San Mateo County Behavioral Health & Recovery Services
Quality Improvement Work Plan July 2018-June 2019 (Start July 2017)

Requirement: Monitor Quality Improvement Activities (1-3)

Goal 1	Monitor staff satisfaction with QI activities & services.
Intervention	• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department. • 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 2016- Yes 78%, Somewhat 16% = 94% Total responses 110.
Responsibility	Ingall Bull
Due Date	June 2019

Goal 2	Create and update policies and procedures. This includes AOD/Organized Delivery System (ODS) Contract requirements.
Intervention	• Update current policies and procedures for new managed care rules. Update policy Index. • Collaborate with AOD management for integration and establishment of required AOD policies, identify and create policies. • Maintain internal policy committee to address needed policies and procedures. • Retire old/obsolete policies.
Measurement	Continue to amend and create policies as needed. QIC Survey Monkey for policy votes implemented in FY16-17.
Responsibility	Policy Committee: Ingall Bull Claudia Tinoco Jeannine Mealey Holly Severson Tracey Chan Marcy Fraser Clara Boyden – AOD manager
Due Date	June 2019

Goal 3	Comply with QIC Policy and maintain voting membership that represents all parts BHRS
Intervention	1) Review/amend QIC Policy as necessary. 2) Maintain QIC voting membership of approx. 30 that represents BHRS system
Measurement	1) Ensure compliance with QIC Policy: communicate with QIC members as necessary. 3) Verify and document 30 QIC Voters that represents BHRS system by 6/2019 (continuous)
Responsibility	Ingall Bull Holly Severson

Due Date	June 2019

Requirement: Monitoring the MHP's Service Delivery System (4a)

Goal 1	Improve compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.
Intervention	Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.
Measurement	Track training compliance, HIPAA, & FWA of new staff and current staff. Current staff: Goal = or > 90% for each training. New Staff: Goal = 100%. The assigned months for each training will be Compliance -Nov 2018 FWA -Nov 2018 HIPAA -Aug 2018
Responsibility	Tracey Chan Nicola Freeman Jeannine Mealey
Due Date	June 2019

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 staff completing the training. New Staff: Goal = 100%.
Responsibility	Clinical Documentation Workgroup Amber Ortiz Ingall Bull Claudia Tinoco Tracey Chan
Due Date	June 2019

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	Tracey Chan Nicola Freeman
Due Date	June 2019

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 2019

Goal 5	Improve customer service and satisfaction for San Mateo County Access Call Center
Intervention	• Create scripts and procedures for administrative and clinical staff at Access Call Center • Develop standards for answering calls * Increase training for Optum call center staff on standards for answering calls.
Measurement	Test calls and call logs 90% test call rated as positive
Responsibility	Selma Mangrum Tracey Chan - QM Lead Ingall Bull Claudia Tinoco
Due Date	June 2019

Goal 6	Tracking Incident Reports (IR) and Suicide Rates in SMC
Intervention	• Collect data on known or suspected suicides reported to BHRS by Department IR • Compare baseline statistics from BHRS population to County Coroner's office for method, demographics. • Conducted review of cases identified in the highest impact population (older adults). year over year • Track rate of highest impact population over 2 years Conduct review of highest impact population segments • Report trends and current data to QIC and leadership • Review information with Countywide Suicide Prevention Task Force • Enter deaths and major incident in to System to See
Measurement	• Compare population specific suicide rates year to year with emphasis on older adults • Track rates, methods and demographics for future outreach efforts to reduce rates of suicide • Investigate deaths by accidental overdose versus those ruled suicide
Responsibility	Ingall Bull Bob Cabaj Karen Krahn Toni DeMarco
Due Date	June 2019

Requirement: Monitoring the Accessibility of Services (4b)

Goal 1	Develop a workgroup with BHRS leadership to implement the new managed care requirements for timeliness of service
Intervention	• Develop data collection points and tracking mechanism for gathering timeliness data • Develop a baseline measurement for meeting timeliness to service requirements
Measurement	Establish Baseline Establish Data Points
Responsibility	Scott Gruendl Karen Krahn Toni DeMarco Ingall Bull
Due Date	June 2019

Goal 2	Develop and implement a protocol for concurrent review of inpatient acute hospital admissions. Improve continuity of care through timely access to needed services after hospital discharge and prevention of hospital readmissions
Intervention	Develop a protocol to preform concurrent reviews for inpatient charts.
Measurement	# of successful concurrent reviews
Responsibility	Claudia Tinoco Holly Severson Tracey Chan
Due Date	June 2019

Goal 3	Reduce the rate of disallowances of Pro fee progress notes (Services) billed to BHRS
Intervention	Review and track charts submitted for payment from Pro fee providers
Measurement	# of Pro fee submissions reviewed
Responsibility	Claudia Tinoco Holly Severson Tracey Chan
Due Date	June 2019

Goal 4	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 San Mateo Medical Center Psychiatric Emergency Services.
Measurement	Review percentage of clients attending appointment within timeline compared to baseline.
Responsibility	Scott Gruendl Toni DeMarco Karen Krahn
Due Date	June 2019

Goal 5	24/7 Call Center will be able to successfully screen and refer AOD clients
Intervention	Develop Workflows for 24/7 to log requests for services; screen, and make appropriate AOD referrals Modify test call scripts to include inquiries about AOD services.
Measurement	90% of test callers report being successfully screened and referred for AOD services to 24/7 line 3 AOD test calls will be made per quarter 100% of AOD Test Call are logged
Responsibility	Erika Jennings Tracey Chan Selma Mangrum Claudia Tinoco
Due Date	March 2019

Goal 6	Monitor 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 monthly to 24/7 toll-free number. Make 1 call monthly for AOD services Make 1 test call a month in another language. Make 1 call after standard business hours 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	Erika Jennings Tracey Chan - QM Lead
Due Date	June 2019

Goal 7	Comply with managed Care Rule to implement new Provider Directory (DHCS IN 18-020) and Network Adequacy reporting standards (DHCS IN 18-011)
Intervention	• Deploy new electronic Provider Directory • Develop protocol for timely updates and maintenance of Provider information required for the Provider Directory and Network Adequacy reporting tool • Identify gaps in current data collection systems and implement new fields in Avatar to manage provider information.
Measurement	100% of provider information will be maintain in the Avatar EMR.
Responsibility	Ingall Bull Doreen Avery Jeannine Mealey Kim Pijma
Due Date	June 2019

Goal 8	Improve trauma informed services to clients in our Adult system of care by employing Neuro-sequential Model of Therapeutics (NMT).
Intervention	Train staff in the MNT Protocol Identify a pilot group of clients appropriate for this modality. Compare results of “Time 1” and “Time 2” NMT Assessments Deliver NMT services to identified clients
Measurement	% of clients reporting improvement based on pre and post intervention client NMT service surveys
Responsibility	Tracey Chan Toni DeMarco
Due Date	June 2019

Goal 9	Decrease rates of delayed discharge from inpatient psychiatric care, readmission to psychiatric care, and follow up PES visits.
Intervention	Clients identified in our Whole Person Care program that are currently admitted to an inpatient unit will be assigned a peer support worker or family partner to assist in their discharge and transition out of the hospital through our Heart and Soul Helping Our Peers Emerge (HOPE) program
Measurement	Number of repeat visits, after discharge, to PES or admission to inpatient care for identified client base.
Responsibility	Claudia Tinoco Talisha Racy Kimberly Kang Karen Krahn
Due Date	June 2019

Goal 10	Track authorization for Adult Residential services
Intervention	• Develop a written protocol and procedure for tracking Adult Residential authorizations in Avatar • Identify gaps in current Avatar authorization and implement changes as needed. • Train staff on the use of the protocol
Measurement	• Completion of protocol and procedures • # of authorizations being tracked in Avatar
Responsibility	Talisha Racy Phillipe Nicolay Betty Gallardo Kimberly Kang Ingall Bull
Due Date	June 2019

Goal 11	Implement Child and Adolescent Needs and Strengths (CANS) tool per DHCS requirement outlined in ACL 18-09 and MHSUDS IN 18-007
Intervention	• Develop CANS in Avatar • Create written procedure and protocol for BHRS MHP, ODS, and PPN for completion of CANS assessments and data entry • Ensure staff are trained and certified to conduct CANS Assessment • Develop reporting protocol to DHCS
Measurement	# of CANS Assessments Completed in Avatar
Responsibility	Toni DeMarco Karen Krahn Regina Moreno Tracey Chan - QM lead
Due Date	Go Live October 1, 2018. June 2019

Requirement: Monitoring Beneficiary Satisfaction (4c)

Goal 1	Grievances will be resolved within 90 days of receipt of grievance and appeals within 30 day timeframe, expedited appeals will be resolved within 72 hours after receipt of expedited appeal in 100% of cases filed.
Intervention	Grievance and appeals regularly addressed in Grievance and Appeal Team (GAT) Meeting.
Measurement	Annual reports on grievances, appeals, and State Fair Hearings to QIC. Annual report with % of issues resolved to client/family member fully favorable or favorable. Annual report with % grievances/appeals resolved within 90/30 days.
Responsibility	GAT Team
Due Date	June 2019

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 Claudia Tinoco - QM Lead
Due Date	October 1 2018, January 1 2019, April 1 2019, July 1 2019

Goal 3	Ensure that Grievance and NOABD process are in compliance with Policies and procedures for handling grievances .
Intervention	• GAT will review all relevant revisions to the 2017-2018 Grievance Protocol and make any changes required. • Update NOABD and Grievance Policy to be in compliance with new DHCS regulations (IN 18-010E) • Train BHRS staff and contractors on new grievance procedures • Track compliance with new Grievance and NOABD policy
Measurement	• Completed Policy revision • # of successfully issued NOABDs • # of successfully completed Grievances
Responsibility	Ingall Bull - QM Lead GAT Team
Due Date	January 1, 2019

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. • Present to QIC on a quarterly basis
Measurement	Annual review of requests for change of provider.
Responsibility	Tracey Chan
Due Date	June 2019

Goal 5	Providers will be informed of results of the beneficiary/family satisfaction surveys bi-annually.
Intervention	Develop communication plan to inform providers/staff of the results of each survey within a specified timeline.
Measurement	Completion of notification twice a year. Presentation and notification of the results yearly.
Responsibility	Jeannine Mealey QM-Lead David Williams
Due Date	Due January 1 2019, July 1, 2019

Goal 6	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 Eleanor Dwyer
Due Date	Due June 30, 2019

Goal 7	Improve Linguistic Access for clients whose preferred language is other than English
Intervention	Services will be provided in the clients preferred language
Measurement	100% of services provided in the clients preferred language Baseline = 90%
Responsibility	Claudia Tinoco Doris Estremera Maria Lorente-Foresti Erica Britton

Goal 8	Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.
Intervention	All staff will complete mandatory training on cultural humility
Measurement	65% of staff will complete the Cultural Humility training.
Responsibility	Claudia Tinoco Doris Estremera Erica Britton
Due Date	Due June 30, 2019

Goal 9	Implement data collection guidelines regarding sexual orientation and gender identify (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) • Add not asked to all questions on all forms to be able to track if the question is asked. • Implement SOGI with contractors by 11/1
Measurement	• # of completed SOGI questions in Avatar assessments. Separate by contract agencies and county programs • Obtain baseline data from day of addition of "Not Asked" indicator in identified fields • Obtain Baseline for Call Center, ODS, County programs, and contractor agencies
Responsibility	Claudia Tinoco Doris Estremera Erica Britton Maria Lorente-Foresti
Due Date	Due June 30, 2019

Requirement: ODS Implementation

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	Sheryl Uyan Eliseo Amezcua Clara Boyden
Due Date	June 30, 2019

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 to 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 an ASAM level of care referral prior to discharge from detox services • % 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
Responsibility	Clara Boyden Eliseo Amezcua Giovanna Bonds
Due Date	June 30, 2019

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 Sheryl Uyan Christine O'Kelly
Due Date	June 30, 2019

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	95% of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy (NRT.) The baseline for FY 17-18 is 93%
Responsibility	Mark Korwald
Due Date	June 30, 2019

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 30, 2019

Goal 6	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.
Measurement	• Eighty percent (80%) of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs. • FY 17-18 baseline is 50%.
Responsibility	Diana Hill Christine O'Kelly Sheryl Uyan
Due Date	June 30, 2019

Goal 7	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	• Eighty percent (80%) of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually. • FY 17-18 baseline is 35%.
Responsibility	Diana Hill Christine O'Kelly Sheryl Uyan
Due Date	June 30, 2019

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 Scott Gruendl Kim Pijma Dave Williams
Due Date	June 30, 2019