San Mateo County Behavioral Health & Recovery Services
Quality Improvement Work Plan: July 2016-June 2017
Year End Review June 30, 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.
Measurement	**Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%.** Last Measurement **Satisfaction Survey Responses** **Are you satisfied with the help that you received from the Quality Management staff person? 2015** Yes 71%, Somewhat 24%=95% Nov 2015 –Total responses 125. **Nov 2016- Yes 78%, Somewhat 16% = 94%** **Total responses 110.**
Responsibility	Jeannine Mealey
Due Date	November 2016
Status	Met/Continued next year
Year End Review	Goal was met for the year.

Goal 2	**Update QIC Policy and establish voting membership that represents all parts BHRS**
Intervention	1) Update QIC Policy 2) Create Policy Development Policy 3) Identify a QIC voting membership of approximately 30 individuals that represent BHRS system
Measurement	1) QIC Policy updated and voting membership defined by 6/2017 2) Policy Development Policy approved and in place by 6/2017 3) Appoint 30 QIC Voting Members that represents BHRS system by 6/2017
Responsibility	Jeannine Mealey Holly Severson
Due Date	June 2017
Status	Met
Year End Review	QIC Policy created and implemented 8/2016 Policy Development Policy as above, finished 8/2016 New member list created 10/2016, ongoing process d/t staff and contractor staff changes

Goal 3	Create and update policies and procedures. This includes AOD/ODS 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 and ODS. 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: Jeannine Mealey Kathy Koeppen Marcy Fraser Holly Severson
Due Date	June 2017
Status	Met
Year End Review	Many new policies created throughout FY 16-17 (and ongoing) This includes several compliance policies and AOD policies Old policies amended or obsoleted as needed Policy Index updated monthly QM Policy Committee meets weekly via Skype to manage entire policy process, begun 12/2016. Detailed tracking spreadsheet (6/2017) Survey Monkey policy votes to QIC voting members as needed Policies written or revised, signed and completed include: 03-15 Compliance Officer Duties 03-16 Compliance and Delegation Oversight 04-01 Compliance Policy for Contracted Providers 04-05 Compliance Improvement Hotline 04-07 Advanced Healthcare Directives 08-02 Policy Management and Development 16-02 Standards and Code of Conduct 16-03 Compliance Plan and Program 16-05 Non-Retaliation & Non-Intimidation for Reporting Compliance 16-10 Continuing Education for AOD/SUD 16-11 Quality Improvement Committee 16-12 Psychiatric Medication Consent for Adults and Youth 90-08 Management of Threatening & Potentially Violent Behavior 98-01 Change of Clinician Request (incl Charitable Choice) 99-02 Medication Authorization for Dependent Children

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

Goal 1	Improve compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandate.
Intervention	Staff will complete online HIPAA, FWA, & Compliance Training at hire

	and annually thereafter.
Measurement	Track training in compliance, HIPAA, & FWA of new staff and current staff. Current staff: Goal = or > 90% for each training. New Staff: Goal = or > 100%. The designated months for each training will be changed in FY16-17. Compliance -Oct 2016 FWA -Oct 2016 HIPAA -Aug 2016
Responsibility	Betty Gallardo Nicola Freeman
Due Date	June 2017
Status	Met
Year End Review	The current status of the trainings for Compliance, HIPAA & FWA are as follows: Compliance: **91.60%** of all staff completed it. HIPAA: **94.91%** of all staff completed it. FWA: **92.53%** 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 and current staff completing the training. New Staff: Goal = 100%.
Responsibility	Clinical Documentation Workgroup Betty Ortiz-Gallardo Amber Ortiz
Due Date	June 2017
Status	Met
Year End Review	All new staff are required to take these trainings and will not be able to access our EMR system unless they complete all clinical and compliance trainings. The trainings are tracked by Amber Ortiz, Credentialing Specialist

Goal 3	**Program staff to improve overall compliance with timelines and paperwork requirements.**
Intervention	Maintain system-wide, annual audit program. Improve documentation tracking reports to encourage and monitor teams' compliance with requirements. Send monthly emails with documentation compliance rates to all county program managers and directors.
Measurement	Audit 10% Medi-Cal Charts Yearly.
Responsibility	Jeannine Mealey QM Audit Team
Due Date	January 2017
Status	Met
Year End Review	Monthly reports were sent to all county Medi-Cal programs. 10% of SOC contractors were audited. All or 10% of County charts with completed assessments during this year were audited and staff were given feedback and made requested corrections.

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	Decrease disallowances Target: Medi-Cal Audit: <5%
Responsibility	Jeannine Mealey QM Audit Team
Due Date	June 2017
Status	Partially met
Year End Review	Disallowance in draft DHCS report was 19%. This is a significant improvement over last Triennial MediCal audit when the disallowance rate was 78%

Goal 5	**ODS & Drug Medi-Cal Goal Needed**
Intervention	Implement the use of ASAM for central screening and Residential Referral
Measurement	% of clients requesting AOD Services that are screened with the ASAM
Responsibility	Clara Boyden

Due Date	March 2017
Status	Met
Year End Review	As of 2/1/17, 100% of AOD clients referred for residential treatment were screened using the ASAM criteria. The BHRS Call Center and all contracted DMC ODS treatment providers began using a uniform ASAM Screening tool developed by BHRS. Individuals with an ASAM screen indicating possible residential treatment needs are referred to the AOD Residential Treatment Team (RTX) for an ASAM Residential Evaluation. Upon completion of the Residential Evaluation, when clinically appropriate, an authorization for residential treatment and referral to an appropriate provider is generated by the RTX team.

Goal 6	**Improve customer service and satisfaction with 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
Measurement	Test calls and call logs: 90% test calls rated as positive
Responsibility	Jeannine Mealey Kathy Koeppen Selma Mangrum Rosamaria Oceguera Betty Ortiz-Gallardo
Due Date	January 2017
Status	Partially Met
Year End Review	Scripts and procedures have been implemented to meet the minimum DHCS requirements for test calls, as well as developing a standard for staff when answering calls from clients. Goal is to increase client satisfaction. Based on 11 (as of 6/13/17) test calls for FY 16/17 about 70% of the callers' experiences were rated as positive. Although this is an improvement in previous test call results, our hope is that at least 90% of test calls will be rated as positive. To further this goal, we will increase test calls and continue to train current and incoming staff using new scripts and other tools.

Goal 7	**Tracking Incident Reports and Suicide Rates in SMC**
Intervention	Monitor suicide events in SMC Collect data on suicides reported to BHRS by Incident Reports Work with County Coroner to include those who were not known to BHRS
Measurement	Demographics on all suicides, methods, compare with BHRS clients Retrospective review of previous years; establish baseline

Responsibility	Marcy Fraser
Due Date	June 2017
Status	In progress
Year End Review	Met with medical director regarding suicide data requests. With assistance from the County Coroner's office obtained additional info on ethnicity, location and method of reported, known/ruled suicides. Requested Coroner data to compare with reported suicides of BHRS clients. Plan: present info to QM, Medical Director and leadership Participated in Suicide Prevention Task force across disciplines and county departments. Community training planned for Sept 2017 for caregivers of vulnerable adults.

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
Due Date	June 2017
Status	Met
Year End Review	For 2017, the initiation rate is 60%

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
Due Date	June 2017
Status	Unmet This goal will be continued to next year.
Year End Review	There still is not a report to track this measure.

Goal 3	24/7 Call Center will be able to successfully screen and refer AOD clients
Intervention	Develop Workflows for 24/7 coverage to log requests for services; screen, and make appropriate AOD referrals
Measurement	90% of test callers report being successfully screened and referred for AOD services to 24/7 line 3 AOD test calls are made per quarter 100% of AOD Test Call are logged
Responsibility	Selma Mangrum Rosamaria Oceguera Betty Ortiz-Gallardo
Due Date	March 2017
Status	Continued for Next Year.
Year End Review	Test calls for AOD were not performed except for 1 (as of 6/13/17) which was for a co-occurring disorder. This call was successfully screened and was transferred to AOD right away. This goal will be continued to next year. The DMC ODS has recently started implementation. This will assist callers to increase AOD awareness as DMC is rolled out.

Goal 4	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	95 % of calls answered 95 % of test calls logged. 100% of interpreter used
Responsibility	Betty Gallardo
Due Date	June 2017
Status	Partially Met/Continued for Next Year
Year End Review	This last year, we had an abundance of calls in one quarter and no calls in another quarter. This goal will be continued to next year in order to improve the number of test calls per quarter. As of 6/13/17, 11 of test calls were made: 8 were successfully logged (72%), 2 were not logged and 1 call was partially logged. The partially logged call did not fully comply because the name of the caller was not logged. None of the calls came from a caller who needed an interpreter.

Requirement: **Monitoring Beneficiary Satisfaction (4c)**

Goal 1	**Complete resolution of grievances/appeals within 30/45 day time frame in 100% of cases filed, with 80% fully favorable or favorable.**
Intervention	Grievance and appeals regularly addressed in GAT Meeting.
Measurement	Annual reports on grievances, appeals, and State Fair Hearings to QIC. Annual report with % of issues resolved to client/family member fully favorable or favorable. Annual report with % grievances/appeals resolved within 30 days.
Responsibility	GAT Team
Due Date	June 2017
Status	Goal Met
Year End Review	All grievances and appeals were resolved within the required timeline. GAT continues to meet weekly to discuss and address all grievances and appeals with the involved staff and managers in order to ensure that all grievances are resolved with the required timeline.

Goal 2	**Decision is made for clients' 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	Kathy Koeppen
Due Date	June 2017
Status	In Progress
Year End Review	In the last year we have made partial progress in completing this goal. For FY16/17 there were a total of 109 Change of Provider Request forms sent to Quality Management for tracking. Of those submitted 30% of the requests took longer than 14 days to process and inform clients of the decision.

Goal 3	**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	Scott Gruendl
Due Date	Due January 2017
Status	Met
Year End Review	All providers (management) were given the summary of their results. The executive team was given the summary of results across all

	programs by age group.

Goal 4	**Improve cultural and linguistic competence**
Intervention	"Working Effectively with Interpreters in Behavioral Health" in-person training will be required for all staff who have direct client contact and their management team with updated online "refresher course" every 3 years.
Measurement	Will establish a current baseline number of staff who have attended the in-person "Working Effectively with Interpreters in Behavioral Health" training and increase completion to 80% of all staff by June 30, 2017. Of those staff who took the in-person training 3 or more years ago, 80% will take the refresher course of " Working Effectively with Interpreters in Behavioral Health" by June 30, 2017.
Responsibility	Ellie Dwyer Jei Africa Doris Estremera
Due Date	Due June 2017
Status	Partially met/continued next year.
Year End Review	1. Baseline data of staff who completed Interpreter training, as of 4/17 is a total of 717 people (including staff who have since resigned/retired) who took the course since 2010. BHRS currently has over 700 employees which meets goal of 80% 2. The online refresher course of "Working Effectively with Interpreters in Behavioral Health" is in its final revisions to be launched via LMS in FY 17/18 for staff who received the in-person training 3+ years ago

Goal 5	**Improve Linguistic Access for clients whose preferred language is other than English**
Intervention	All staff with direct client contact will provide services in the client's "Preferred Language" and indicate this by using the drop down language option in Avatar (EMR) progress notes. English will no longer be the default language in Avatar (EMR).
Measurement	Measurement is the language field in the EMR Progress Note. Increase the current baseline of providing services in the preferred language from 45% to 75%. Improve reporting of which language the service was provided in every Avatar Progress Note by March 1, 2017.
Responsibility	Ellie Dwyer Jei Africa Doris Estremera

Due Date	Due January 2017
Status	Goal met
Year End Review	As of January 2017 goal was partially met. By March 2017, exceeded the work plan goal of 75% when reached 90.3% with implementation of the Avatar update that requires dropdown language option of preferred language