SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

Color Legend: MHP SUDS/AOD MHP/SUD

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## 1. Quality Improvement Activities

| Goal 1 | Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates. |
|---|---|
| Intervention | Staff will complete online HIPAA, FWA & Compliance Training at hire and annually. |
| Measurement | Track training compliance, HIPAA, & FWA of new staff and current staff.<br><br>Current staff: Goal = or > 90% for each training.<br>New Staff: Goal = 100%.<br><br>The assigned months for each training will be<br>Compliance -Nov 2019<br>FWA -Nov 2019<br>HIPAA -Aug 2019 |
| Responsibility | Tracey Chan<br>Jeannine Mealey |
| Due Date | June 2020 |

| Goal 2 | Improve clinical documentation and 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<br>Amber Ortiz<br>Ingall Bull<br>Claudia Tinoco<br>Tracey Chan |
| Due Date | June 2020 |

| Goal 3 | Program staff to improve overall compliance with timelines and paperwork requirements. |
|---|---|
| Intervention | • Maintain system-wide, yearly-audit program.<br>• Send monthly emails with documentation compliance rates to all county program managers and directors to monitor teams' compliance with requirements. |
| Measurement | Reports sent to programs Monthly |
| Responsibility | Jeannine Mealey<br>Tracey Chan<br>A.B. Limin |
| Due Date | June 2020 |

| Goal 4 | Maintain disallowances to less than 5% of sample. |
|---|---|
| Intervention | • Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System.<br>• Send progress reports to county programs. |
| Measurement | • Audit 10% of SDMC System of Care client charts annually<br>• Decrease disallowances, Target: Medi-Cal Audit: <5% |
| Responsibility | Jeannine Mealey<br>QM Audit Team |
| Due Date | June 2020 |

| Goal 5 | Monitor staff satisfaction with QI activities & services. |
|---|---|
| Intervention | • Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.<br>• Determine Optimal timing for conducting survey |
| Measurement | Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%.<br>• Are you satisfied with the help that you received from the Quality Management staff person?<br>• Baseline: Nov 2018-<br>o Yes 71.79%, Somewhat 21.79% = 93%, No = 6.41%<br>o Total responses 108. |
| Responsibility | Ingall Bull, Jeannine Mealey |
| Due Date | December 2019 |

| Goal 6 | Create and update policies and procedures in BHRS for Mental Health and SUD |
|---|---|
| Intervention | • Update current policies and procedures for new managed care rules. Update policy Index.<br>• Maintain internal policy committee to address needed policies and procedures.<br>• Retire old/obsolete policies.<br>• Create new, amend existing, and retire obsolete policies |
| Measurement | # of Policies Created<br># of Policies Retired<br># of Policies Amended |
| Responsibility | Policy Committee:<br>Ingall Bull<br>Claudia Tinoco<br>Jeannine Mealey<br>Holly Severson<br>Eri Tsujii<br>Annina Altomari<br>Tracey Chan<br>Clara Boyden – AOD manager |
| Due Date | June 2020 |

| Goal 7 | Comply with QIC Policy and maintain voting membership that represents all parts BHRS |
|---|---|
| Intervention | • Review/amend QIC Policy as necessary.<br>• Maintain QIC voting membership that represents BHRS system |
| Measurement | • Ensure compliance with QIC Policy: communicate with QIC members as necessary.<br>• Verify and document QIC Voters that represents BHRS system by 6/2020 (continuous) |
| Responsibility | Ingall Bull<br>Holly Severson |
| Due Date | June 2020 |

| Goal 8 | Improve Usability of the EMR system (Avatar) |
|---|---|
| Intervention | • Develop Consoles and Widgets that will make client information more easily accessible<br>• Implement Consoles and push out throughout the EMR<br>• Develop a post implementation survey for collecting user feedback. |
| Measurement | • Go live Date<br>• Post implementation survey results for user acceptance and feedback |
| Responsibility | Kim Pijma<br>QM Team |
| Due Date | September 2019 |

| Goal 9 | Tracking Incident Reports (IR) |
|---|---|
| Intervention | • Continue to monitor and track all Incident reports.<br>• Present data to Executive Team<br>• Report trends and current data to QIC and leadership<br>• Enter deaths and major incident in to System to See |
| Measurement | Annual Reports to Executive Team and QIC |
| Responsibility | Tracey Chan |
| Due Date | June 2020 |

## 2. Performance Improvement Projects (PIP)

| Goal 1 | BHRS will develop two on going Performance Improvement Projects (PIP) for the MHP |
|---|---|
| Intervention | • Gather baseline data from BHRS sources to identify improvement areas.<br>• Form a PIP committee to select improvement areas to focus on for a clinical PIP and a non-clinical PIP based on data gathered.<br>• Identify interventions to address the identified problem(s).<br>• Identify a population (Adult and/or Youth) for the PIP. |
| Measurement | • Development of 2 PIP's that are rated as active and meet EQRO standards<br>• Committee Minutes |
| Responsibility | Eri Tsujii |
| Due Date | October 2019 |

| Goal 2 | Identify new PIP interventions for the current fiscal year. |
|---|---|
| Intervention | • Review recent ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas.<br>• Work with the ODS QI subcommittee for input into direction and selection of clinical and administrative PIPs. |
| Measurement | • Meeting Minutes<br>• Developed PIPs |
| Responsibility | Clara Boyden<br>Diana Hill<br>Mary Fullerton<br>Ingall Bull<br>Eri Tsujii |
| Due Date | June 2020 |

## 3. Utilization and Timeliness to Service Measures

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

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| | o Mechanisms for determining Over Utilization and Under Utilization<br>o Review Reports, and trend analysis<br>o Compare against DHCS POS data across fiscal years |
| Measurement | • Revise UM Plan and process for SMHS<br>• Implemented Concurrent Review UM program for Inpatient Psychiatric hospitalizations |
| Responsibility | Ingall Bull<br>Eri Tsujii<br>Tracey Chan<br>Claudia Tinoco |
| Due Date | June 2020 |

| Goal 2 | Track time from first request to first assessment and treatment appointment for BHRS and contractor programs for new SDMC Mental Health, Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client) |
|---|---|
| Intervention | **New Client is a beneficiary who has Medi-cal and is not currently open to SDMC services*<br>• Create a workgroup focused on determining how to track and implementing timeliness measures<br>• Identify gaps in data collection and create data points needed to track timeliness to service and follow up for service.<br>• Develop a process for capturing data and tracking timeliness information from initial request to encounter for the following areas:<br>o Offered assessment and treatment appointments<br>o Time to first kept assessment and/or 1st kept treatment appointment.<br>o Time to first psychiatric service<br>o Time from request for *Urgent* appointment to actual encounter<br>o Time to appointment for post-psychiatric inpatient discharge<br>o Inpatient readmission rates with 30 days of discharge<br>o Mental Health Service (incl. Targeted Case Management, Medication Support, and Crisis intervention)<br>• Include data for BHRS and contract agencies serving SDMC clients.<br>• Report to Executive Team and QIC, timeliness data annually.<br>• Create and/or revise policies to incorporate these changes |
| Measurement | • % of clients receiving a mental health service within 10 days from request to first appointment.<br>• % of new clients receiving Psychiatry Services within 15 days from request to first service.<br>• Average time from first request for service to first assessment appointment.<br>• Average time from assessment to first treatment appointment<br>• Average time from request for Urgent appointment to actual encounter. |
| Responsibility | Eri Tsujii |
| Due Date | June 2019 |

| Goal 3 | Develop process for capturing data for Youth and Foster Care for tracking medication use. (SB1291) |
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|---|---|
| Intervention | Develop a process for capturing data for the following HEDIS measures<br>o Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)<br>o Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)<br>o Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)<br>o Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)<br>Revise JV 220 oversight process to incorporate these measures<br>Identify and update policies as needed |
| Measurement | Creation of a protocol and process for oversite<br>Updated policies |
| Responsibility | QM Workgroup<br>Ingall bull<br>Eri Tsujii<br>Claudia Tinoco<br>Tracey Chan |

4. Access and Call Center

| Goal 1 | Improve customer service and satisfaction for San Mateo County Access Call Center |
|---|---|
| Intervention | • Develop standards for answering calls<br>* 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<br>Tracey Chan<br>Ingall Bull<br>Claudia Tinoco |
| Due Date | June 2020 |

| Goal 2 | Monitor 24/7 access to care through Call Center and Optum. 100% of calls will be answered. 100% of test callers will be provided information on how/where to obtain services if needed. |
|---|---|
| Intervention | • Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services.<br>• Make 1 test call in another language and 1 for AOD services<br>• QM will report to call center the outcome of test calls |
| Measurement | 95 % or more calls answered<br>95 % or more test calls logged.<br>100% of requested interpreters provided<br>75% of call will be rated satisfactory (Caller indicated they were helped) |
| Responsibility | Tracey Chan |
| Due Date | June 2020 |

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

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|---|---|
| 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.<br>• Annual report with % of issues resolved to client/family member fully favorable or favorable.<br>• Annual report with % grievances/appeals resolved within 90/30 days. |
| Responsibility | GAT Team |
| Due Date | June 2020 |

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|---|---|
| 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<br>Annina Altomari |
| Due Date | October 2019, January 2020, April 2020, July 2020 |

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|---|---|
| Goal 3 | Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances. |
| Intervention | • GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required.<br>• Train BHRS staff and contractors on new grievance procedures<br>• Track compliance with new Grievance and NOABD policy |
| Measurement | • # of successfully issued NOABDs<br>• # of Appeals completed with outcome % for favorable outcomes for client<br>• # of successfully completed Grievances |
| Responsibility | Ingall Bull<br>GAT Team |
| Due Date | January 2020 |

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| 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.<br>• Obtain baseline/develop goal. |
| Measurement | Annual review of requests for change of provider. |
| Responsibility | Tracey Chan |
| Due Date | June 2019 |

## 6. Client Satisfaction and Culturally Competent Services

| Goal 1 | Providers will be informed of results of the beneficiary/family satisfaction surveys bi-annually. |
|---|---|
| Intervention | Develop communication plan to inform providers/staff of the results of each survey within a specified timeline. |
| Measurement | Completion of notification twice a year.<br>Presentation and notification of the results yearly. |
| Responsibility | Ingall Bull<br>David Williams |
| Due Date | July 2019, January 2020 |

| Goal 2 | Improve cultural and linguistic competence |
|---|---|
| Intervention | "Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years. |
| Measurement | • 100% of New staff will complete in-person "Working Effectively with Interpreters in Behavioral Health"<br>• 75% of Existing staff who have taken the initial training will take the refresher training at lease every three years. |
| Responsibility | Claudia Tinoco<br>Maria Lorente-Foresti<br>Doris Estremera |
| Due Date | June 2020 |

| Goal 3 | Expand Translation of BHRS Consumer Documents to meet Threshold Languages (Spanish, Tagalog, Chinese) |
|---|---|
| Intervention | Update BHRS Consumer facing communications to be in our threshold languages<br>Update Policies to include threshold languages |
| Measurement | • Completion of translation identified communication<br>• Posted on Website<br>• Printed Materials distributed to Clinics and Contractors |
| Responsibility | Tracey Chan<br>Maria Lorente-Foresti<br>Doris Estremera |
| Due Date | June 2020 |

| Goal 4 | Improve Linguistic Access for clients whose preferred language is other than English |
|---|---|
| Intervention | Services will be provided in the clients preferred language |
| Measurement | % of clients with a preferred language other than English receiving a service in their preferred language |
| Responsibility | Claudia Tinoco<br>Doris Estremera<br>Maria Lorente-Foresti<br>Chad Kempel |
| Due Date | June 2020 |

| Goal 5 | Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations. |
|---|---|
| Intervention | All staff will complete mandatory training on cultural humility |
| Measurement | 65% of staff will complete the Cultural Humility training. |
| Responsibility | Claudia Tinoco<br>Doris Estremera<br>Erica Britton |
| Due Date | Due June 30, 2019 |

| Goal 6 | Monitor data collection guidelines regarding sexual orientation and gender identity (SOGI) |
|---|---|
| Intervention | • All clients to be assessed for their sexual orientation and gender identity All staff with direct client contact will appropriately ask client's sexual orientation and gender identity questions (SOGI) |
| Measurement | • # of completed SOGI questions in Avatar assessments. Separate by contract agencies and county programs<br>• Baseline = |
| Responsibility | Claudia Tinoco<br>Doris Estremera<br>Erica Britton<br>Maria Lorente-Foresti |
| Due Date | June 2020 |

7. DMC-ODS Pilot

| Goal 1 | Increase offender access to SUD care post release at re-entry to the community |
|---|---|
| Intervention | • Continue training criminal Justice partners.<br>• Complete ASAM Evaluations of in-custody clients upon request.<br>• Link clients to appropriate level of care post release |
| Measurement | • % of ASAM in-custody evaluation completed<br>• % of inmates released to the appropriate level of care |
| Responsibility | Mary Fullerton<br>Eliseo Amezcua<br>Clara Boyden |
| Due Date | June 2020 |

| Goal 2 | Increase number of clients discharged from residential detox services with a referral to the appropriate level of care based ASAM criteria and who are subsequently admitted follow-up care. |
|---|---|
| Intervention | • AOD care coordinator will complete and ASAM evaluation and treatment referral.<br>• Coordinate the discharge and subsequent admission to the next recommended level of care. |
| Measurement | • % of clients with a referral (ASAM level of care) prior to discharge from detox services. # of referral/# of discharges<br>• % of clients being admitted to a subsequent follow up appointment/treatment with 7 days of discharge<br>• % of clients re-admitted to detox within 30 days<br><br>Baseline: Calendar Year 2018:<br>• 710 discharges occurred from Palm Avenue (AD413601) between 1/1/2018 and 12/31/2018<br>• 456 of the 710 Palm Ave discharges (64%) received a first service within 7 days of discharge.<br>• 73% of discharges received first service within the first 14 days.<br>• 79% of discharges received first service within the first 30 days. |
| Responsibility | Clara Boyden<br>Eliseo Amezcua<br>Giovanna Bonds |
| Due Date | June 2020 |

| 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.<br>• Develop an audit tool and protocols in for chart audits conjunction with QM<br>• Pilot Audit with each of the DMC-ODS providers |
| Measurement | # of charts reviewed for each DMC-ODS providers |
| Responsibility | Diana Hill<br>Christine O'Kelly |
| Due Date | June 2020 |

| Goal 4 | Ensure timely access to NRT/OTP. |
|---|---|
| Intervention | NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment |
| Measurement | • % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy (NRT.)<br>o County Target is 95%.<br>o FY 17-18 is 93%<br>o FY 18/19 is 90%<br>• % of clients who received first service within 3 days of request (State Standard) - establish baseline. |
| Responsibility | Diana Hill |
| Due Date | June 2020 |

| 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<br>• Develop of a Training Plan that incorporates Evidenced-Based Practices.<br>• Implement training plan |
| Measurement | • Completion of the training plan protocol<br>• # of trainings offered |
| Responsibility | Diana Hill<br>Kathy Reyes |
| Due Date | June 2020 |

| Goal 6 | 80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs. |
|---|---|
| Intervention | • Implement Training Plan for provider clinicians, counseling and supervisory staff.<br>• Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs.<br>• Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements. |
| Measurement | • % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs.<br>• FY 18-19 performance is 28% |
| Responsibility | Diana Hill<br>Christine O'Kelly<br>Kathy Reyes<br>Erica Britton |
| Due Date | June 2020 |

| Goal 7 | 80% All provider Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually. |
|---|---|
| Intervention | Implement a Training Plan for provider clinicians. |
| Measurement | • % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually.<br>• FY 17/18 baseline is 35%.<br>• FY 18/19 = 55%. |
| Responsibility | Diana Hill<br>Christine O'Kelly |
| Due Date | June 2020 |

| 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<br>• Analyze gap between data needs and data points available.<br>• Develop new data points as needed<br>• Identify reports needed |
| Measurement | • # of reports developed that meet reporting requirement for DMC-ODS |
| Responsibility | Clara Boyden<br>Diana Hill<br>Kim Pijma (contract monitor)<br>Dave Williams |
| Due Date | June, 2020 |

| Goal 9 | BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs. |
|---|---|
| Intervention | • Develop a Process to capture and analyze timeliness data for:<br>o Outpatient SUD services (excl. Opioid Treatment Programs)<br>o Opioid Treatment Programs<br>• Include data for BHRS programs and contractor agencies serving DMC-ODS clients<br>• Analyze and report timeliness data annually with NACT Submission on April 1, 2020. |
| Measurement | • % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.<br>• % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment. |
| Responsibility | Chad Kempel<br>Clara Boyden |
| Due Date | April 1, 2020 |

| Goal 10 | Create and implement after-hours access policies and procedures |
|---|---|
| Intervention | • Research requirements to meet standard<br>• Convene BHRS QI staff representative, DMC ODS staff and providers to develop a policy and procedures to ensure after-hours access to care is available.<br>• Implement policy and monitoring process for after-hours access. |
| Measurement | Copy of approved policy and procedures |
| Responsibility | Diana Hill<br>Ingall Bull<br>Clara Boyden |
| Due Date | June 2020 |

| Goal 11 | Track coordination of physical health and mental health services. |
|---|---|
| Intervention | • Implementing contract standard for physical health and mental health care coordination of services at the provider level<br>• Audit charts to monitor compliance with standard<br>• Analyze TPS client survey data to monitor client satisfaction with care coordination |
| Measurement | • % of audited client charts which comply with DMC ODS physical health examination requirements.<br>• % of MD reviewed physical health examinations with a subsequent referral to physical health services.<br>• % of audited client charts with a completed ACOK screening<br>• % of positive AC OK Screens with a subsequent referral to mental health services. |
| Responsibility | Diana Hill<br>Christine O'Kelly |
| Due Date | June 2020 |