REQUEST FOR QUALIFICATIONS

Quality Management Unit Assessment RFQ

2016-002

County of San Mateo

Behavioral Health & Recovery Services

Release Date: October 21, 2016

Responses must be Received

by 5:00 p.m. Pacific Standard Time

on November 18, 2016

REQUEST FOR QUALIFICAITONS

FOR

Quality Management Assessment RFQ

Responses must be submitted electronically to

SAN MATEO COUNTY

BEHAVIORAL HEALTH AND RECOVERY SERVICES

Attn: SCOTT GRUENDL, ASSISTANT DIRECTOR

sgruendl@smcgov.org

By 5:00 p.m. Pacific Time on November 18, 2016

RESPONSES WILL NOT BE ACCEPTED AFTER THIS DATE AND TIME

Note regarding the Public Records Act:

Government Code Sections 6250 *et seq.*, the California Public Record Act, defines a public record as any writing containing information relating to the conduct of the public business. The Public Record Act provides that public records shall be disclosed upon written request and that any citizen has a right to inspect any public record unless the document is exempted from disclosure.

Be advised that any contract that eventually arises from this Request For Qualifications is a public record in its entirety. Also, all information submitted in response to this Request For Qualifications is itself a public record **without exception**. Submission of any materials in response to this Request For Qualifications constitutes a waiver by the submitting party of any claim that the information is protected from disclosure. By submitting materials, (1) you are consenting to release of such materials by the County if requested under the Public Records Act without further notice to you and (2) you agree to indemnify and hold harmless the County for release of such information.

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SECTION I – GENERAL INFORMATION

A. STATEMENT OF INTENT

As outlined in more detail in Section II – Scope of Work, this RFQ seeks responses from any and all qualified agencies or individuals to provide consulting services. Consultant will assess the Quality Management Unit of Behavioral Health & Recovery Services and make recommendations to the agency on potential changes to align with State and Federal regulatory requirements, new Managed Care regulations, and new Drug Medi-Cal Organized Delivery System requirements; as well as recommendations that enhance the quality improvement work of the unit.

B. THE REQUEST FOR QUALIFICATIONS PROCESS

The County of San Mateo seeks by way of this RFQ to survey qualified providers about their knowledge and expertise regarding the provision of consulting services, or similar services, indicated. Agencies or individuals must be able to show that they are capable of performing the services requested. Such evidence includes, but is not limited to, the respondent's demonstrated competency and experience in delivering services of a similar scope and type and local availability of the respondent's personnel and equipment resources.

The information in this RFQ is in no way final nor does it represent what may be contained in a future RFP. This RFQ does not constitute a commitment to issue an RFP, award a contract, or pay any costs incurred in the preparation of a response to this request.

SECTION II – SCOPE OF WORK

A. DESCRIPTION

Determine the highest quality level of services that the Quality Management Unit of Behavioral Health & Recovery Services ("Unit") should strive to achieve; Assess the current state of the Unit relative to this level of service; Determine the status of compliance of the Unit with existing regulatory requirements; Assess the state of the Unit as compared to higher Federal standards; Determine the readiness of the Unit to comply with requirements of the Drug Medi-Cal Organized Delivery System; Recommend modifications in preparation for regulatory changes including managed care regulations; and Recommend how to enhance the quality improvement services of the Unit.

B. FUNDING

This contract is for $25,000 or less.

C. ADDITIONAL REQUIREMENTS/CONSIDERATIONS

Consultant shall have experience working in or with a county, state, federal, or managed care entity for the provision of quality assurance/quality improvement

services in a health or behavioral health setting; the ability to assess such work to determine compliance with existing State and Federal regulation; the knowledge to recommend modifications in preparation for new regulations imposed on managed care; and the knowledge and experience to recommend enhancement of quality improvement services.

SECTION III – GENERAL TERMS AND CONDITIONS

Register at publicpurchase.com. All potential respondents must register with Public Purchase to receive important updates about the RFQ process and to submit responses.

Read all Instructions. Read the entire RFQ and all enclosures (if any) before preparing your response.

Questions and Responses Process. Submit all questions relating to this RFQ to the designated questions field associated with this RFQ to Scott Gruendl, Assistant Director at sgruendl@smcgov.org.

All questions must be received no later than 5:00 p.m. on November 9, 2016.

All questions and responses will be posted to http://www.smchealth.org/bhrs/rfp.

If changes to the RFQ are warranted, they will be posted to the http://www.smchealth.org/bhrs/rfp website. It is the responsibility of each respondent to check the website for changes and/or clarifications to the RFQ prior to submitting a response.

Contact With County Employees. As of the issuance date of this RFQ and continuing until the final date for responses, all respondents are specifically directed not to hold meetings, conferences, or technical discussions with any County employee for purposes of responding to this RFQ except as otherwise permitted by this RFQ.

Respondents may submit questions or concerns using the questions and answers process as stated above.

Miscellaneous. This RFQ is not a commitment or contract of any kind. The County reserves the right to pursue any and/or all ideas generated by this RFQ. The responses shall be used to determine the respondent's ability to render the services to be provided. The failure of a respondent to comply fully with the instructions in the RFQ may eliminate its response from further evaluation as determined at the sole discretion of the County.

SECTION IV – REQUEST FOR QUALIFICATIONS PROCEDURE

This section describes the general RFQ procedure used by the County, and the remaining sections of this RFQ list the requirements.

A. TENTATIVE SCHEDULE OF EVENTS

EVENT	DATE
Release Request for Qualifications	October 21, 2016
Questions Submitted to County Deadline	November 9, 2016
Release Responses to Questions	November 11, 2016
RFQ Response Deadline	November 18, 2016
Review of Responses (1)	November 23, 2016

(1) Dates are subject to change

B. SUBMISSION OF RESPONSES

Registration: Providers/service providers interested in responding to this RFQ must register online with the County of San Mateo at http://www.smchealth.org/bhrs/rfp. The County will not be held responsible for or liable for registration errors.

Responses: The RFQ response will be submitted electronically to sgruendl@smcgov.org by 5:00 p.m. Pacific Standard Time on November 18, 2016.

All responses must be received by the stated date and time in order to be considered for review. The County will not be responsible for and may not accept late responses due to slow internet connection, or for any other electronic failure (including but not limited to information transmission and internet connectivity failures).

C. RESPONSE REVIEW AND SELECTION

During the review process, the County may require a respondent's representative to answer specific questions orally and/or in writing. The County may also require a visit to the respondent's offices, other field visits or observations by County representatives, or demonstrations as part of the overall RFQ review.

Responses to this RFQ must adhere to the format detailed in Section V - RESPONSE SUBMISSION REQUIREMENTS. The criteria used as a guideline in the review will include, but not be limited to, the following:

- Firm qualifications and experience, including capability and experience of key personnel and experience with other public or private agencies to provide these services
- Proposed approach, including clarity of understanding of the scope of services to be provided and appropriateness of the proposed solution/services
- Customer service

- History of successfully performing services for public or private agencies
- Ability to meet any required timelines or other requirements
- Cost to the County for the primary services described by this RFQ
- References
- Compliance with County RFQ and County requirements

SECTION V – RESPONSE SUBMISSION REQUIREMENTS

The response should be submitted in the following format:

A. GENERAL INSTRUCTIONS

All responses should be typewritten or prepared on a computer and have consecutively numbered pages, including any exhibits, charts, and/or other attachments.

All responses should adhere to the specified content and sequence of information described by this RFQ.

See section C.2 Response Content and Format for instructions on the submission process.

B. COVER LETTER

Provide a one page cover letter on your letterhead that includes the address, voice and facsimile numbers, and e-mail address of the contact person or persons. List the name of each person authorized to represent the respondent in negotiations.

C. RESPONSE CONTENT AND FORMAT

1) Response Narrative (5 pages maximum)
   Items below contain brief descriptions of material that must be included in this response.
   - o Summary of Qualifications
     Describe the agency's history, mission, programs, and services it provides; administrative structure; and experience in providing similar services. With the history include length of time in business, and any experience working with public agencies. Attach an organizational chart.

   - o Staffing – Organizational Capacity
     Describe proposed staff and their duties, including disciplines and degrees, as appropriate. Identify the person who will be overseeing the County account. Provide the level of education, background and experience that this person has.

   - o Implementation Timeline
     Describe your proposed timeline for your work plan.

- Work Plan
  Describe your proposed work plan indicating the major milestones and deliverables.

- References
  Include three references recently familiar with the quality and reliability of the respondent's work. Include the name, mailing address, contact person, and phone number for each reference.

- Insurance
  The County has certain insurance requirements that must be met. In most situations those requirements include the following: the contractor must carry $1,000,000 or more in comprehensive general liability insurance; the contractor must carry motor vehicle liability insurance, and if travel by car is a part of the services being requested, the amount of such coverage must be at least $1,000,000; if the contractor has two or more employees, the contractor must carry the statutory limit for workers' compensation insurance; if the contractor or its employees maintain a license to perform professional services (e.g., architectural, legal, medical, psychological, etc.), the contractor must carry professional liability insurance; and generally the contractor must name the County and its officers, agents, employees, and servants as additional insured on any such policies (except workers compensation). Depending on the nature of the work being performed, additional requirements may need to be met.

- Cost Analysis and Budget for Primary Services
  - Provide a detailed explanation for all costs associated with your providing the requested services.

2) Response Submissions
   - Submit one (1) signed, complete electronic (PDF, Microsoft Word document, etc.) version of your response and any required attachments to the County via sgruendl@smcgov.org. Responses must be signed by the respondent. An unsigned response may be rejected. A response may be signed by any authorized agency representative of the respondent.

3) Response Due Date
   All responses must be received by **5:00 p.m. on Friday, November 18, 2016.** Responses are not considered complete unless they include the following items: one (1) original including original signature of respondent and three (3) copies of response. Address responses to:

Scott Gruendl, Assistant Director
San Mateo County, Behavioral Health & Recovery Services
225 37th Avenue, 3rd Floor
San Mateo, CA 94403

E-mail: sgruendl@smcgov.org

Any responses delivered after 5:00 p.m. on Friday, November 18, 2016 may be rejected by the County as not meeting the requirements of this RFQ.

SECTION VI – ENCLOSURES

1. Quality Management Program Description
2. Quality Improvement Work Plan July 2015 – June 2016

SAN MATEO BEHAVIORAL HEALTH & RECOVERY QUALITY MANAGEMENT PROGRAM DESCRIPTION

I. QUALITY MANAGEMENT STRUCTURE AND PROCESSES

A. QUALITY MANAGEMENT PROGRAM

The purpose of the Quality Management Program of San Mateo County Behavioral Health and Recovery Services is to provide a framework within which the Mental Health Plan (MHP) and the Substance Use Disorder programs may:

- Define high standards of care for clients and their families;
- Enhance care to individuals and families through ongoing assessment of their needs and preferences, with focused attention on cultural, ethnic and language differences;
- Monitor the system-wide quality of clinical care, clinical services, and administrative or member services against objective standards;
- Promote fair, efficient, effective and appropriate use of behavioral health resources;
- Pursue opportunities to improve services, and
- Resolve identified problems.

The QM Program further defines:

- The scope and content of the Quality Improvement(QI) program;
- The authority, roles and responsibilities of individuals who are involved in the program;
- The role, structure, function and meeting frequencies of the QI Committee and its subcommittees, and
- The relationship of the QI program to other organizational components, including agency and individual contractors.

The QM Program is written in full compliance with Quality Improvement and Utilization Review Standards developed by DHCS, SUDS, OSD, and CMS. It affirms that San Mateo County will monitor changes in state and federal regulation or policy and will make every effort to assure consistent, full compliance with regulations. The QM Program further affirms that San Mateo County will make every effort to comply with all relevant legal mandates in its delivery of behavioral health services. These QM mandates are written into individual and agency contracts to assure their regulatory compliance in administrative and clinical practice.

B. SCOPE OF QM AUTHORITY

This QM Program is broad in scope and informs the structure and process of all behavioral health services provided by San Mateo County. These include:

- All community-based services directly provided by the County;
- All community-based services provided by contracted individual providers;
- All community-based services provided by contracted mental health and substance use disorder organizational providers;
- All psychiatric inpatient services for indigent and Medi-Cal clients provided by contracted private hospitals; and additionally
- All psychiatric inpatient services for indigent and Medi-Cal clients provided by the San Mateo Medical Center.

Unless otherwise noted, services to children and youth, adults, and older adults will follow general descriptions and definitions of service structure and expectations for service delivery. Special needs and exceptions will be clearly identified in appropriate sections of the plan.

C. QM PROGRAM STRUCTURE

Authority and Responsibility

- The Behavioral Health Director maintains overall authority for program direction and management.
- The Mental Health Medical Director is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical and medical procedures.
- The Quality Manager must be a licensed mental health practitioner. The Quality Manager is responsible for implementation of the QM Program.
- The QM program, through the QI Manager, is accountable to the Behavioral Health Director, the Assistant Director/Compliance Officer, and the Medical Director.

Quality Improvement Committee

The QI Committee is a standing Policy Committee within BHRS. It oversees QI activities and is actively involved in reviewing, analyzing and enhancing the QM Program. The QI Committee meets every other month. The QI Committee has a broad-based membership that is multidisciplinary and representative of BHRS groups and service programs. Membership includes lived experience peers and family members.

Contemporaneous, dated and signed minutes reflect all QI Committee decisions and activities. Minutes are distributed to QI Committee members.

The functions and duties of the San Mateo County Behavioral Health and Recovery Services (BHRS) Quality Improvement Committee (QIC) are specified in the Quality Improvement Committee: Policy 16-11.

Quality Management Program with the assistance of the Quality Improvement Committee will:

Regulatory requirements to assess youth and adult outcomes, youth system of care data collection mandates, federal requirements to monitor grievances, and managed care requirements to collect financial and clinical data are examples of ongoing QM processes.

1. Implement a monitoring process in San Mateo County utilizing at least the following array of activities and sources of information:

- Critical Incident Data Collection
- Psychological Autopsy Process
- Medication Monitoring Activities
- Utilization Management Data
- Case Review Boards and Committees
- Outcomes Assessment Data
- Satisfaction Surveys
- Grievances and Fair Hearing Logs
- Access Data and other Managed Care Data
- System of Care Data
- Results from planning, or approving and overseeing the progress of at least 2 quality improvement activities yearly (PIP).
    - At least two of these activities shall be conducted at the level of standards for Performance Improvement Projects (PIPs) as defined in DHCS protocol. One of these PIPs shall be in a clinical area and one in a non-clinical area.

Standard: QI Committee will assure at least two Performance Improvement Projects annually, one in a clinical and one in a non-clinical area. These quality improvement activities must reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries.

2. Conduct an annual review (fiscal year) of the QM Plan and update the plan as necessary.

3. Develop an annual work plan (fiscal year) to include the following state mandated activities:

   - An evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including Performance Improvement Projects, have contributed to meaningful improvements in clinical care and client services, and describing completed and in-process QI activities, including PIPs.
   - Monitoring of previously identified issues, including tracking of issues over time;
   - Planning and initiation of activities for sustaining improvement, and
   - Establishing objectives, scope and planned activities for the coming year. Within this objective, there shall be QI activities in each of the following six areas:
     - Monitoring the service delivery capacity of the MHP.
     - Monitoring the accessibility of services
     - Monitoring client satisfaction
     - Monitoring the MHP's service delivery system and meaningful clinical issues that affect its clients.
     - Monitoring continuity and coordination of care with physical health care providers and other human service agencies.
     - Monitoring provider appeals.

Subcommittees

The QI Committee may name subcommittees to perform specific tasks. Subcommittees meet regularly or on an *ad hoc* basis and report findings and recommendations to the QI Committee. The Quality Manager or staff delegate may serve on any and all committees. Subcommittees include (see policy Quality Improvement Committee: Policy 16-11 for full list of subcommittees):

Research Subcommittee (Institutional Review Board [IRB])

- Meets the week before the QI Committee meets, as needed.
- Has the following membership: Quality Manager, QI Committee members with special expertise in research methodology and/or the subject matter in the proposed study, and the Medical Director.

- Reviews all research proposals for compliance with MH Policy 95-02, Research Policies and Procedures.
- Considers study design, burden or risk to client, ethical considerations, and other unique factors in study.

D. PRINCIPLES FOR QUALITY MANAGEMENT

All standards of care and administrative policies must be structured in a manner that ~~to~~ enables consistent monitoring. Wherever possible, the monitoring process and the assignment of responsibility for that monitoring (e.g., supervisor), or department (e.g., Management Information Systems [MIS], QI) will be identified.

QI monitoring and evaluation will be based on the following principles:

- Recruitment of front line participants, including clients and family members, in detecting and improving quality problems;
- Positive support, not criticism, for becoming aware of problems;
- Prevention of problems before they occur;
- Continuous effort at reducing the occurrence of significant problems;
- Focus on correcting inefficient/ineffective systems instead of blaming individuals or teams;
- Open display of findings.

E. MEDICATION MONITORING

Mental Health Policy 04-08, (Medication Monitoring) sets the standards for the Medication Monitoring process.

Purpose

The purpose of Medication Monitoring is to assure the quality of psychotropic medication treatment for mental health clients. The objectives are to:

- Increase the effectiveness of psychotropic medication use.
- Reduce inappropriate prescribing of psychotropic medication.
- Reduce the likelihood of the occurrence of adverse effects.
- Assure appropriate laboratory work is obtained at the onset and during the course of treatment.
- Increase the likelihood that related physical examinations occur and are documented.
- Improve the client and family's treatment compliance with respect to psychotropic medication use.
- Encourage client/family education about psychotropic medications in order to improve their participation in informed consent procedures and in treatment.

Standard: At least 5% of unduplicated clients shall be reviewed annually at each clinical site and at every contracted organizational provider where medication services are provided.

F. CRITICAL INCIDENT DATA COLLECTION

The Critical Incident Report is a CONFIDENTIAL reporting tool to document occurrences inconsistent with usual administrative, clinical, and facility practice (see MH Policy 93-11, Critical Incident Reporting). The reporting form indicates areas of significant risk, variability and concern that would trigger a report. This listing is not meant to be all-inclusive and the judgment of staff is relied upon to report all incidents that impact quality care or service. The critical incident report provides:

- A mechanism for immediate notification to Behavioral Health Administration of unusual events within our system, and
- A risk management/quality improvement tool that facilitates clinical and administrative procedure development, in-service education, facility improvement, and improvements in care models.
- The requirement to document, report and analyze critical incidents applies to all county mental health staff and also to staff of community mental health agencies.

G. PSYCHOLOGICAL AUTOPSY PROCESS

A psychological autopsy is a protected Peer Review process applied whenever there has been a client death by suicide, homicide, or suspicious circumstances (see MH Policy No. 94-1). The focus of this QI review is to identify system procedures or policies that could be improved.

Standard: 100 percent of cases where a client death is by suicide, homicide, or suspicious circumstances has occurred will be reviewed in a Psychological Autopsy.

The Medical Director has the responsibility to assure that Psychological Autopsies occur in a timely manner, and to report findings to the QI Committee.

H. PEER REVIEW

Peer Review is a valued QI process, intended to improve care for clients, not to function as a supervisory tool for managers. Peer Review is a legally protected activity, and is not

subject to discovery; Peer Review may not be described as a case conference and is not reported in the client chart.

Peer Review is mandated by MH Policy 94-03, Peer Review, and is inclusive of all county mental health clinical staff and clinical staff of community mental health agencies. The policy applies to full and part-time staff, but is optional for trainees.

Standard: Any staff member who has direct clinical involvement with clients will present one client's case to a group of clinician's peers at least once annually.

Monitoring by QI assures that Peer Review occurs, but does not include review of the checklists written for individual clinicians.

I. CREDENTIALING PROCESS

The MHP will assure that its healthcare practitioners have the training and experience to provide quality care. Choosing practitioners who will work well in the care delivery system is part of this responsibility. The credentialing process will operate in a timely manner to allow for early detection of potential problems that could have an impact on the care provided to clients.

Credentialing policies apply to all licensed, waivered and registered mental health practitioners. This includes psychiatrists, psychologists, clinical social workers, marriage and family therapists, registered nurses, and nurse practitioners.

Credentialing policies shall be applied across the entire MHP, to assure high quality care wherever services are offered.

County Operated Clinics

The MHP relies on San Mateo County Employee and Public Services (EPS) policies to assure the competency and appropriateness of new applicants for employment as clinical practitioners. However, while the initial screening and selection process is a valuable and important component in a credentialing process, it does not perform all the critical reviews necessary to fully assess the practitioner's ability to deliver care.

MH Policies 98-16 and 99-04 establish objective credentialing and re-credentialing criteria for licensed, waivered, or registered professional staff employed or contracted with County Mental Health Services.

Standard: All licensed, waivered, or registered candidates for employment or under consideration for contract will be subject to credentialing review as defined in current policy.

All professional employees as described above will be re-credentialed at the time of license or certification renewal.

Any negative findings from an initial or subsequent credentialing review will be reported to appropriate supervisors or managers for their review and action.

Contracted Community Agencies

The function of assuring the competency of their clinical staff is delegated to community mental health agencies through the clinic certification process. The MHP shall verify the integrity of this process during site certification visits and more often as appropriate and necessary to assure compliance.

Standard: Agencies shall follow MHP criteria for internal credentialing of licensed staff.

Agencies shall document their procedures to assure the competency of other clinical and administrative staff to provide quality mental health care and to process claims for services

Contracted Individual Providers

The MHP recognizes its responsibility to develop and implement a credentialing and re-credentialing process to select and evaluate the practitioners who participate in service delivery for its clients. The following policies refer to that process:

- MH Policy 98-05 - Managed Care - Credentialing Process
- MH Policy 98-07 - Provider Selection and Performance Criteria
- MH Policy 98-08 - Credentialing Committee
- MH Policy 98-10 - Concerns/Complaints about MHP Providers

Delegation of Credentialing

The MHP is responsible for assuring its clients that the same standards for provider participation are adhered to across the entire organization. There are circumstances where delegation of credentialing is appropriate, as long as policies are developed that specify at least the same credentialing criteria as are used by the MHP. In addition to community mental health agencies, other organizations to which credentialing may be delegated include professional group practices, hospital-based clinics, Independent Practice Associations (IPAs), and Administrative Services Organizations (ASO). See MH Policy 98-09, Delegation of Credentialing, Re-credentialing, Re-certification or Reappointment of Providers.

Other Oversight Functions

Certification of Organizational (agency) Provider Sites - Effective with statewide consolidation of outpatient Medi-Cal services and the assumption of greater county risk in providing those services, the responsibility for site certification was given to counties. (See MH Policy 98-12, Provider Certification.)

DMH has retained the responsibility for certifying/recertifying county owned and operated sites.

Inpatient chart reviews are conducted by QI staff on charts from all private hospitals, contract or noncontract, serving MHP clients. This utilization review function consists of retrospective review of charts, and currently includes close to 100% of episodes claimed to Medi-Cal for MHP clients in private hospitals.

San Mateo County Behavioral Health & Recovery Services
Quality Improvement Work Plan July 2015-June 2016 (Start July 2015)

Requirement: Monitor Quality Improvement Activities (1-3)

Goal 1	**Monitor staff satisfaction with QI activities & services.**
Intervention	Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management department.
Measurement	Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%. Last Measurement **Satisfaction Survey Responses Dec 2014** **Are you satisfied with the help that you received from the Quality Management staff person?** Yes 83%(62) (14% Improvement), Somewhat 16%(12) Dec 2014 –Total responses 104
Responsibility	Jeannine Mealey
Due Date	November 2015

Goal 2	**Maintain attendance and active participation in QIC.**
Intervention	Invite specific constituents, including under-represented groups, families and individuals 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: Client, Family, Office of Consumer and Family Affairs, Management, Programs - Youth, Adult, Senior, Contractors, Medical Director, Training Committee, Cultural Committee, Alcohol and Other Drugs (AOD).
Responsibility	Jeannine Mealey Holly Severson

Goal 3	**Create and update policies and procedures. This includes AOD/OSD Contract requirements.**
Intervention	Update current policies and procedures. Update policy Index. Collaborate with AOD management for integration and establishment of required AOD policies, identify and create policies for iMAT. 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 FY15-16.
Responsibility	Policy Committee: Jeannine Mealey Kathy Koeppen Marcy Fraser Holly Severson

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

Goal 1	**Improve compliance with HIPAA and Compliance training mandate.**

Intervention	Staff will complete online HIPAA & online Compliance Training at hire and annually.
Measurement	Track training compliance of new staff and current staff. Current staff: Goal = or > 90%. New Staff: Goal = 100%. The assigned months for each training will be changed in FY15-16. Compliance Nov 2015 HIPAA July 2016
Responsibility	Betty Gallardo

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 = 100%.
Responsibility	Clinical Documentation Workgroup Kathy Koeppen Jeannine Mealey Betty Ortiz-Gallardo

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 track and monitor teams' compliance with requirements. Reports to improve: Document 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

Goal 4	**Maintain disallowances to less than 5% of sample.**
Intervention	Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System. Implement Chart Audit Program.
Measurement	Audit 10% Medi-Cal Charts Yearly. Decrease disallowances Targets: Medi-Cal: <5%
Responsibility	Jeannine Mealey QM Audit Team

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 med services 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 calculate 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 scripts and procedures for administrative and clinical staff at Access Call Center • Develop/Implement standards for answering calls • Streamline calls by utilizing a phone tree with appropriate languages options for callers • Utilize LEAN Quality Improvement processes
Measurement	Customer surveys, test calls and call logs.
Responsibility	Jeannine Mealey Kathy Koeppen Lilian Montalvo Selma Mangrum Rosamaria Oceguera Betty Ortiz-Gallardo
Status/Dates	Begun March 2015, currently in work progress.

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

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

Goal 3	**Monitor access to after hours 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. Develop new Avatar Call Log Tracking System.
Measurement	% of calls answered. Goal 100% % of test calls logged. 75% % of interpreter used. 90% Baseline- Date Range: June- December 2013 Calls Answered/Total Calls Made: 21/24 = 88% Calls Logged/ Calls Answered: 9/21 = 43% Interpreter Used/Total Non-English Calls: 5/7 = 71%
Responsibility	QM Staff OCFA- Client/Family Members

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 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. Post to the Health System public web site. Annual report with % grievances/appeals resolved within 30 days.
Responsibility	GAT Team

Goal 2	**Decision is made for request of Change of Provider within 2 weeks**
Intervention	Change of Provider Request forms will be sent to Quality Management for tracking. Obtain baseline/develop goal.
Measurement	Annual review of requests for change of provider.
Responsibility	Jeannine Mealey Kathy Koeppen

Goal 3	**Providers will be informed of results of the beneficiary/family satisfaction surveys bi-annually.**
Intervention	Post results on public website.
Measurement	Completion of notification twice a year. Presentation and notification of the results yearly.
Responsibility	Scott Gruendl

Goal 4	**Streamline Clinical Work Flow to standardize the work across the system.**
Intervention	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.
Measurement	Use a specific question in QM Satisfaction Survey to identify training gaps for staff. Review of staff productivity around documentation
Responsibility	Jeannine Mealey Hung-Ming Chu Kathy Koeppen Betty Ortiz-Gallardo Chad Kempel Bob Cabaj