Clinical Staff v7.16.19	4
Avatar OrderConnect for BHRS: Medical Staff v7.16.19	3
Avatar Progress Note Demonstration for BHRS v7.15.19	14
Avatar Treatment Plan Demonstration for BHRS v7.15.19	11
BHRS Confidentiality and HIPAA for MH & AOD: 2018 Annual Update	2
Client Treatment & Recovery Plan for BHRS Mental Health: Clinical Staff v7.15.19	15
Compliance Training for BHRS	1
Compliance Training for BHRS: 2018 Update	1
Compliance Training for BHRS: All New Staff v7.14.19	77
Confidentiality & HIPAA for BHRS Mental Health and AOD: All New Staff v7.16.19	117
Critical Incident Management for BHRS: All New Staff v2_7.14.19	76
Fraud, Waste, & Abuse Training for BHRS 2018 Annual Update	1
Fraud, Waste, & Abuse Training for BHRS: All New Staff v7.14.19	100
Introduction to the BHRS Avatar Electronic Medical Record: All New Avatar Users v7.16.19	3
Introduction to the BHRS Avatar Electronic Medical Record: All New Avatar Users v8.21.19	36
LOCUS Training for BHRS: Adult Program Clinical Staff v7.16.19	6
Progress Notes for BHRS: Part 1, Writing progress notes v7.15.19	23
Progress Notes for BHRS: Part 2, Group progress notes v7.15.19	18
Progress Notes for BHRS: Part 3, Billing for progress notes v7.15.19	19
Grand Total	1079

Training summary 2019 BHRS Quality Management

Live WEBINAR Provided in 2019

Training Title	Training Start Date	Total Attended
Assessments & Treatment Plans that will Pass the Audit: WEBINAR	9/3/2019 10:00	24
Assessments & Treatment Plans that will Pass the Audit: WEBINAR	9/4/2019 15:00	57
Assessments & Treatment Plans that will Pass the Audit: WEBINAR	9/5/2019 9:30	43
Assessments & Treatment Plans that will Pass the Audit: WEBINAR	9/26/2019 12:30	43
BHRS Managed Care & Private Provider Network (PPN) Clinical Documentation: WEBINAR	11/14/2019 10:00	106
BHRS Managed Care & Private Provider Network (PPN) Clinical Documentation: WEBINAR	11/20/2019 14:00	100
Coding & Billing for Meeting with Other Professionals, CFT, Case Conference, and Collaborating with BHRS MH Staff & Contractors: Webinar	10/30/2019 15:00	50
Coding & Billing for Meeting with Other Professionals, CFT, Case Conference, and Collaborating with BHRS MH Staff & Contractors: Webinar	11/7/2019 10:00	36
Coding & Billing for Traveling to Appointments and Providing Services in the Community (MH BHRS Staff & Contractors): Webinar	10/16/2019 15:00	63
Coding & Billing for Traveling to Appointments and Providing Services in the Community (MH BHRS Staff & Contractors): Webinar	10/17/2019 9:30	42
Coding for Progress Notes & Documenting Your Services: WEBINAR	8/27/2019 11:00	50
Coding for Progress Notes & Documenting Your Services: WEBINAR	8/28/2019 15:00	65
Coding for Progress Notes & Documenting Your Services: WEBINAR	8/29/2019 11:00	61
Coding for Progress Notes & Documenting Your Services: WEBINAR	9/25/2019 9:00	54
Grand Total		**794**

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 2020
Status	Met
Summary	Monthly reports were sent to all SDMC programs. Documentation compliance rates within acceptable limits- run date 6.16.2020.

Totals for YOUTH SERVICES - COUNTY

Assessments Overdue: 0	**# of Open Clients:** 1,233	**# Tx Plan Overdue:** 48
Overdue Assessments 61 + days after Admission: 11	**# Overdue Assessments Not Assigned to Care Coordinator:** 3	**Overdue Tx Plan 61 + days after Admission:** 29
Total Assessment Overdue: 11		**Total Treatment Plans Overdue:** 77
Assessment Percentage Overdue: 0.89%		**Percentage Tx Plan Overdue:** 6.24%

Totals for ADULT SERVICES - COUNTY

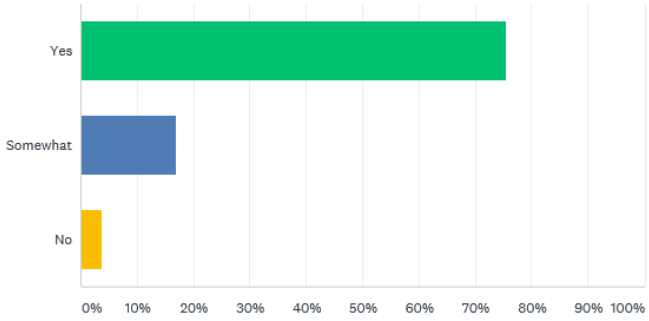
Assessments Overdue: 3	**# of Open Clients:** 3,416	**# Tx Plan Overdue:** 88
Overdue Assessments 61 + days after Admission: 22	**# Overdue Assessments Not Assigned to Care Coordinator:** 0	**Overdue Tx Plan 61 + days after Admission:** 41
Total Assessment Overdue: 25		**Total Treatment Plans Overdue:** 129
Assessment Percentage Overdue: 0.73%		**Percentage Tx Plan Overdue:** 3.78%

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 2020
Status	Met
Summary	There was a DHCS chart audit during this time period however San Mateo has not received the report of finding.

Program Type	Charts Audited	Services Audited	Services Disallowed	Dollars Audited	Disallowance	Disallowance Rate
Contractor Adult	69	1458	366	$ 251,948.70	$ 48,504.56	19%
Contractor Youth	31	668	39	$ 112,083.23	$ 5,254.31	5%
County Adult	84	1300	427	$ 232,145.78	$ 62,472.96	27%
County Youth	12	413	55	$ 85,981.60	$ 7,900.67	9%
Private Provider Network	83	640	219	$ 46,791.58	$ 14,488.65	31%

	Totals	**279**	**4479**	**1106**	**$ 728,950.89**	**$138621.15**	**19%**

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 71.79%, Somewhat 21.79% = 93%, No = 6.41% o Total responses 108.
Responsibility	Ingall Bull, Jeannine Mealey
Due Date	December 2019
Status	Met
Summary	The survey was open from Feb 7th, 2020 to Feb 26th 2020. Total Responses: 61 people responded to the survey. Are you satisfied with the help that you received from the Quality Management staff person? Yes 75.47%, Somewhat 16.98% = 92.45%, No = 3.77% If so, were you satisfied with the help that you received from the QM/QI staff person? Answered: 53 Skipped: 9



ANSWER CHOICES	RESPONSES	
Yes	75.47%	40
Somewhat	16.98%	9
No	3.77%	2
TOTAL		53

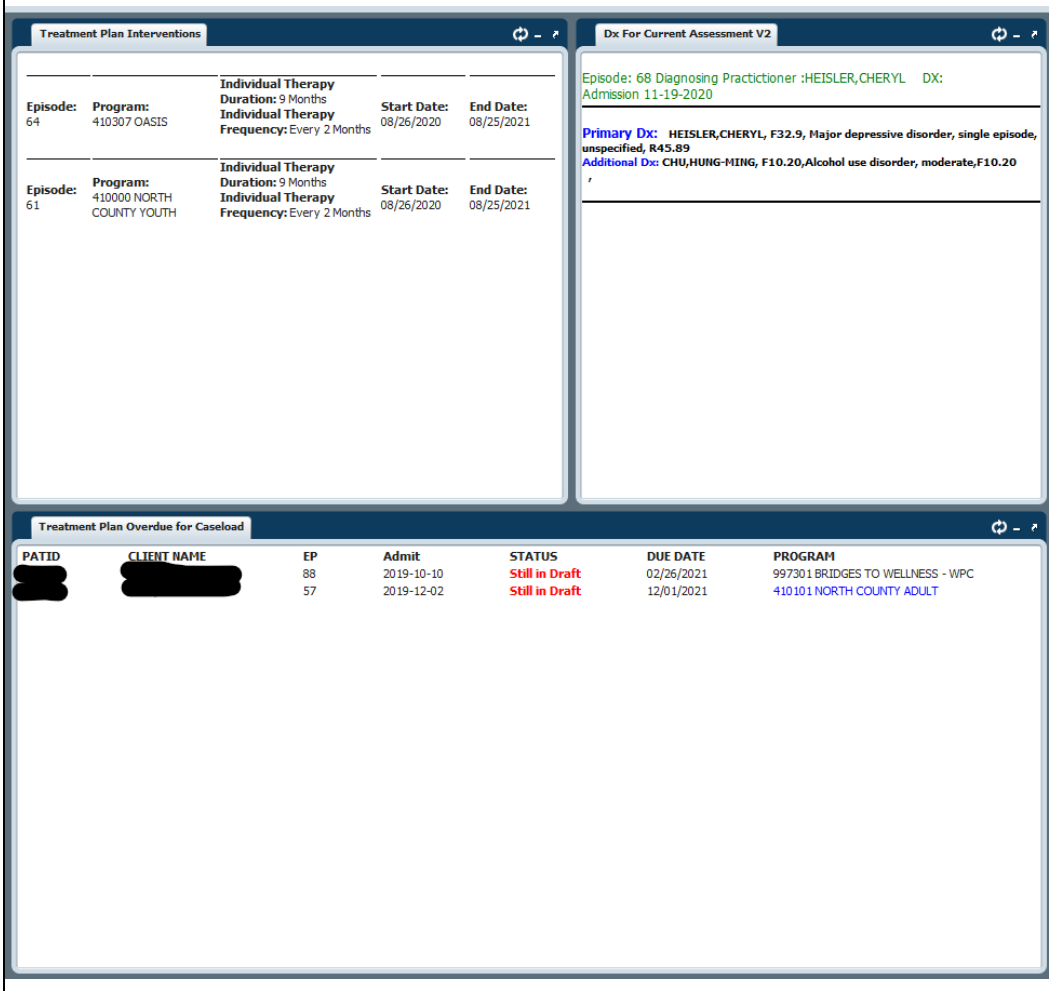
Goal 6	Create and update policies and procedures in BHRS for Mental Health and SUD
Intervention	• Update current policies and procedures for new managed care rules. Update policy Index. • Maintain internal policy committee to address needed policies and procedures. • Retire old/obsolete policies. • Create 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 manager
Due Date	June 2020
Status	Met
Summary	**In FY 2019-2020 (July 2019 -June 2020) the Policy Committee made the following changes:** **# of Policies Created: 17** 1. **19-02: Standard Pre-Service Organizational Determinations** (on 8/28/19) **Managed Care* 2. **19-03: Expedited Pre-Service Organizational Determinations** (on 8/28/19) **Managed Care* 3. **19-04: Utilization Management Program – Interrater Reliability Testing** (on 9/11/19) **Managed Care* 4. **19-05: Medical Necessity Criteria for Specialty Mental Health Services** (on 11/20/19) 5. **19-06: Provider Directory** (on 12/18/19) 6. **19-07: Provider Selection and Retention (MH Network of Care)** (on 12/21/19) 7. **19-08: Credentialing and Re-Credentialing Providers** (on 12/31/19) 8. **20-01: Continuity of Care for Specialty Mental Health** (on 1/10/20) 9. **20-02: Authorization of Adult Residential Services** (on 1/17/20) 10. **20-03: Presumptive Transfer** (on 1/9/20) 11. **20-04: Authorization of Youth SMHS** (on 1/9/20) 12. **20-05: Utilization Management Program and Authorization of SMHS** (on 1/9/20) 13. **20-06: Utilization Management of Inpatient Psychiatric Services** (on 2/4/20) 14. **20-07: Medication Monitoring for Youth** (on 1/8/20) 15. **20-08: Full Service Partnership** (on 5/11/20) 16. **20-09: MHSA Administration and Components** (on 6/4/20) 17. **20-10: MHSA Issue Resolution Process** (on 6/4/20)

	# of Policies Retired: 16 1. **92-09: Adult and Older Adult Eligibility Criteria** (superseded by 19-05: Medical Necessity Criteria for SMHS on 11/20/19) 2. **96-12: Medical Necessity – Adults Receiving System of Care Services – Procedure for Reassessment** (superseded by 19-05: Medical Necessity Criteria for SMHS on 11/20/19) 3. **05-03: Eligibility Criteria, Child/Youth** (superseded by 19-05: Medical Necessity Criteria for SMHS on 11/20/19) 4. **98-03: Provider Contracts** (superseded by 19-07: Provider Selection and Retention on 12/31/19) 5. **98-07: Provider Selection and Performance Criteria** (superseded by 19-07: Provider Selection and Retention on 12/31/19) 6. **98-16: Credentialing for County Licensed Professional Staff** (superseded by 19-08: Credentialing and Re-Credentialing Providers on 12/31/19) 7. **98-08: Credentialing Committee** (superseded by 19-08: Credentialing and Re-Credentialing Providers on 12/31/19) 8. **98-09: Delegation of Credentialing, Credentialing, Recertification or Reappointment of Individual Practitioners** (superseded by 19-08: Credentialing and Re-Credentialing Providers on 12/31/19) 9. **04-01: Compliance Policy for Funded Services Provided by Contracted Organizational Providers** (superseded by 19-08: Credentialing and Re-Credentialing Providers on 12/31/19) 10. **04-02: Employee and On-site Contractor Screening and Orientation** (superseded by 19-08: Credentialing and Re-Credentialing Providers on 12/31/19) 11. **04-03: New Professional Contractors, Screening and Orientation** (superseded by 19-08: Credentialing and Re-Credentialing Providers on 12/31/19) 12. **03-03: Grievance and Appeal System** (superseded by 19-01: Consumer Problem Resolution & NOA on 6/21/19) 13. **04-10: Notice of Action** (superseded by 19-01: Consumer Problem Resolution & NOA on 6/21/19) 14. **99-08: Referral Procedures (Inpatient) Special Circumstances** (superseded by 20-06: Utilization Management of Inpatient Psychiatric Services on 2/4/20) 15. **00-06: Client Access to Mental Health Record** (superseded by 20-06: Utilization Management of Inpatient Psychiatric Services on 2/4/20) 16. **05-06: Clinical Forms** (retired without replacement on 8/1/19) **# of Policies Amended/Technical Edits: 19** 1. **98-14: Fingerprinting of BHRS Providers** (on 1/8/20) 2. **99-01: Services to Clients in Primary or Preferred Languages** (on 1/9/20) 3. **99-03: Medication Room Management** (on 2/11/20) 4. **99-09: Private Provider Contracts- Language Capabilities** (on 1/9/20) 5. **01-08: Bilingual Salary Differential – Spanish and Tagalog Speaking Staff** (on 1/9/20)

	6. **03-01: Confidentiality/Privacy of Protected Health Information** (on 5/15/20) 7. **03-02: Notice of Privacy Practices** (on 10/19) 8. **05-01: Translation of Written Materials** (on 1/9/20) 9. **05-05: Admission Materials** (on 1/9/20) 10. **98-05: Credentialing for Independent Contracted Providers** (on 10/25/19 & 1/16/20) 11. **17-01: Electronic Medical Record Security and Electronic Signatures** (on 1/10/20) 12. **18-01: Cultural Humility, Equity and Inclusion Framework; Implementation of CLAS Standards** (on 1/9/20) 13. **19-01: Consumer Problem Resolution & NOA** (on 10/10/19 & 1/9/20) 14. **19-08: Credentialing and Re-Credentialing Providers** (on 1/9/20) 15. **20-06: Utilization Management of Inpatient Psychiatric Services** (on 2/24/20) 16. **93-11: Critical Incident Reporting** (on 11/18/19) 17. **98-01: Change of Clinician Request** (on 10/25/19) 18. **16-02: SMC BHRS Code of Conduct** (on 12/18/19) 19. **17-02: Delegation Oversight & Audit Program** (on 12/18/19) **Policy Index was last updated on:** 2/25/20. An updated version is currently in progress to reflect recently passed policies. **Policy Committee for FY 2019-2020 included QM members:** Ingall Bull, Claudia Tinoco, Jeannine Mealey, Holly Severson, Eri Tsujii, Annina Altomari, Tracey Chan

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 6/2020 (continuous)
Responsibility	Ingall Bull Holly Severson
Due Date	June 2020
Status	Met
Summary	• **Policy 16-11: Quality Improvement Committee** was last updated on 6/25/19.

Goal 8	Improve Usability of the EMR system (Avatar)
Intervention	• Develop Consoles and Widgets that will make client information more easily accessible • Implement Consoles and push out throughout the EMR • Develop a post implementation survey for collecting user feedback.
Measurement	• Go live Date • Post implementation survey results for user acceptance and feedback

Responsibility	Kim Pijma QM Team
Due Date	September 2019
Status	Sent
Summary	The new Consoles for the Avatar system were deployed in the fall of 2019.These consoles contain a collectin of Widgets that display important information on clients to the user without having to search through the chart. The new Consoles include the following widgets. We did not complete an after implementation survey due to resource restriction caused by the COVID-19 Health emergency. 1. **Treatment Plan Interventions**- Displays current active interventions that are approved on the treatment plan. 2. **Current Diagnosis** 3. **Treatment Plan Over Due for Caseload –** Displase Tx Plans that are overdue for a User's caseload 4. **Consent Tracking –** displays current consents on file for the client. 5. **Assessment View –** Displays the history and direct access to all assessments on file for the client. 

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 2020
Status	Partially Complete
Summary	QM continues manage the Incident reporting process. Presentation had not occured when COVID-19 Health emergency was implemented. This delayed the presentation of this material. Below is a breakdown of Incident report for the fiscal year.

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	October 2019
Status	Partially Completed
Summary	PIP 1: Timely Initial Assessment PIP. Youth system was experiencing delays in getting new clients in for their initial assessment, which led to delays in accessing treatment. This PIP is to develop form in Avatar that can help clinicians keep track of when requests for services come in, and require staff to have appointment times set aside each week that are available for initial assessments with new clients. Intervention began to be implemented in February 2020. COVID-19 led to a pause in this new process in March 2020. Committee made modifications to the process to account for telehealth/phone appointments. Modified PIP interventions resumed in mid-April 2020. PIP is measuring the number of days it takes for new clients to be offered and attend their initial assessment and treatment appointments. PIP 2: Youth PES PIP. New clients who entered our system through PES were experiencing delays in access to treatment. A number of factors were identified that were contributing this delay that were specific to Youth Case Management's role in linking client's to treatment. Committee identified ways in which YCM could standardize their information gathering and referral making process so that treatment teams would have the information treatment teams need in order to set an initial appointment and assign a therapist in a timely manner. This intervention required the creation of a new form in Avatar. COVID-19 impacted the creation of this form as the IT team needed to focus their resources and staff on getting

	staff equipped for teleworking. The PIP intervention has not yet been implemented. When the intervention is able to be implemented, this PIP will measure the number of days it takes for youth discharged from PES, who are not previously connected to BHRS service, to attend their first follow-up appointment after PES discharge.

Goal 2	Identify new PIP interventions for the current fiscal year.
Intervention	• Review recent ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas. • Work with the 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
Due Date	June 2020
Status	Implementation Delayed Due to COVID-19 Health Emergency
Summary	PIPs developed. Implementation of non-clinical and clinical PIPs focused on increasing treatment admissions in outpatient (non-clinical) and residential (clinical) treatment was delayed due to the COVID shelter in place order effective 3/17/2020. Due to the evolving nature of the pandemic, we will engage in ongoing exploration and data analysis to determine if the existing PIPs will continue to be relevant during this time, if the existing PIPs need to be modified, or if new PIPs will need to be developed.

3. Utilization and Timeliness to Service Measures

Goal 1	The MHP's Utilization Management (UM) Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively. (MHP Contract, Ex. A, Att. 5)
Intervention	Review and update UM program policies and procedures to reflect changes released in DHCS Information Notice 19-026 and include that • They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field. • They consider the needs of beneficiaries. • They are adopted in consultation with contracting health care professionals. • Update authorization process for SMHS residential care • They are reviewed and updated periodically as appropriate. • Develop a process for concurrently reviewing inpatient psychiatric hospitalization. • Create a SMHS Utilization Committee to develop the following o UM Plan o Mechanisms for determining Over Utilization and Under Utilization o Review Reports, and trend analysis o Compare against DHCS POS data across fiscal years
Measurement	• Revise UM Plan and process for SMHS

	• Implemented Concurrent Review UM program for Inpatient Psychiatric hospitalizations
Responsibility	Ingall Bull Eri Tsujii Tracey Chan Claudia Tinoco
Due Date	June 2020
Status	Sent Ingall
Summary	

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* • Create a workgroup focused on determining how to track and implementing timeliness measures • Identify gaps in data collection and create data points needed to track timeliness to service and follow up for service. • Develop a 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) • Include data for BHRS and contract agencies serving SDMC clients. • Report to Executive Team and QIC, timeliness data annually. • Create and/or revise policies to incorporate these changes
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	Eri Tsujii
Due Date	June 2019
Status	Partially Met
Summary	System of Care – UM workgroup started its meetings in September of 2019. We met regularly to develop the timeliness data collection tool to meet the requirements of Network Adequacy and CSI Assessment information, from that group the Timeliness Data Tracking form was created in Avatar. (See Below) North County Youth was chosen as the site to pilot the form and to develop the workflow for completing the form which began in January of 2020 and was combined with a PIP process. OUR pilot program revealed several issues with the intended form and a new process was developed.

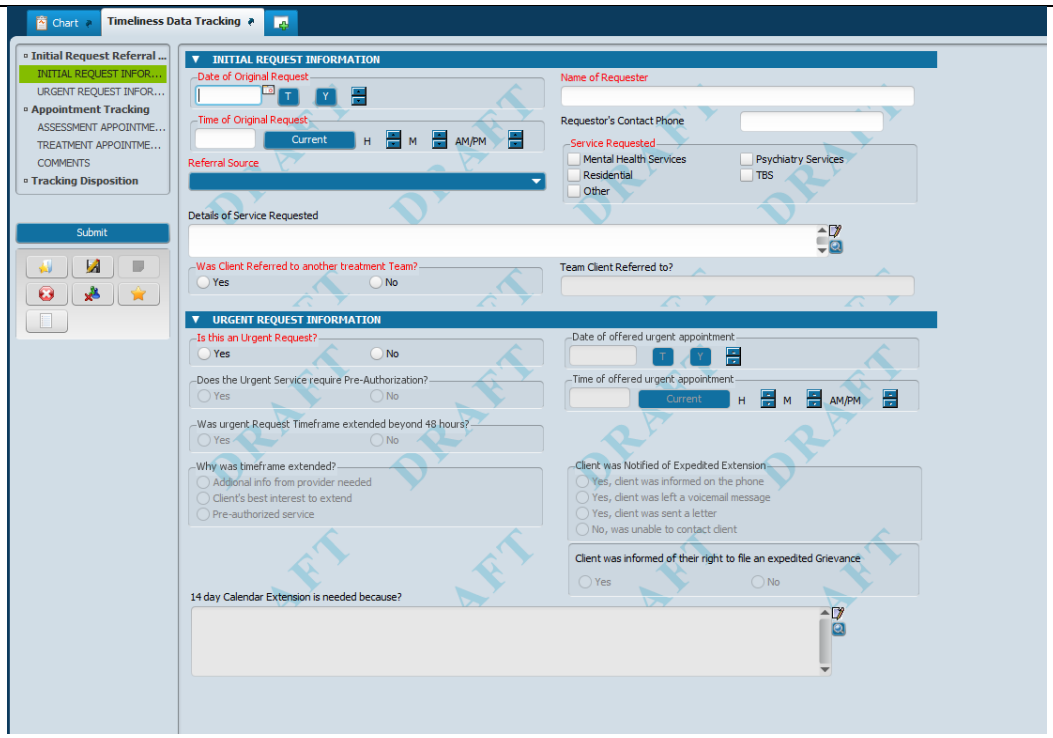


Chart
Timeliness Data Tracking
Initial Request Referral ...
INITIAL REQUEST INFOR...
URGENT REQUEST INFOR...
Appointment Tracking
ASSESSMENT APPOINTME...
TREATMENT APPOINTME...
COMMENTS
Tracking Disposition
Submit
INITIAL REQUEST INFORMATION
Date of Original Request
Name of Requester
Requestor's Contact Phone
Time of Original Request
Current
H
M
AM/PM
Service Requested
Mental Health Services
Psychiatry Services
Residential
TBS
Other
Referral Source
Details of Service Requested
Was Client Referred to another treatment Team?
Yes
No
Team Client Referred to?
URGENT REQUEST INFORMATION
Is this an Urgent Request?
Yes
No
Date of offered urgent appointment
Does the Urgent Service require Pre-Authorization?
Time of offered urgent appointment
Was urgent Request Timeframe extended beyond 48 hours?
Why was timeframe extended?
Additional info from provider needed
Client's best interest to extend
Pre-authorized service
Client was Notified of Expedited Extension
Yes, client was informed on the phone
Yes, client was left a voicemail message
Yes, client was sent a letter
No, was unable to contact client
Client was informed of their right to file an expedited Grievance
14 day Calendar Extension is needed because?
DRAFT

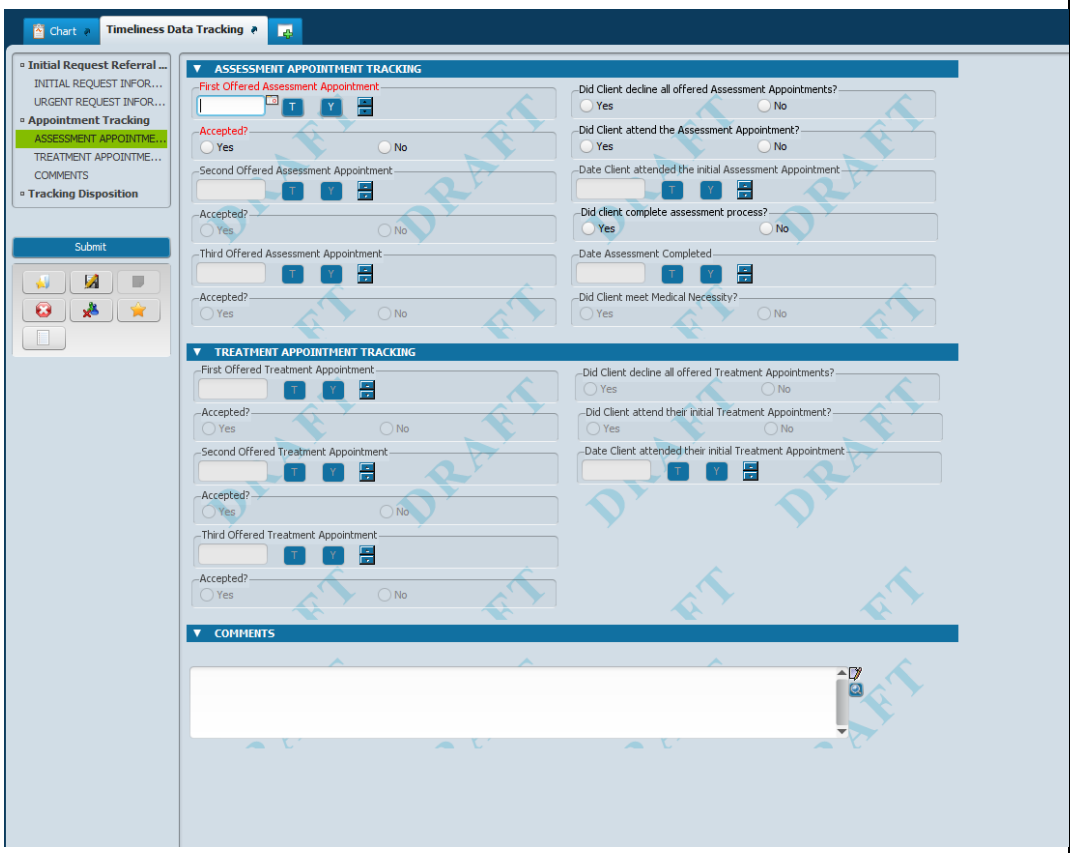
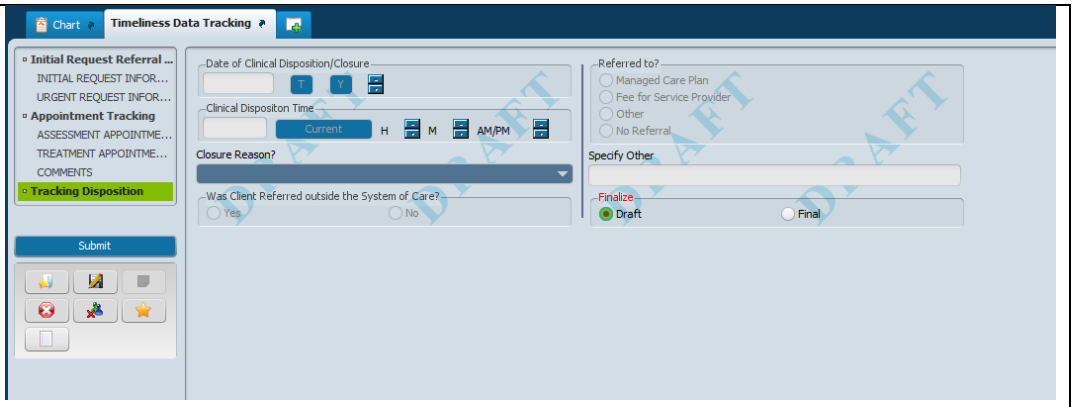


Chart
Timeliness Data Tracking
Initial Request Referral ...
INITIAL REQUEST INFOR...
URGENT REQUEST INFOR...
Appointment Tracking
ASSESSMENT APPOINTME...
TREATMENT APPOINTME...
COMMENTS
Tracking Disposition
Submit
ASSESSMENT APPOINTMENT TRACKING
First Offered Assessment Appointment
Did Client decline all offered Assessment Appointments?
Yes
No
Accepted?
Did Client attend the Assessment Appointment?
Second Offered Assessment Appointment
Date Client attended the initial Assessment Appointment
Did client complete assessment process?
Third Offered Assessment Appointment
Date Assessment Completed
Did Client meet Medical Necessity?
TREATMENT APPOINTMENT TRACKING
First Offered Treatment Appointment
Did Client decline all offered Treatment Appointments?
Did Client attend their initial Treatment Appointment?
Second Offered Treatment Appointment
Date Client attended their initial Treatment Appointment
Third Offered Treatment Appointment
COMMENTS
DRAFT

Goal 3	Develop process for capturing 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) o Revise JV 220 oversight process to incorporate these measures o Identify and update policies as needed
Measurement	Creation of a protocol and process for oversite Updated policies
Responsibility	QM Workgroup Ingall bull Eri Tsujii Claudia Tinoco Tracey Chan
Status	Partially Completed
Summary	BHRS completed a set up in Avatar to identify all Foster Care youth in our System. We created a tracking episode that is updated once per month based on MMEF reporting of clients who are identified as being in foster care. Clients are opened or closed depending on their status month to month. Ongoing reporting on the metrics have been delayed in part to COVID-19 health emergency.

4. Access and Call Center

Goal 1	Improve customer service and satisfaction for San Mateo County Access Call Center
Intervention	• 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	Selma Mangrum Tracey Chan Ingall Bull Claudia Tinoco
Due Date	June 2020
Status	Not 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 17 (as of 6/17/2020) test calls for FY 19/20 about 76% of the callers' experiences were rated as positive. This is a decrease in previous FY test call results, our continued goal is at least 90% of test calls will be rated as positive. To further 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 2020
Status	Partially Met/Continued for next year
Summary	Test calls answered: 100% Test calls logged: 94% Requested Interpreter provided: 50% Call rated satisfactory: 76% For the 1st quarter there were 9 test calls, 2nd quarter there were 5 test calls, 3rd quarter there were 2 test calls, and in the 4th quarter was 1 test call. This goal will be continued to next year in order to improve the number of test calls per quarter, as of 6/17/20 17 test calls were made: all 17 calls were answered, and 16 calls were logged. 2 test callers requested an interpreter and only 1 caller was provided an interpreter. 6 of our 17 test calls were completed in another language.

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

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 2020
Status	Ongoing
Summary	BHRS received a total of 72 regular grievances, out of which 71 were resolved at the time of this report. The average number of days to resolution was 24.7 with 18 grievances lasting longer than 30 days, 4 lasting longer than 60 and one over 70 days. The grievance that lasted longer than 70 days was resolved in 126 days due to not being able to obtain the information necessary to conduct a thorough investigation, in spite of multiple attempts to reach the client. The issue was investigated as far as possible but the grievance was erroneously filed as a non-grievance; time the mistake was found and corrected several months later. The barrier was a lack of procedural clarity for managing these types of grievances. As a result, GAT implemented a procedure to inform clients who do not provide enough information that GAT would not be able to conduct a grievance investigation without them providing more statements. After two weeks of unsuccessful contact attempts, clients will be sent a letter giving them another two weeks to contact GAT before the issue is closed without cataloguing it as a grievance. No appeals were received during the period of this report.

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	October 2019, January 2020, April 2020, July 2020
Status	Ongoing
Summary	At the time of this report, 71 grievances were resolved by GAT out of which 100% of providers were informed on the same day the grievance was resolved. Meeting this goal was possible thanks to the procedure implemented to track it within the Grievances Log. Only until this requirement is met can

	a grievance be listed as completed. The Log has two columns dedicated to this goal, one showing the date that providers were mailed a copy of the grievance resolution letter with a cover letter, and another indicating that a printed copy of the letter is on the paper file. Additionally, each grievance has an individual tracking form with a reminder check box specific to this item. Impact of COVID-19: GAT has been unable to create or audit the paper folders, but reviews of the digital folders have been conducted to ensure all materials are complete.

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	January 2020
Status	Partially Met
Summary	Total of NOABD is 46 and grievances is 71.

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 2019
Status	Continued for next year
Summary	In FY 2019-2020, 62 requests to change provider were received. There were a total of 69 requests for FY 2018-2019, and 105 requests for FY 2017-2018). 82% of decisions were made within14 days (73% for FY18-19, 76% for FY17-18). In summary, 56 requests were approved and 6 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 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	Ingall Bull

	David Williams
Due Date	July 2019, January 2020
Status	Completed
Summary	May 2019 Client Satisfaction Survey was presented at QIC in November 2019 **May 2019 Outcome Results** **ADULT Performance outcome results** (all measures improved) **Access** 91.88% **Outcome** 78.74% **Participation** 92.24% **Quality/Appropriateness** 90.08% **Satisfaction** 92.08% **Youth Performance Outcome** Results (2 of 5 measures improved) **Access** 92.39% **Outcome** 93.62% (Improved) **Participation** 72.92% **Quality/Appropriateness** 85.11% **Satisfaction** 90.63% **Family (Youth)** (4 of 5 measures improved) **Access** 93.60% (improved) **Cultural Sensitivity** 97.66% **Outcome** 78.57% (improved) **Participation** 91.13% (improved) **Satisfaction** 92.19 (improved) **Older Adult Performance Outcome Results** **Access** 93.59% **Outcome** 79.08% **Participation** 84.42% **Quality/Appropriateness** 88.46% **Satisfaction** 89.31%

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 2020
Status	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 having 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	Completed

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 2020

Status	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
Due Date	Due June 30, 2019
Status	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.

Goal 6	Monitor data collection guidelines regarding sexual orientation and gender identity (SOGI)
Intervention	• All clients to be assessed for their sexual orientation and gender identity All staff with direct client contact will appropriately ask client's sexual orientation and gender identity questions (SOGI)
Measurement	• # of completed SOGI questions in Avatar assessments. Separate by contract agencies and county programs • Baseline =
Responsibility	Claudia Tinoco Doris Estremera

	Erica Britton Maria Lorente-Foresti
Due Date	June 2020
Status	Partially completed.
Summary	SOGI questions are now a required part of all BHRS assessments and are required fields to be filled out when a clinician completes an assessment on a client. SOGI questions are now deployed throughout our BHRS system.

7. DMC-ODS Pilot

Goal 1	Increase offender access to SUD care post release at re-entry to the community
Intervention	• Continue training criminal Justice partners. • Complete ASAM Evaluations of in-custody clients upon request. • Link clients to appropriate level of care post release
Measurement	• % of ASAM in-custody evaluation completed • % of inmates released to the appropriate level of care
Responsibility	Mary Fullerton Eliseo Amezcua Clara Boyden
Due Date	June 2020
Status	discontinued
Summary	FY 19/20 continued implementation intervention related to FY17/18 PIP. Data for this goal not pulled at year-end due to severe staffing shortage impacted by COVID reassignments, hiring freeze, multiple staff on medical leaves. This intervention is not part of standard business process and will be discontinued for FY 20/21.

Goal 2	Increase number of clients discharged from residential detox services with a referral to the appropriate level of care based ASAM criteria and who are subsequently admitted follow-up care.
Intervention	• AOD care coordinator will complete and ASAM evaluation and treatment referral. • Coordinate the discharge and subsequent admission to the next recommended level of care.
Measurement	• % of clients with a referral (ASAM level of care) prior to discharge from detox services. # of referral/# of discharges • % of clients being admitted to a subsequent follow up appointment/treatment with 7 days of discharge • % of clients re-admitted to detox within 30 days Baseline: Calendar Year 2018: • 710 discharges occurred from Palm Avenue (AD413601) between 1/1/2018 and 12/31/2018 • 456 of the 710 Palm Ave discharges (64%) received a first service within 7 days of discharge. • 73% of discharges received first service within the first 14 days. • 79% of discharges received first service within the first 30 days.
Responsibility	Clara Boyden

	Eliseo Amezcua Giovanna Bonds
Due Date	June 2020
Status	Continue
Summary	Calendar Year 2019 data • 400 discharges occurred from Palm Avenue (AD413601) between 1/1/2019 and 12/31/2019 • 280 of the 400 Palm Ave discharges (70%) received a first service within 7 days of discharge • 75% of discharges received first service within the first 14 days. • 80% of discharges received first service within the first 30 days. • FY 19/20 year end data for this goal not pulled at year-end due to severe staffing shortage impacted by COVID reassignments, hiring freeze, multiple staff on medical leaves.

Goal 3	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. • Develop an audit tool and protocols in for chart audits conjunction with QM • Pilot Audit with each of the DMC-ODS providers
Measurement	# of charts reviewed for each DMC-ODS providers
Responsibility	Diana Hill Christine O'Kelly
Due Date	June 2020
Status	Not met
Summary	This goal was not completed due to the pandemic restrictions and. Our monitoring tools developed to address DMC-ODS documentation requirements. Paper chart audits could not occur after March 2020 due to COVID shelter in place. Data for this goal not pulled at year-end due to severe staffing shortage impacted by COVID reassignments, hiring freeze, multiple staff on medical leaves.

Goal 4	Ensure timely access to NRT/OTP.
Intervention	NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment
Measurement	• % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy (NRT.) o County Target is 95%. o FY 17-18 is 93% o FY 18/19 is 90% • % of clients who received first service within 3 days of request (State Standard) - establish baseline.
Responsibility	Diana Hill
Due Date	June 2020
Status	Revised
Summary	In FY 19/20, 88.2 % of clients who requested admission to our NRT program were admitted within 24 hours of making their request. Reporting not developed for measurement of three day standard due to COVID assignments, Avatar SUD ReStart rollout delays, and severe staff shortage.

Goal 5	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 a Training Plan that incorporates Evidenced-Based Practices. • Implement training plan
Measurement	• Completion of the training plan protocol • # of trainings offered
Responsibility	Diana Hill Kathy Reyes
Due Date	June 2020
Status	Continue (Delayed due to COVID-19 health Emergency)
Summary	This goal was not able to be worked on due to pandemic restrictions and due to severe staffing shortage impacted by COVID reassignments, hiring freeze, and multiple staff on long term medical leaves.

Goal 6	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 2020
Status	Continue (Delayed due to COVID-19 health Emergency)
Summary	This goal was not able to be worked on due to pandemic restrictions and limited staff resources due to severe staffing shortage impacted by COVID reassignments, hiring freeze, multiple staff on extended medical leaves.

Goal 7	80% All provider 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
Due Date	June 2020
Status	Continue (Delayed due to COVID-19 health Emergency)

Summary	This goal was not able to be worked on due to pandemic restrictions and limited staff resources due to severe staffing shortage impacted by COVID reassignments, hiring freeze, multiple staff on extended medical leaves.

Goal 8	Create reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards
Intervention	• Identify needed data points for report generation • Analyze gap between data needs and data points available. • Develop new data points as needed • Identify reports needed
Measurement	• # of reports developed that meet reporting requirement for DMC-ODS
Responsibility	Clara Boyden Diana Hill Kim Pijma (contract monitor) Dave Williams
Due Date	June, 2020
Status	Implementation delayed
Summary	An analysis of reports needed for ODS was developed and submitted. Avatar EHR expansion (SUD ReStart) and rollout was delayed by approximately nine months due to COVID. Report development was subsequently delayed in part due to Avatar delays, due to severe staffing shortages throughout the year, and because of redirection of technical resources to COVID response and reporting.

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	April 1, 2020
Status	Implementation delayed
Summary	This goal is in the process of being completed A referral tracking process was created in Avatar that all of BHRS contracted SUD treatment providers are being trained on. Estimated training completion timeline is April 2021; after that, timeliness data will be able to be tracked.

Goal 10	Create and implement after-hours access policies and procedures
Intervention	• Research requirements to meet standard • Convene BHRS QI staff representative, DMC ODS staff and providers to develop a policy and procedures to ensure after-hours access to care is available. • Implement policy and monitoring process for after-hours access.
Measurement	Copy of approved policy and procedures

Responsibility	Diana Hill Ingall Bull Clara Boyden
Due Date	June 2020
Status	Partially Completed
Summary	A collaboration among Optum after hours contract counties Marin, Contra Costa, Sonoma, and San Mateo County met several times to create a uniform tool, standards, and processes for Optum. Demands of the pandemic and staffing shortages prevented the completion of this goal.

Goal 11	Track coordination of physical health and mental health services.
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 • 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
Due Date	June 2020
Status	Continue (Delayed due to COVID-19 health Emergency)
Summary	In November 2019, TPS data show that 87% of clients surveyed said care was coordinated with well with physical health providers; and 86.4% said care was coordinated with well with mental health providers. Chart auditing required to measure this was not completed on due to pandemic restrictions and limited staff resources due to extended leaves of absence.