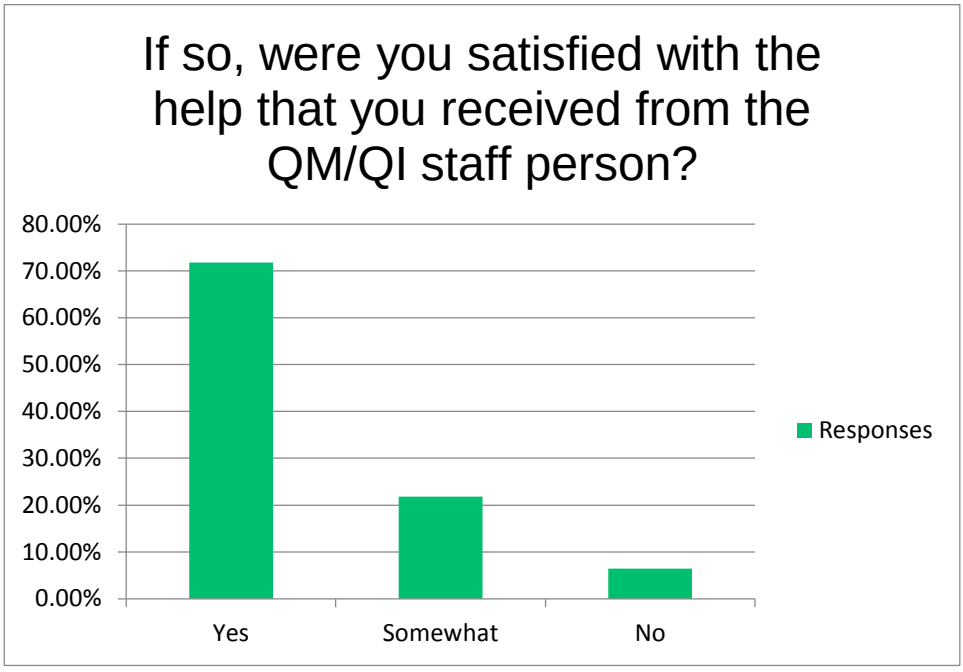
Requirement: Monitor Quality Improvement Activities (1-3)

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
Status	Ongoing
Year End Review	The QI satisfaction survey was completed by staff in Nov. 2018. Results for the question; We're you satisfied with the help you received from QM/QI Team? Yes = 71.79%, Somewhat = 21.79%, No = 6.41% 

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
Status	Ongoing
Year End Review	QM and QIC have continued to review, amend and develop policies as needed, in conjunction with BHRS Managers/Exec team and others to meet changing demands and regulations. Substantial tech edits/new policies are in process due to new DHCS Info Notices/regulations. AOD policies as needed are integrated into existing BHRS policies or are developed, with fewer new AOD policies needed this year. In conjunction w/the above: Policy Index updated when policy changes are made. QM Policy Committee continues to meet weekly via Skype to manage entire policy process that was begun in 12/2016. Detailed tracking spreadsheet continues to be used. Survey Monkey policy votes to QIC voting members as needed Policies written or revised, signed and completed include: 19-01: Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System (replaces Policies 04-10 and 03-03) 04-06: Pharmaceutical/Vendor Representatives Access and Accountability 18-02 Network Adequacy Standards and Timely Treatment Access for Mental Health (MHPs) and Drug Medical Organized Delivery System (DMC_ODS) Services (Renamed and amended) 99-01: Services to Clients in Primary/Preferred Languages 17-03: Access to Services for the Organized Delivery System (ODS) for Substance Use Disorder (SUD) Services 03-03: Client Grievance and Appeal system (later rolled into new policy, as 19-01, see above) 97-05: 72-Hour Holds – Authorization to Write 18-04: Credentialing and Service/Billing Privileges for Mental health Rehabilitation Specialists 07-04: Claims Processing Guidelines and Procedures

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
Status	Partially met/Continued next year
Year End Review	QIC policy was reviewed and only change made was to QM staff liaisons with outside committees. QIC membership is currently at 26 members. In FY18-19, QIC attendance has fluctuated from a low of 20 to 30. New BHRS Director and QM team are committed to diversifying and recruiting new members. A few contractor reps left and were replaced by other agency staff (one was not.) One BHRS client and one family member currently attend; our goal is to have three or more regular attendees with lived experience (family/clients). We do have a family member and a client/consumer employee who attend, which helps give that perspective, but we continue to recruit others.

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
Status	Met/Continued for next year.
Year End Review	The status of the current staff trainings for Compliance, HIPAA & FWA are as follows: Compliance: **93.4%** of all staff completed it. HIPAA: **94.4%** of all staff completed it. FWA: **94.8%** of all staff completed it. 100% of all newly hired staff have completed all three trainings.

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
Status	Ongoing
Year End Review	All new staff are required to complete QM's Online and Avatar and Documentation training as a part of the onboarding process before being given access to the Avatar EMR system.

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
Status	Met. Continue next year
Year End Review	Monthly reports were sent to all Specialty Mental Health Providers. 10 % of CBO charts were audited. Two CBO agencies were issued plan of corrections and are being monitored for compliance. County program charts were audited ongoing as treatment plans were completed, approximately 200 emails were sent to different clinicians with specific feedback about their documentation and training material for any problem areas. Clinicians were informed of billing that required a void. In FY 2018-19 to date, upon audit, 3921 services were blocked from Medi-Cal billing due to the treatment plan not being complete.

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
Status	
Year End Review	

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
Status	Met/Continue next year
Year End Review	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 11 (as of 6/19/2019) test calls for FY 18/19 about 90% of the callers' experiences were rated as positive. This is an improvement in previous FY test call results, our continued goal 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 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
Status	Completed

Year End Review	QM recorded 5 Suicides for FY 18/19 through the incident reporting system. 3 were individuals in their 30's, 2 were individuals over 55. IR's were flagged by QM as suicides and reviewed by the executive team.

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
Status	Not Met, continued in new goal
Year End Review	BHRS did not create a specific workgroup for timeliness to service for FY 18/19. This group will be created for FY 19/20

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
Status	Not met
Year End Review	DHCS did not release the information notice with requirements for concurrent review until mid-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

Status	Partially Met.
Year End Review	Audit team reviewed Mills Peninsula Hospital charts. Review of Pro Fee progress notes resulted in 100% disallowance.

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
Status	Met
Year End Review	The intervention of referral to outpatient services within 7 days following a stay at Psychiatric Emergency Services (OES) was achieved for 91.02% of the clients, or 1.02% better than expected. During the period of July 1, 2018 and June 30, 2019 approximately 1,407 BHRS clients that had a PES episode. Of these, 1,308 or 91.02% received a service within 7 days of discharge from PES. In FY 17/18, there were approximately 1,297 clients with a PES episode and of these, 1,161 received a service within 7 days of discharge from PES or 90%. Therefore, in comparing FY 18/19 against FY17/18, there is an improvement over year to year although marginal. BHRS is able to achieve high performance in a number of ways, including staff dedicated to facilitating step down from higher levels of care for both adults and youth that initiate discharge planning while the patient is still hospitalized; maintains permanent hospital beds to better manage placement outside of PES; developed a network of private providers that are actively managed; and improved communication with PES staff. There has been significant turn over in the leadership at PES and in FY19/20 the focus will be to strengthen the decision-making processes at PES and provide closer training and consultation for PES leadership. When researching the performance of other organizations, one must point out that the 2017 HEDIS benchmarks for Follow Up to Hospitalization within 7 Days for Medicaid, the national average is 37% and Follow Up to Emergency Visits within 7 Days is 40% . In conclusion, although the improvement year over year is marginal, BHRS is at the near upper tier of performance as the national Medicaid benchmark for comparable providers is 37% for follow up to hospitalization within 7 days and 40% for follow up to emergency visits within 7 days. Therefore, it should be anticipated that further improvement will be negligible as BHRS performs at a superior level for this measure.

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
Status	Not met. Continued for next year.
Year End Review	4 AOD test calls were completed and logged for the fiscal year. This goal will be continued to next year in order to meet 3 AOD calls per quarter. To further this goal, we will increase test calls and recruitment of test callers.

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
Status	Partially Met. Continued for next year.
Year End Review	Test calls answered: 100% Test calls logged: 81% Requested Interpreter provided: 100% For the 1st quarter there was 1 test call, 2nd quarter there were 2 test calls, 3rd quarter there were 2 test calls, and in the 4th quarter were 6 test calls. This goal will be continued to next year in order to improve the number of test calls per quarter, as of 6/20/18 11 test calls were made: all 11 calls were answered, and 9 calls were logged. 1 test caller requested an interpreter and was given one in less than 1 minute. 3 of our 11 test calls were completed in another language.

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
Status	Completed
Year End Review	Our New Provider Directory went live in the fall of 2018 for our MHP, SUDS, and MCP Network. You can reference the Provider Directory at https://www.smchealth.org/post/find-behavioral-health-providerprogram

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
Status	Not Met
Year End Review	Surveys were not created or administered.

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
Status	Partially Met
Year End Review	Prior to receiving peer support services, participants had a total of 15 PES admissions and 5 admissions to 3 A/B. After receiving peer support services, participants experienced a total of ten PES and five 3 A/B re-admissions.

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
Status	Not Met
Year End Review	The team that would be responsible for tracking authorization is not fully staffed. Once the team is fully staffed they will develop protocol and procedures.

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
Status	Partially Completed
Year End Review	CANS went live in Avatar on October 1, 2018. Subsequent to the writing of this goal it was determined that CANS Assessment would only be completed for “New Clients” in Mental Health Services.

	BHRS developed a written procedure in the form of a Policy Memo 03-18 and Avatar CANS Quick start guides posted on line at: https://www.smchealth.org/post/find-behavioral-health-providerprogram Initially staff were trained via live trainings and online training was provided ongoing. 194 staff have been trained as of June 2019 Due to vendor delays (Netsmart). Reporting out on CANS is not available yet. Netsmart provided the patch for this capability in mid-June 2019. We are currently testing this function. CANS Assessments completed from October 1, 2018 – June 30, 2019

Form Type	% of Total	N
Initial	80.59%	407
Subsequent	5.35%	27
Annual	1.58%	8
Discharge	5.94%	30
Administrative Close	0.59%	3
Unknown status	5.94%	30
	Total	505

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
Status	Met
Year End Review	All grievances and appeals were resolved with the required timelines. GAT continues to meet biweekly to discuss and address all grievances and appeals to ensure that all grievances are resolved within the required timeline. The Annual report on grievances, appeals, and State Fair Hearings to QIC was on November 14, 2018 73.26% grievances were resolved fully favorable 19.77 grievance were favorably resolved. 100% of grievances/appeals resolved within 90/30days

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
Status	Met
Year End Review	100% of providers received the grievance resolution in a timely manner. The tracking from was modified and the provider letter template is included on the Resolutions Letter Template to ensure completion. This is also verified during the review of the Internal Grievance Folder Audit done at GAT meetings.

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
Status	Partially Completed
Year end Review	QM developed a new Policy, 19-01 Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System which was approved on June 21, 2019. https://www.smchealth.org/Grievance_NOA The policy was posted to the website and the policy was reviewed with Managers, Supervisors and Executive Team Members. Currently individual programs create the NOA forms. BHRS is working to centralize this process to improve consistency.

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
Status	Continued for next year.
Year End Review	In FY 2018-19, 69 requests to change provider were received (105 requests were turned in last year). 73% of decisions were made within 14 days (76% were on time last year). In summary, 59 requests were approved and 10 were resolved without a change of provider.

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
Status	
Year End Review	

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
Status	Partially Met
Year End Review	Currently, the BHRS New Hire Orientation which is a total of 3 sessions has one cycle per year. For fiscal year 2018-2019 the dates for the 3 sessions were September 26, 2018, November 6, 2018, and January 31st, 2019. Potential participants are notified via outlook invitation about the dates of the upcoming sessions. The WET Team works with the BHRS HR/Payroll department to identify eligible staff. Staff are contacted via outlook invitation. Potential participants are sent reminders and they receive training hours via LMS for attendance. There has been significant revision in the process of notification about the requirement; however, we are not yet at full compliance. The onboarding process by Supervisors is not consistent across the department, thus the information is not necessarily relayed consistently. Securing a training location is a significant barrier to providing required trainings to staff, as a result it is very difficult to find an appropriate site without incurring additional expense. Some staff work at sites with 24 hours schedule therefore it is difficult for them to attend trainings. Many

	of our trainings are in person which is difficult for staff in outlying areas of the county to attend. Training attendance is often capped due to location size. There were 59 people who were hired in time to attend the cycle presented this fiscal year. Approximately 20% of those people attended the scheduled sessions. The remaining attendees were people who had been hired prior to July 1, 2018 or after January 1, 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
Status	Partially Met
Year End Review	For FY 18_19 BHRS provided services in a clients preferred language 88% of the time.

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
Status	Partially Met
Year End Review	The BHRS Director sent a notification about the Cultural Humility and Inclusion policy. And announcements have been made in leadership meetings across BHRS. There have been 349 BHRS Staff and providers who participated in the Cultural Humility foundational trainings between January 1st and June 30th fiscal year 2018-2019. The WET team adopted a model of regularly scheduled trainings from Jan 2019 to Jun 2019. Each training day was two sessions of up to 40 people. Each training was 3 hours. Trainings were posted and announcements were emailed. The Office of Diversity & Equity's WET team has encountered several barriers in order to meet this goal. In general, the barriers fell into two categories: logistics and capacity. Logistically, the mandate for all BHRS staff to receive the training requires that each training session have maximum attendance. In the last 18 months the training locations for larger training sessions, those with an expected attendance of 30 participants or more, have greatly diminished. As a result, there is increased competition with other entities in reserving training locations, it is extremely difficult to obtain appropriate, no cost or low fee training

	venues. Additionally, the Cultural Humility Trainings Cohort is not large enough to increase the number of trainings session.

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
Status	Met
Year End Review	• 2411 Clients had SOGI information updated in Avatar for FY 18/19. • The data was not captured in a way to break it out by Call Center, ODS, County Programs, and Contractors **Included totals for SOGI Reponses by Question** **Sexual Orientation** Straight 2132 Lesbian or Gay 46 Bisexual 60 Queer 5 Declined to Answer 134 Did not Ask 25 Another 9 **Gender Identification** Male 1615 Female 658 Transgender Male 2 Transgender Female 5 Gender Queer/Not exclusively Male or Female 5 Declined to answer 105 Another 3 Did not ask 18 **Preferred Pronouns** He/Him 1613 She/Her 662 They/Them 8 Another 5

	Declined to answer	103
	Did not Ask	21
	Diagnosed with an Intersex Condition	
	Yes	16
	No	2244
	Declined to answer	112
	Did not Ask	39
	Gender on Original Birth Certificate	
	Male	1620
	Female	665
	Declined to answer	104
	Did not ask	22

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
Status	Partially Met
Year End Review	We believe this goal was partially met. (7/1/2019 – 4/30/2019) • 196 requests were received for Residential Evaluations from criminal justice partners YTD (7/1/2019 – 4/30/2019) • 77.5% or 152 residential evaluation were completed in-custody. • 136 for client eligible to receive services in San Mateo County, and • 88 jail releases of eligible clients (the rest are still in-custody) • 54 were admitted to the recommended level of care, or 61%.

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
Status	Partially Met
Year End Review	We believe this goal was partially met. Our data shows we conducted 143 evaluations for residential treatment at Palm Detox since July 2018 with level of care referral prior to discharge from Palm and out of those 102 clients or 71% were then subsequently admitted to the indicated level of care. In 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.

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
Status	Met
Year End Review	91 client charts were reviewed. A plan was developed, the audit tool was developed, and it was completed with the DMC-ODS providers.

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
Status	Partially Met
Year End Review	90% of clients were admitted within 24 hours of their initial request. BAART, our NRT provider, has experienced significant staffing shortages that has strained their ability to meet the need for services.

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
Status	Met
Year End Review	A total of 26 trainings were offered. Trainings offered: Motivational Interviewing, CBT, Trauma-Informed Treatment, and Relapse Prevention to comply with ODS EBPs. Additional ODS required trainings included ASAM, Documentation, and cultural competence trainings

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
Status	Partially Met
Year End Review	25 personnel file reviews. Of the 25, only 7 had evidence of training on at least 2 EBPs, for a rate of 28%. Providers report struggling to meet this requirement because of staffing shortages and trainings held during the day when staff are needed to treat clients.

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
Status	Partially Met
Year End Review	55% of the LPHA personnel charts reviewed had evidence of 5 hours of training in addiction medicine. Most reported not receiving this training. However, in April, May and June 2019, 3 day-long ASAM trainings were conducted that meet the addiction medicine training requirement. Between 64-80 provider attended each training.

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
Status	Partially Met
Year End Review	A contract was secured with a vendor to upgrade Avatar for use as an EHR for providers. As part of the upgrade, we will create ways to collect the data points and run the reports needed to comply with DMC-ODS performance measures related to timely access, etc.