



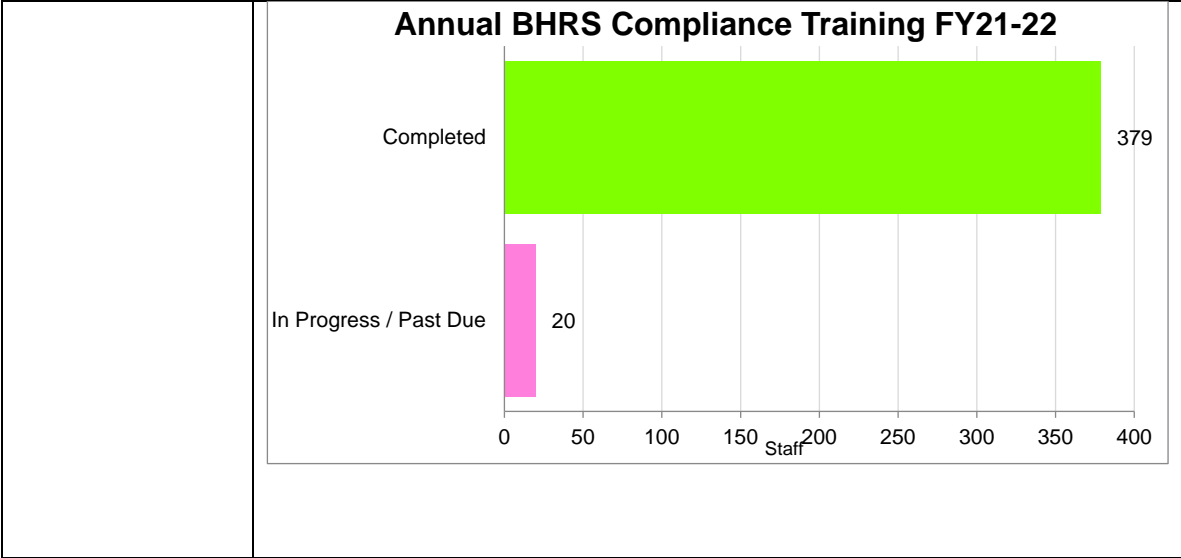
Color Legend: MHP SUDS/AOD MHP/SUD

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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. Current staff: Goal = or > 90% for each training. New Staff: Goal = 100%. <u>Annual Required Compliance Bundle: BHRS Staff Only:</u> The assigned months for each training will be November <ul style="list-style-type: none"> Annual: BHRS Compliance Mandated Training – October 2022 Annual: BHRS Fraud, Waste, & Abuse Training – October 2022 Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD: All BHRSv3.3 – November 2022 BHRS Critical incident Tracking – November 2022
Responsibility	Tracey Chan Jeannine Mealey
Due Date	June 2022
Status	Met, continue for next year
Summary	In FY 21-22, 94% of staff completed trainings.



Goal 2	Improve clinical documentation and quality of care.
Intervention	Maintain clinical documentation training program for all current and new staff.
Measurement	Report on trainings provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.
Responsibility	Clinical Documentation Workgroup QM Manager Jeannine Mealey Claudia Tinoco Tracey Chan
Due Date	June 2022
Status	Met, continue for next year
Summary	QM has posted on our website previous webinars that were widely attended by BHRIS staff and CBO staff. All staff able to re-watch and access webinars at any time.

Goal 3	Program staff to improve overall compliance with timelines and paperwork requirements.
Intervention	<ul style="list-style-type: none"> • 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	Jeannine Mealey Tracey Chan A.B. Limin
Due Date	June 2022
Status	Met, discontinued for next year
Summary	<p>The following monthly reports were continuously sent to all SDMC programs and contractors with the following explanation of each report. This goal will be discontinued for next. We will look at the procedures to see how to fit the new CalAIM requirements.</p> <p>Hello Supervisor/Manager:</p> <p>****Please address your questions/ concerns to: ASK QM <HS_BHRS_ASK_QM@SMCGOV.ORG></p> <p>QM appreciates the quality care your team continues to provide for our clients during this challenging time. QM would like to support you and help you navigate changes in the documentation of services in these times. Please send us your questions.</p> <p>The full assessment and treatment plan may be completed over the phone or by telehealth (video).</p>

Attached you will find the following reports:

Assessment Overdue Status Report
 Do the best that you can to complete the different areas of the assessment. For areas that you are unable to assess, you will state in that area of the assessment “Unable to assess due to assessment being completed over the phone.” **You may finalize the assessment even if you have areas in the assessment that you were not able to assess. Do NOT leave the assessment in draft.** If you later find out additional information that is relevant for the areas in the assessment that you were previously unable to assess, you would do an assessment addendum to add that information to the client’s record.

Treatment Plan Overdue and Coming Due Status Report
Please do your best to complete treatment plans and note the participation with your client on the treatment plan and in the progress note. If your treatment plan is late, this will not cause a disallowance in an audit, Avatar automatically blocks billing, but we are NOT able to bill Medi-Cal for these clients. Please continue to using the appropriate services codes (DO NOT CODE EVERYTHING 55). Complete a treatment plan when you can, and do NOT back date the start dates once you complete them- the start date is the date that they are completed. **You may finalize the treatment plan without the client’s signature.**

Days to Document (Summary)
 We have included this report for your review. Please note that this report only reflects completed notes. Any notes still in draft status are not shown on this report. If you have a clinician that you would like more specifics on their documentation, you can run the report called Days to Document (Single). Select the name of the clinician and it will let you know more specifics about their documentation and timelines. **This is run for one month. If the number of progress notes is less than the number of services that staff person provided, that staff person is not documenting all of their services.**

Thank you to you and your team, for your valuable contribution to BHRS Mental Health and for your attention to our feedback. Your dedication in this difficult time is deeply appreciated. There is no need to respond to this email but please feel free to email ASK QM anytime with any questions or concerns HS_BHRS_ASK_QM@smcgov.org

Sincerely,
 QM TEAM

Goal 4	Maintain disallowances to less than 5% of sample.
Intervention	<ul style="list-style-type: none"> • Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System. • Send progress reports to county programs.
Measurement	<ul style="list-style-type: none"> • 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 2022

Status	Partially Met, continue for next year																								
Summary	<p>There was no external Medi-Cal audit this FY. QM audited county SDMC programs. There was a disruption to the audit program due to COVID-19. Not all CBOs were audited due to COVID-19. There was a total of 23 County BHRS programs and 13 CBO agencies programs audited in FY21-22, summary below. The remaining CBOs are currently being audited by the BHRS audit team. Services rated to be disallowed were or will be voided. Self-Disallowance Rate: County Programs 13% and CBOs 3%. The average is 12% services were determined to be self-disallowed (voided) due to audit</p> <p>SDMC</p> <table border="1"> <thead> <tr> <th>Programs Audited</th> <th>Charts Audited</th> <th>Services Audited</th> <th>Services Disallowed</th> <th>\$ Dollars Audited</th> <th>\$ Disallowance</th> <th>Disallowed PNs</th> <th>\$Disallowance Rate</th> </tr> </thead> <tbody> <tr> <td>County (23)</td> <td>336</td> <td>3640</td> <td>544</td> <td>\$963,652</td> <td>\$122,784</td> <td>15%</td> <td>13%</td> </tr> <tr> <td>CBO (13)</td> <td>34</td> <td>721</td> <td>29</td> <td>\$94,028</td> <td>\$2,406</td> <td>4%</td> <td>3%</td> </tr> </tbody> </table>	Programs Audited	Charts Audited	Services Audited	Services Disallowed	\$ Dollars Audited	\$ Disallowance	Disallowed PNs	\$Disallowance Rate	County (23)	336	3640	544	\$963,652	\$122,784	15%	13%	CBO (13)	34	721	29	\$94,028	\$2,406	4%	3%
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Goal 5	Monitor staff satisfaction with QI activities & services.
Intervention	<ul style="list-style-type: none"> 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	<p>Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%.</p> <ul style="list-style-type: none"> Are you satisfied with the help that you received from the Quality Management staff person? Baseline: Nov 2018- <ul style="list-style-type: none"> Yes 75.47%, Somewhat 16.98% = 92.45%, No = 3.77% Total responses 61 Yes 74.29%, Somewhat 18.57% = 92.86%, No = 7.14% Total
Responsibility	QM Manager
Due Date	June 2022
Status	Not Met, continue for next year

Summary

Of our staff and contractors 73 individuals completed this survey.

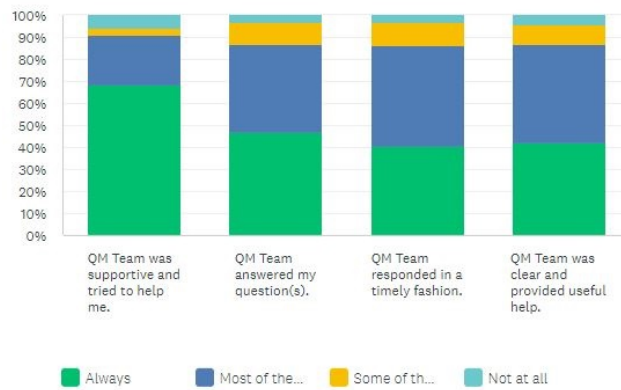
Areas that Staff found QM resources helpful

- Live QM webinars
- Written guidelines
- QM Online LMS trainings

Areas for continued Development/Improvement

- New Documentation Guides/Templates
- Development of New Online Trainings

Please rate your overall experience with the QM/QI Team in 2021.



Goal 6	Create and update policies and procedures in BHRS for Mental Health and SUD
Intervention	<ul style="list-style-type: none"> • Update current policies and procedures for new managed care rules. • Update policy Index. • Maintain internal policy committee to address needed policies and procedures. • Retire old/obsolete policies. • Create new, amend existing, and retire obsolete policies
Measurement	# of Policies Created # of Policies Retired # of Policies Amended
Responsibility	Policy Committee QM Manager Annina Altomari Clara Boyden – AOD Deputy Director Diana Hill – AOD Health Services Manager Mary Taylor Fullerton – AOD Clinical Services Manager
Due Date	June 2022
Status	Met, continue for next year
Summary	5 Policies created 6 Policies retired 6 Policies amended/updated Policies continue to be created, amended and retired as needed based on information notices from DHCS and BHRS practices and procedures. The QM policy committee meets monthly to review policies and procedures and make needed updates. This committee also retires outdated policies and develops new policies as needed. QM and SUD work collaboratively to review SUD related polices and make updates as needed. Policy index is updates on an ongoing basis as changes occur with policies. The QM policy committee maintains the index and all master copies of BHRS policies.

Goal 7	Comply with QIC Policy and maintain voting membership that represents all parts BHRS
Intervention	<ul style="list-style-type: none"> Review/amend QIC Policy as necessary. Maintain QIC voting membership that represents BHRS system
Measurement	<ul style="list-style-type: none"> Ensure compliance with QIC Policy: communicate with QIC members as necessary. Verify and document QIC Voters that represents BHRS system by 6/2021 (continuous)
Responsibility	QM Manager Annina Altomari
Due Date	June 2022
Status	Partially Met, continue for next year
Summary	<p>Our QIC currently has 28 members, 23 are voting members. Our Quality Improvement Committee policy states a goal of 35 voting members. Our committee is also lacking more community involvement with only 2 community members.</p> <p>Outreach is needed to recruit additional members (especially from Clients/Consumers/Community/Family Members and Contracted Community-Based providers) and verify membership from participants that are in questionable standing.</p> <p>QIC policy was last updated 6/25/2019. Policy is still current and communication with QIC occurs as necessary.</p>

Goal 8	Tracking Incident Reports (IR)
Intervention	<ul style="list-style-type: none"> Continue to monitor and track all Incident reports. Present data to Executive Team Report trends and current data to QIC and leadership
Measurement	Annual Reports to Executive Team and QIC
Responsibility	Tracey Chan
Due Date	June 2022
Status	Partially Met, continue for next year
Summary	QM Continues to manage the incident reporting process each incident report is sent to the Executive Team for their review.

Goal 9	Develop protocol for eligibility screening for ICC and IHBS services for youth services
Intervention	<ul style="list-style-type: none"> Develop Policy and Procedures for screening for ICC/IHBS services Develop a universal screening form to be completed by direct service staff Develop training for direct service staff.
Measurement	Completed Policy and Procedure Sample Forms
Responsibility	QM Manager Regina Moreno Ziomara Ochoa Annina Altomari
Due Date	June 2022
Status	Not Met, continue for next year

Summary	The workgroup was temporarily paused during the Public Health emergency and will resume next fiscal year.
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Goal 10	Develop a process to identify and report on Health disparities for services by site, region and population served
Intervention	<ul style="list-style-type: none"> • Develop to analyze disparity in services by site, region and population serviced.
Measurement	Completed Policy and Procedure Sample Forms
Responsibility	QM Manager Chad Kempel Maria Lorente-Foresti
Due Date	June 2022
Status	Not Met, Discontinued
Summary	This goal was not started and not fully developed due to low staffing and transition delays in the QM Department. This goal will be discontinued for FY 22/23

2. Performance Improvement Projects (PIP)

Goal 1	BHRS will continue work on two on-going Performance Improvement Projects (PIP) for the MHP
Intervention	<ul style="list-style-type: none"> • Continue with second year of current clinical and non-clinical PIPs. • Analyze data to measure progress on the clinical and non-clinical PIPs. • Identify additional interventions to address the identified problem(s).
Measurement	<ul style="list-style-type: none"> • Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes
Responsibility	Eri Tsujii
Due Date	June 2022
Status	Met, PIPs were approved in March 2022 EQRO for continuation into FY2022-2023.
Summary	BHRS continues to implement existing interventions for both PIPs, but will also supplement with additional trainings to staff on how to use the interventions to increase the use of the interventions. BHRS is currently working on developing additional ways to make accessing telehealth services easier due to feedback from stakeholders, for instance, by adding Zoom Health to the suite of approved telehealth platforms.

Goal 2	Identify new or revised PIP interventions for the current fiscal year.
Intervention	<ul style="list-style-type: none"> • Review current PIPs in light of COVID-19 and assess viability for continuation. • Review recent DMC ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas. • Work with the DMC ODS QI subcommittee for input into direction and selection of clinical and administrative PIPs.
Measurement	<ul style="list-style-type: none"> • Meeting Minutes • Developed PIPs
Responsibility	Clara Boyden Diana Hill

	Mary Fullerton QM Manager Eri Tsujii Eliseo Amezcua Desirae Miller
Due Date	June 2022

3. Utilization and Timeliness to Service Measures

Goal 3	Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client)
Intervention	<ul style="list-style-type: none"> • Include data for BHRS and contract agencies serving SDMC clients. • Report to Executive Team and QIC, timeliness data annually.
Measurement	<ul style="list-style-type: none"> • % of clients being offered or receiving an assessment appointment 10 days from request to first appointment. • % of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service. • Track Timeliness from assessment to first treatment appointment • Track Timeliness from request for Urgent appointment to actual encounter. (48 hrs for non-authorized service; 96 hrs for pre-authorized services)
Responsibility	QM Manager Eri Tsujii Chad Kempel
Due	June 2022
Status	Partial Progress made and we will continue the goal for the following year
Summary	<p>BHRS has been actively collecting data for Timely Access for MHP clients based on CSI Timely Access Criteria. Staff from both BHRS programs and Contract Agencies have been actively inputting data into the CSI Timely Access form in Avatar, and QM Program Specialist, Eri Tsujii, has been checking data for errors and fixing errors to ensure accurate information.</p> <ul style="list-style-type: none"> • % of clients being offered or receiving an assessment appointment 10 days from request to first appointment: 83% were offered an appointment within 10 business days, 73% attended their initial assessment appointment within the time frame. • The average number of business days to the first offered treatment appointment is 5.64 days from the end of the assessment, and the average number of business days to the first attended treatment appointment is 7.09 days from the end of the assessment. <p>Currently, the CSI Timely Access requirements only require measurement to the first SMHS service and does not differentiate between Psychiatry and Non-psychiatry services. While we currently have added a temporary system to identify if the original request was for psychiatry or non-psychiatry services, measurement of first service delivered based on type of service will be developed as the CSI requirements evolve.</p> <p>There was a problem with the data from the EHR that resulted in the “urgent” flag not being reflected in the data report. A request was sent to our vendor to resolve this issue but was not completed in time for this due date. The issue will be resolved to allow for this to be completed for the following year’s goal.</p> <p>The previous solution that was established in identifying foster youth in the system proved to be inaccurate and made it difficult to determine if the foster youth was currently a foster youth or was no longer a foster youth. A new flagging system was implemented in the EHR and will be used in this upcoming year to identify foster youths’ timely access measures.</p>

Goal 4	Develop reporting capability for disaggregating data for Youth and Foster Care for tracking medication use. (SB1291)
Intervention	<p>Develop a process for capturing data for the following HEDIS measures</p> <ul style="list-style-type: none"> ○ Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) ○ Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH) ○ Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) ○ Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) <p>Revise JV 220 oversight process to incorporate these measures Identify and update policies as needed</p>
Measurement	Creation of a protocol and process for oversight Updated policies
Responsibility	Quality Manager Eri Tsujii Chad Kempel
Due	June 2022
Status	Not Met, Discontinued
Summary	This item will be temporarily discontinued as other priorities related to CalAIM and various CAPs and other audit requirements have now been prioritized over this goal. However, this will continue to be explored and will make it back as an active goal after CalAIM implementation is completed.

4. Access and Call Center

Goal 1	Improve customer service and satisfaction for San Mateo County Access Call Center
Intervention	<ul style="list-style-type: none"> • Review and Revise, as needed, standards for answering calls • Provide 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 Claudia Tinoco
Due Date	June 2022
Status	Met, continue for next year
Summary	<p>Out of 18 answered calls, 17 callers felt like they were helped equaling that about 94% of test callers felt like they were helped when the call was answered.</p> <p>Out of 18 answered calls, 18 callers felt like the staff that answered the call was knowledgeable equaling that about 100% of the test callers felt the staff was knowledgeable when the call was answered.</p> <p>On 11/4/21, the BHRS Access Call Center reviewed the Call Center script, triage, and referral standards with staff. The triage and referral documents are reviewed anytime there are process changes with HSPM, BHRS, community agencies, when new staff are hired, or when a related grievance is made.</p>

	<p>Monthly, the BHRS Access Call Center reviews any training needs related to workflow issues.</p> <p>In the past year, BHRS SUD call answering workflows were reviewed to improve consumer satisfaction. Improvements made include BHRS Access Call Center staff now send referrals directly to Residential Alcohol and Drug referral team to ensure timely access to services. BHRS Access Call Center leadership and BHRS SUD leadership meet biweekly to review and update processing of calls and referrals.</p> <p>In June 2022, the BHRS Access Call Center and BHRS SUD team reviewed Optum's resource list which included SMHS description, grievance policy and standards for answering calls.</p> <p>Access Call Center staff and Optum will continue to meet quarterly to review resources, the Call Center script, discuss technical issues and consumer experience.</p>
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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	<ul style="list-style-type: none"> • Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services. • Make 1 test call in another language and 1 for AOD services • QM will report to call center the outcome of test calls
Measurement	<p>95 % or more calls answered</p> <p>95 % or more test calls logged.</p> <p>100% of requested interpreters provided</p> <p>75% of call will be rated satisfactory (Caller indicated they were helped)</p>
Responsibility	Tracey Chan
Due Date	June 2022
Status	Partially Met, continue for next year
Summary	<p>94% of calls were answered</p> <p>94% or more test calls logged</p> <p>No callers requested interpreters</p> <p>94% of call will be rated satisfactory</p> <p>Summary of Calls</p> <ul style="list-style-type: none"> • First Quarter: 4 calls • Second Quarter: 6 calls • Third Quarter: 7 calls • Fourth Quarter: 2 calls • Total: 19 total calls (including one call not answered and one call not logged). <ul style="list-style-type: none"> • <i>All calls were made in English</i> • <i>One call was made for AOD services</i> <p>Areas of improvement include increasing non-English test calls as well as the requesting of interpreters to be able to appropriately test this goal.</p>

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

Goal 1 (required)	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	<ul style="list-style-type: none"> • 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 2022
Status	Met, continue for next year
Summary	<p>FY 20/21: Grievance Report presented to QIC on October 13, 2021</p> <p>FY 21/22: Favorable: 73.68%, Partially Favorable: 14.03%, Unfavorable: 12.28%</p> <p>FY 20/21 Grievances:70.17% resolved with 30 days. 100% of grievances resolved within 90 days.</p> <p>FY 20/21: 0 Appeals</p>

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 Annina Altomari Claudia Tinoco
Due Date	June 2022
Status	Met, continue for next year
Summary	100% of providers received the grievance resolution at the time the client is informed. Documented in Grievance Log. Resolved grievance folders are reviewed in Supervision meetings and tracked in Weekly Staff meetings.

Goal 3	Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.
Intervention	<ul style="list-style-type: none"> • GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required. • Train BHRS staff and contractors on new grievance procedures • Track compliance with new Grievance and NOABD policy
Measurement	<ul style="list-style-type: none"> • # of successfully issued NOABDs • # of Appeals completed with outcome % for favorable outcomes for client • # of successfully completed Grievances

Responsibility	Tracey Chan GAT Team																																																																																																															
Due Date	June 2022																																																																																																															
Status	Met, continue next year																																																																																																															
Summary	<p>114 grievances resolved within the 90-day period. 84 grievances were resolved favorably. The Grievance and Appeal team handled all grievances for FY 21-22. QM has posted on our website a webinar regarding NOABD, and all staff can re-watch and access whenever they want.</p> <table border="1"> <thead> <tr> <th colspan="3">GRIEVANCES</th> </tr> <tr> <th>CMS NUMBER</th> <th>INDICATOR</th> <th>TOTAL COUNT</th> </tr> </thead> <tbody> <tr> <td>D1.IV.10</td> <td>Resolved</td> <td>56</td> </tr> <tr> <td>D1.IV.11</td> <td>Active</td> <td>16</td> </tr> <tr> <td>D1.IV.14</td> <td>Timely Resolution</td> <td>56</td> </tr> <tr> <td colspan="3">Number of grievances resolved by plan during the reporting period related to the following services: (A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)</td> </tr> <tr> <td>D1.IV.15c</td> <td>Inpatient</td> <td>14</td> </tr> <tr> <td>D1.IV.15d</td> <td>Outpatient</td> <td>47</td> </tr> <tr> <td colspan="3">Number of grievances resolved by plan during the reporting period related to the following reasons: (A single grievance may be related to multiple reasons and may therefore be counted in multiple categories below.)</td> </tr> <tr> <td>D1.IV.16a</td> <td>Related to Customer Service</td> <td>5</td> </tr> <tr> <td>D1.IV.16b</td> <td>Related to Case management</td> <td>17</td> </tr> <tr> <td>D1.IV.16c</td> <td>Access to Care</td> <td>7</td> </tr> <tr> <td>D1.IV.16d</td> <td>Quality of Care</td> <td>40</td> </tr> <tr> <td>D1.IV.16e</td> <td>County (Plan) Communication</td> <td>0</td> </tr> <tr> <td>D1.IV.16f</td> <td>Payment/Billing issues</td> <td>0</td> </tr> <tr> <td>D1.IV.16g</td> <td>Suspected Fraud</td> <td>0</td> </tr> <tr> <td>D1.IV.16h</td> <td>Abuse, Neglect or Exploitation</td> <td>7</td> </tr> <tr> <td>D1.IV.16i</td> <td>Lack of Timely Response</td> <td>0</td> </tr> <tr> <td>D1.IV.16j</td> <td>Denial of Expedited Appeal</td> <td>0</td> </tr> <tr> <td>D1.IV.16k</td> <td>Filed for other reasons</td> <td>0</td> </tr> <tr> <td colspan="2">TOTAL</td> <td>265</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="3">APPEALS</th> </tr> <tr> <th>CMS NUMBER</th> <th>INDICATOR</th> <th>TOTAL COUNT</th> </tr> </thead> <tbody> <tr> <td>D1.IV.1</td> <td>Resolved</td> <td>0</td> </tr> <tr> <td>D1.IV.2</td> <td>Active</td> <td>0</td> </tr> <tr> <td>D1.IV.5a</td> <td>Timely Resolution (standard)</td> <td>0</td> </tr> <tr> <td>D1.IV.5b</td> <td>Timely Resolution (expedited)</td> <td>0</td> </tr> <tr> <td>D1.IV.6a</td> <td>Denial or Limited Authorization of Service(s)</td> <td>23</td> </tr> <tr> <td>D1.IV.6b</td> <td>Reduction, Suspension, or Termination of a Previously Authorized Service</td> <td>8</td> </tr> <tr> <td>D1.IV.6c</td> <td>Payment Denial</td> <td>5</td> </tr> <tr> <td>D1.IV.6d</td> <td>Service Timeliness</td> <td>135</td> </tr> <tr> <td>D1.IV.6e</td> <td>Untimely Response to Appeal or Grievance</td> <td>0</td> </tr> <tr> <td>D1.IV.6g</td> <td>Denial Of Beneficiary Request to Dispute Financial Liability</td> <td>0</td> </tr> <tr> <td colspan="3">Number of appeals resolved during the reporting period related to the following services: (A single appeal may be related to multiple service types and may therefore be counted in multiple categories below.)</td> </tr> <tr> <td>D1.IV.7c</td> <td>Inpatient</td> <td>13</td> </tr> <tr> <td>D1.IV.7d</td> <td>Outpatient</td> <td>158</td> </tr> <tr> <td colspan="2">TOTAL</td> <td>342</td> </tr> </tbody> </table>	GRIEVANCES			CMS NUMBER	INDICATOR	TOTAL COUNT	D1.IV.10	Resolved	56	D1.IV.11	Active	16	D1.IV.14	Timely Resolution	56	Number of grievances resolved by plan during the reporting period related to the following services: (A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)			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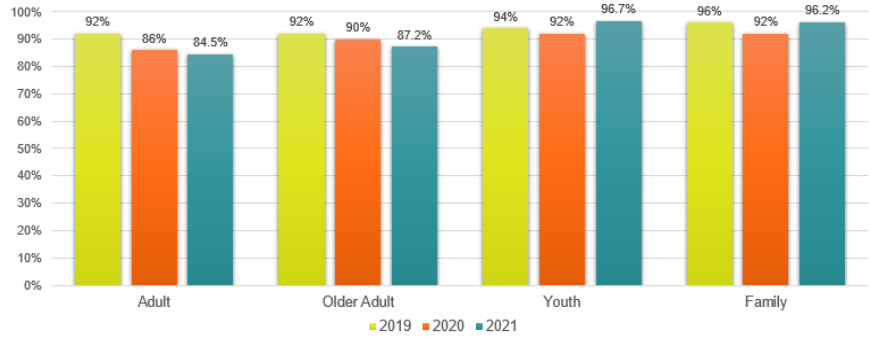
Goal 4	Decision for client's requested Change of Provider within 2 weeks
Intervention	<ul style="list-style-type: none"> Change of Provider Request forms will be sent to Quality Management for tracking. Obtain baseline/develop goal.
Measurement	Annual review of requests for change of provider.
Responsibility	Tracey Chan
Due Date	June 2022
Status	Met, Continued for FY 22-23
Summary	<p>In FY 21-22, 69 total requests to change provider were received.</p> <ul style="list-style-type: none"> 47 requests in FY 20-21 62 requests in FY 19-20 69 requests in FY 18-19

	<ul style="list-style-type: none"> • 105 requests in FY 17-18 <p>81% of decisions were made within 14 days.</p> <ul style="list-style-type: none"> • 87% for FY 20-21 • 82% for FY 19-20 • 73% for FY 18-19 • 76% for FY 17-18 <p>63 requests were approved, 3 requests were resolved without a change of provider, and 3 requests were denied.</p>
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6. Client Satisfaction and Culturally Competent Services

Goal 1	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.
Intervention	Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)
Measurement	<ul style="list-style-type: none"> • Notify programs, according to MHP/ODS requirements, consumer survey results • Presentation and notification of the results yearly.
Responsibility	QM Manager Scott Gruendl Diana Hill
Due Date	June 2022
Status	Partially Met
Summary	<ul style="list-style-type: none"> • Due to transitions in QM manager and limited QM staff, survey results were only presented once and unable to determine if programs were provided notification. • Due to COVID-19 Emergency Health Orders, the survey period was again delayed from May until June 2021. Survey continued to be sent via mail. • Overall Satisfaction was 90% • Adult: All measure stayed relatively stable and there was a 28% increase over 2020 • Older Adults: 27% increase of responses from 2020 • Youth: Response rate continued to decline in 2021

Overall SMC Satisfaction 90%



Youth/Family: Overall, I am satisfied with the services I receive here

Adult/Older Adult: I like the services I receive here

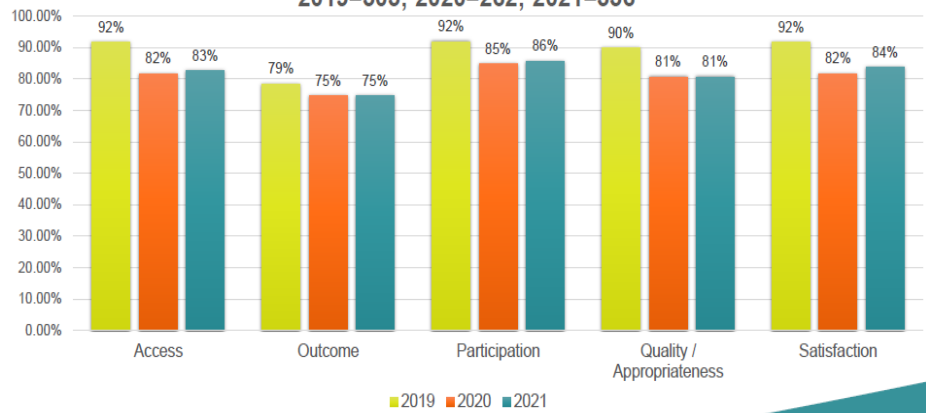
Response Rate Overall: 21%

N=584



Adult Performance Outcome Results

2019=505; 2020=262; 2021=336

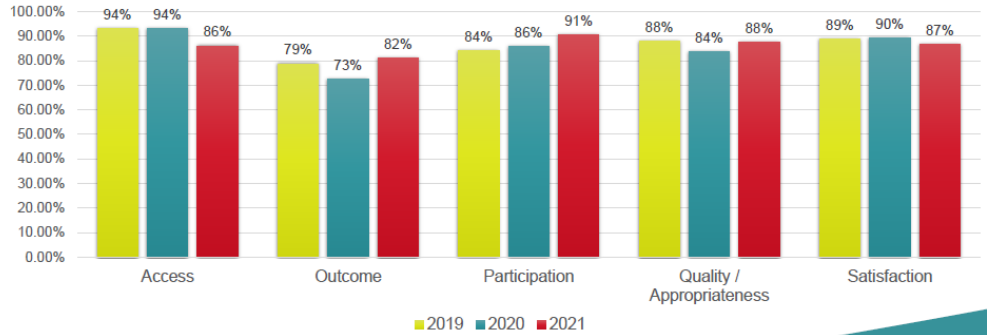


- All Measures have stayed relatively stable
- 28% increase in responses over 2020
- 68% fewer than 2019



Older Adult Performance Outcome Results

2019=159; 2020=125; 2021=164

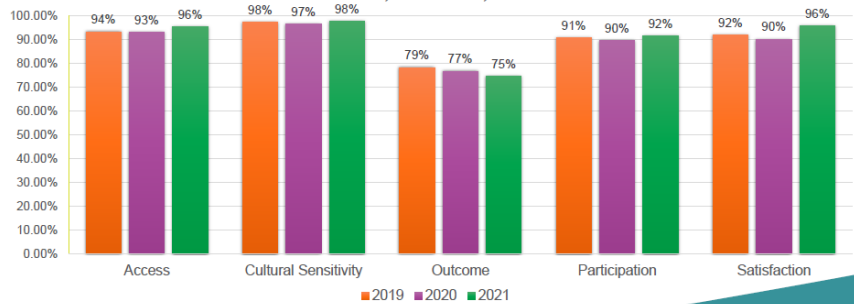


- 3 out of 5 Measures improved
- 27% increase of the responses of 2020



Family (Youth) Performance Outcome Results

2019=128; 2020=63; 2021=54



- 4/5 scores show some improvement.
- # of responses continues to decline since 2019



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	<ul style="list-style-type: none"> • 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	Maria Lorente-Foresti Doris Estremera Claudia Tinoco
Due Date	June 2022
Status	Ongoing

Summary	<p>This fiscal year (FY) 21-22, a total of 74 BHRIS staff completed this training. The training was adapted to be provided on video remote interpretation.</p> <p>BHRIS had a total of 42 new hires this FY 21-22 including regular, extra- hire, relief, and interns. Of these new hires 34 provide some direct service and interact regularly with clients and/or community. Of these direct staff 7% (3) took the Working with Interpreters in Behavioral Health Settings training. The training schedule conflicted with other BHRIS staff meetings, and this year we also saw an increase in BHRIS contracted staff participating and completing this training.</p> <p>BHRIS new staff participate in multiple orientations. New staff are informed of the requirement to attend the “Working with Interpreters in a Behavioral Health Setting” during the New Hire Orientation, the BHRIS Internship Orientation and the Onboarding Orientation provided by the BHRIS Payroll/HR. Supervisors are also asked to inform their new hires during their team onboarding process. New hires are also given BHRIS policy documents referencing this requirement. Lastly, the training was assigned via the BHRIS LMS when the session was offered virtually due to the COVID pandemic. Generally, two in-person Working with Interpreters in a Behavioral Health Setting are provided annually (fall and spring sessions).</p> <p>There are some barriers impacting this ongoing goal. Staff are hired over the course of the fiscal year. There are no permanent positions supporting workforce education and training for BHRIS currently, the</p> <p>Director position is currently vacant. The Office of Diversity & Equity is working on hiring new staff to support this.</p>
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Goal 3	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	Doris Estremera Maria Lorente-Foresti Chad Kempel Claudia Tinoco
Due Date	June 2022
Status	Ongoing
Summary	In FY 2021-2022 the BHRIS saw 3,186 unique requests for interpretation services. There were 2,875 requests for telephonic/Audio interpretation, 155 requests for in-person/onsite interpretation and 156 requests for video remote interpretation. In

	total, there were 34 unique requests for translation of written materials into San Mateo County threshold languages. According to FY 20-21 data, 70.62% of clients with a preferred language other than English received a service in their preferred language.
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Goal 4	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	Doris Estremera Erica Britton Desirae Miller Claudia Tinoco
Due Date	June 2022
Status	Ongoing
Summary	Since 2017 759 BHRS staff have completed the Cultural Humility Training. This fiscal year 2021-2022 BHRS had a total of 94 participants, 21% of current BHRS workforce. Trainings have continued to be provided virtually, which has presented challenges with staff engagement and zoom fatigue. A cohort of Cultural Humility facilitators meets monthly to troubleshoot issues and continue to improve the training experience. This upcoming fiscal year the cohort will be focusing on the data collection tools like the pre and posttest for this training and beginning the transition to hosting them in person. Again, there are no permanent positions supporting workforce education and training for BHRS currently, the Director position is currently vacant. The Office of Diversity & Equity is working on hiring new staff to support this.

7. DMC-ODS Pilot

Goal 1	Develop and implement a Youth SUD Assessment tool.
Intervention	Work with clinical consultants and youth SUD treatment providers to develop an ASAM-based SUD Assessment tool specific to youth ages 12-17 and 18-21. Train contracted providers on its usage and implement in Avatar EMR.
Measurement	<ul style="list-style-type: none"> • The development of a youth SUD Assessment tool. • Import tool into Avatar. • Training and implementing with providers serving youth 17 and under, and with providers serving young people 18-21. • % of client charts audited with a completed Youth SUD Assessment tool.
Responsibility	Diana Hill Christine O’Kelly Desirae Miller IT Manager Mary Taylor Fullerton Stephanie Coate

	Eliseo Amezcua
Due Date	June 2022
Status	Partially Met- will continue next year
Summary	<p>Adolescent ASAM tools used by other DMC ODS Counties (Marin, LA County, Riverside) were requested and reviewed. A tool was reviewed, selected and modified for San Mateo County use. As of 7/1/22, all youth providers are now required to use this tool and scan a copy into the Avatar EHR.</p> <p>Working on creating fillable form to complete electronically and rolling into electronic health record system for ease of completion.</p> <p>Providers scan the youth specific ASAM based tool using Perceptive, a HIPAA and 42 CFR compliant Avatar-based scanning function.</p>

Goal 2	Develop and Implement a Youth Health Screening Tool
Intervention	Work with clinical consultants, youth SUD treatment providers, and medical directors to develop a youth health screening tool specific to youth ages 12-17 and 18-21.
Measurement	<ul style="list-style-type: none"> • The development of a youth health screening tool. • Import into Avatar. • Training and implementing with providers serving youth 17 and under, and with providers serving young people 18-21. • % of client charts audited with a completed youth health screening tool.
Responsibility	Diana Hill Christine O’Kelly Desirae Miller IT Manager Mary Taylor Fullerton Stephanie Coate Eliseo Amezcua
Due	June 2022
Status	Not completed – In Progress
Summary	The current tool used is not youth-specific, but rather based on DHCS’ Health Questionnaire. The Youth Services Network was reconvened in August 2022. Development of a youth-specific health screening tool is on the list of to-do items.

Goal 3	Care Coordination: Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.
Intervention	<ul style="list-style-type: none"> • ASAM evaluation and treatment referral completed prior to residential detox discharge. • Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.
Measurement	<ul style="list-style-type: none"> • # of Res Detox discharges • % of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge • % of clients re-admitted to detox within 30 days
Responsibility	Eliseo Amezcua Giovanna Bonds Melina Cortez Mary Taylor Fullerton

Due Date	June 2022
Status	Not completed
Summary	Horizon/Palm Ave remained closed through June 2022 and StarVista First Chance Detox had extenuating circumstances that challenged their ability to enter client data into Avatar. Therefore, this data was not available to us during this calendar year. Horizon/Palm is scheduled to re-open in October 2022 and First Chance Detox is under a Corrective Action Plan to implement Avatar, so this information should be collected for the next fiscal year.

Goal 4	Monitor Service Delivery System: Increase treatment provider compliance with DMC-ODS documentation regulations.
Intervention	<ul style="list-style-type: none"> • Design and implement a plan for County review of SUD treatment provider Medi-Cal beneficiary charts to allow remote monitoring for COVID-19 safety practices. • Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts. • Pilot Audit with each of the DMC-ODS providers
Measurement	# of charts reviewed for each DMC-ODS providers
Responsibility	Diana Hill Desirae Miller Christine O'Kelly
Due Date	2022
Status	Complete
Summary	

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	<ul style="list-style-type: none"> • Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement • Develop of an annual Training Plan that incorporates Evidenced-Based Practices. • Implement training plan
Measurement	<ul style="list-style-type: none"> • Copy of training plan protocol • # of trainings offered
Responsibility	<ul style="list-style-type: none"> • Diana Hill • Mary Fullerton • Christine O'Kelly
Due Date	June 2022
Status	Partially Met- will continue next year
Summary	Due to high turnover of SUD staff, this goal was partially met and will be continued next year.

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	<ul style="list-style-type: none"> • Implement Training Plan for provider clinicians, counseling and supervisory staff. • Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs.

	<ul style="list-style-type: none"> • Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements.
Measurement	<ul style="list-style-type: none"> • % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs. • FY 18-19 performance is 28%
Responsibility	Diana Hill Christine O'Kelly Erica Britton
Due Date	June 2022
Status	Partially Met- will continue next year
Summary	Due to high turnover of SUD staff, this goal was partially met and will be continued next year.

Goal 7	All providers who are 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	<ul style="list-style-type: none"> • % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually. • FY 17/18 baseline is 35%. • FY 18/19 = 55%.
Responsibility	Diana Hill Christine O'Kelly Mary Taylor Fullerton
Due Date	June 2022
Status	Partially Met- will continue next year
Summary	Due to high turnover of SUD staff, this goal was partially met and will be continued next year.

Goal 8	Monitor Service Delivery System: Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards
Intervention	<ul style="list-style-type: none"> • Implement Avatar SUD enhancements to collect data for measures. • Identified reports are created in Avatar • Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system.
Measurement	<ul style="list-style-type: none"> • List of reports developed that meet reporting requirement for DMC-ODS
Responsibility	Clara Boyden Diana Hill Mary Fullerton Kim Pijma (contract monitor) Dave Williams
Due Date	June, 2022
Status	Partially Met
Summary	SMC Health has developed the follow management dashboard reports using Business Intelligence: <ul style="list-style-type: none"> • Progress Note Services Dashboard, includes AOD Res & NonRes • BHRS Client Diagnosis, by Program Name • BHRS Client Demographics, and includes: Age, Client Ethnicity, Primary Language, Veterans Status, Employment Status, Living Situation, and Smoking Status. Also includes: Client Program Enrollment data and geomapping of active clients.

	<ul style="list-style-type: none"> BHRS Client SOGI data (Sexual Orientation & Gender Identity) by program BHRS Caseload/Active Client Reports
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Goal 9	Timeliness of first contact to first appointment: BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs.
Intervention	<ul style="list-style-type: none"> Develop a process to analyze timeliness data quarterly for: <ul style="list-style-type: none"> Outpatient SUD services (excluding Opioid Treatment Programs) Opioid Treatment Programs Share data for BHRS programs and contractor agencies serving DMC-ODS clients NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment. Report timeliness data annually with NACT Submission on April 1, 2022.
Measurement	<ul style="list-style-type: none"> % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment. % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard) % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment. (State measure/reference only; data not reported as County standard is more stringent).
	Chad Kempel Diana Hill Mary Taylor Fullerton Matt Boyle Diana Campos Gomez
Due Date	June 2022
Status	Partially Met
Summary	BHRS now requires our NTP/OTP provider to submit data on a quarterly basis with the state OTP timeliness for monitoring.

Goal 10	Comply with SABG requirements for Pre-Award Risk Assessments
Intervention	Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.
Measurement	% of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.
Responsibility	Diana Hill Christine O'Kelly Desirae Miller
Due Date	June 2022
Status	Met
Summary	All SABG Pre-Award Risk Assessment tools were completed by April 2022 to meet the June 30 th deadline. Data was pulled to confirm and verified by BHRS Fiscal.

Goal 11	Care Coordination:
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	Care will be coordinated with physical health and mental health service providers.
Intervention	<ul style="list-style-type: none"> Implementing contract standard for physical health and mental health care coordination of services at the provider level Audit charts to monitor compliance with standard Develop system-wide coordination meeting with providers Analyze TPS client survey data to monitor client satisfaction with care coordination
Measurement	<ul style="list-style-type: none"> % of audited client charts which comply with DMC ODS physical health examination requirements. % of MD reviewed physical health examinations with a subsequent referral to physical health services. % of audited client charts with a completed ACOK screening % of positive AC OK Screens with a subsequent referral to mental health services.
Responsibility	Diana Hill Christine O'Kelly Desirae Miller Eliseo Amezcua Mary Fullerton
Due Date	June 2022
Status	Partially Met- will continue next year
Summary	<p>Due to high turnover of SUD staff, this goal was partially met and will be continued next year. For Next Year's Plan.</p> <p>1) Add Quarterly HPMS/AOD Care Coordination meetings in as a intervention</p> <p>2) Consider including TPS Survey results /client ratings as MEASUREMENT in future years. We have 2 TPS questions that ask about how well care is coordinated with Physical Health and MH providers.</p>

Goal 12	Assess client experience of SUD services through annual survey.
Intervention	<ul style="list-style-type: none"> Conduct annual TPS Survey with all provider/beneficiaries Analyze TPS data and share findings with providers and stakeholders.
Measurement	<ul style="list-style-type: none"> % percent of clients surveyed who indicate "staff were sensitive to my cultural background (race, religion, language, etc.)" on an annual treatment perceptions survey. <ul style="list-style-type: none"> FY 19/20: 88.8 % (N=228) – baseline % of clients surveyed who indicated "I chose my treatment goals with my provider's help" as determined by the annual SUD treatment perception survey. <ul style="list-style-type: none"> FY 19/20: 90.8 % (N=228) – baseline % of clients surveyed who indicated, "As a direct result of the services I am receiving, I am better able to do the things that I want to do" as determined by the annual SUD treatment perception survey <ul style="list-style-type: none"> FY 19/20: 90.8% (N=228) - baseline

Responsibility	Diana Hill Christine O'Kelly Desirae Miller Mary Fullerton
Due Date	June 2022
Status	Met
Summary	<p>DMC ODS – Surveys completed during one week in September 2021, as required by DHCS. 311 adult surveys were completed at 22 programs. 9% were in Spanish, 90.9% English; 60% completed on paper, 41% online; .6% completed via automated phone survey. White clients completed 41.2% of the surveys, Latinx completed 26.4%, “other” completed 13.5%, Black clients completed 10%, Asians completed 5.5%, American Indian/Alaskan Natives completed 1.9% of surveys, and demographic data was not completed for 4.5% of surveys. 67.5% per mail, 28.6% were female, 1.3% were transgender; 1.3% were an “other gender identity” and 1.9% declined to answer the question.</p> <p>Results were share with providers via email and results were presented at a Monthly Treatment Provider Meeting. Results were also shared during at the 4/27/2022 BHRS Quality Improvement Committee Meeting, at a 4/25/2022 BHRS AOD Leadership Meeting.</p>