

2019

Quality Improvement Plan



BHSD

Substance Use Treatment Services

V 1.0

Substance Use Treatment Services (SUTS)
Quality Improvement Plan

2019

Santa Clara County
Behavioral Health Services Department,
Substance Use Treatment,
Quality Improvement Division

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1. Mission and Vision

Vision

The Santa Clara County Behavioral Health Services Department (BHSD), Substance Use Treatment Services (SUTS) embraces the philosophy of *Wellness and Recovery*, which is aligned with County of Santa Clara Health System vision of *Better Health for All*, to promote the health and well-being of communities throughout the Santa Clara County.

The vision of SUTS is for individuals and families to have a welcoming, culturally and linguistically competent, gender responsive, trauma-informed, integrated and comprehensive system of care with timely access to treatment.

Mission

SUTS promotes a philosophy of client-centered and client-directed care and focuses on providing services, which are individualized to beneficiaries' needs and directed by beneficiaries' choices so they can lead healthy and meaningful lives in their communities. These services are matched to each beneficiary's unique multidimensional needs based on the American Society of Addiction Medicine (ASAM) criteria of Assessment and Placement in a collaborative and participatory process of assessment and service planning.

The overall goals of the Substance Use Treatment Services (SUTS) are aligned with the Triple Aims of the Institute for Healthcare Improvement. The focus is to improve beneficiaries' experience of care by improving and maintaining optimal quality services for the diverse population of the County through a seamless continuum and by increasing health care value through cost-effective measures. Both the county operated and contractor programs are non-religious affiliated and non-discriminatory towards any religious or spiritual beliefs.

The Quality Improvement Work Plan contains a detailed description of the methods and activities of how we measure performance and manage utilization and capacity in our system of care (SOC).

The SUTS Quality Improvement unit ensures services are:

- outcome-driven
- cost-effective
- culturally competent
- recovery and client/family centered
- innovative and creative

Quality Management (QM) Program Structure and Function

Quality Management is a high priority in the Santa Clara County SUTS and is provided through a program comprised of multiple units: the SUTS Quality Improvement unit (QI), the SUTS Data Standards unit (DS), and the SUTS Research and Outcome Measurement unit (ROM). The QI and DS units are managed by a Quality Improvement and Data Support Division Director and the ROM unit is managed separately by the ROM Research Director. Collectively, these units provide information and evaluation of current operational processes, identify areas for improvement, and ensure that SUTS complies with state and federal mandates related to the provision of services ([Refer to Appendix B – Organization Chart](#)).

Quality Improvement (QI) unit: In 2018-19, Santa Clara County (SCC) SUTS Quality Management Program re-organized its infrastructure to fulfill the requirements of the Inter-governmental Agreement (IA). Previously, Quality Improvement Coordinators (QICs) were responsible for individual providers. QICs acted as consultants, care facilitators, and support mechanisms to their assigned providers. The new and evolving infrastructure segments the QM Program into operational areas with specific functions. The operational areas consist of: utilization and capacity management, beneficiary relations, quality assurance and improvement, care coordination, and data support.

Each operational area houses specific tasks aligned with DMC-ODS requirements and metric monitoring to ensure compliant, evidence-based quality care. QICs act as point persons in each operational area to field provider and system questions, thereby limiting the margin for differing interpretations amongst different providers, with which the former QIDs model struggled. QICs will provide technical assistance, consultation, facilitate complex care coordination, and monitor compliance, supported by data analysts, who provide quality metrics congruent to the DMC-ODS, but also aid QICs to troubleshoot any identified operational barriers to effective quality care. Business Operations works alongside Quality Improvement and Data Support (QIDS) ensuring provider relations are appropriately managed. This new infrastructure establishes a centralized streamlined way of reporting and communicating across the system of care.

Data Support (DS) unit: The DS is part of the QI Division and is managed by the same Division Director. The mission of the Data Support unit is to support the newly formulated functional approach to Quality Management in the SUTS system. The Data Support unit's primary responsibilities are to support Quality Improvement staff by providing quality metrics as described in the Quality Improvement plan. The DS staff are also responsible for reporting on issues related to the Quality Improvement, and technical assistance regarding data base design, and data utilization for Quality Management.

The DS unit is also responsible for uploading and maintaining data quality for CalOMS, the state mandated reporting tool. Data Support is the primary liaison with TSS staff, who manage the department's Management Information System ("Pro-Filer"). This unit is responsible for developing and testing new reports, forms and new data fields, and trouble-shooting problems that are reported from across the system

Research and Outcome Measurement (ROM) unit: Within its role of QM for the SUTS system the ROM unit responsible for developing, testing and creating system performance measures, assessment measures for the DMC ODS, providing support on research and evaluation studies as well as Performance Improvement Projects (PIPs) for External Quality Review Organization (EQRO) and supporting department's federal grants on an as needed basis. Other responsibilities include assessment of EBPs (Evidence-Based Practices), treatment outcomes, and local evaluation of the DMC-ODS. The purpose of the local evaluation is to ensure that service delivery and program integrity is maintained across the SUTS system.

The ROM unit has a key role in facilitating the DMC-ODS implementation. This includes working in coordination with the various program, financial, QM, and business operations work groups that are establishing policy, procedures and operational structures to comply with the Santa Clara County (SCC) waiver plan. Through this coordination effort the ROM unit will produce a "local" evaluation of its own waiver performance.

The QIDS and ROM units, comprise the QM approach to operate the SUTS DMC-ODS waiver treatment system in Santa Clara County.

BHQI Committee

- A. **Description:** The Behavioral Health Services Department made the decision to integrate the Behavioral Health Quality Improvement Committee (BHQIC) and cover both mental health and substance use treatment services. Behavioral Health chairs a Behavioral Health Quality Improvement Committee (BHQIC) to review the quality of SUTS & Mental Health treatment services provided to beneficiaries. The BHQIC recommends policies, reviews and evaluates the results of QI activities, including performance improvement projects (PIPs), and documents BHQIC minutes regarding decisions and actions taken. The purpose of the BHQIC is to ensure program integrity and compliance with DHCS requirements ([Refer to Appendix C – BHQIC Committee Members](#)).
- B. **DMC-ODS Requirement:** The Contractor shall establish a BHQIC to review the quality of SUD treatment services provided to beneficiaries. The BHQIC shall appropriate policies; review and evaluate the results of Quality Improvement (QI) activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes.

C. **Goal:** The BHQIC will meet on a regular basis to review and monitor QI activities and PIPs to ensure compliance to Intergovernmental Agreement (IGA), DMC-ODS, and EQRO requirements.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. BHQIC Committee will review reports that may impact system operation and/or clinical issues.	1. BHQIC will recommend policies and protocol changes.	BHQIC Committee	Ongoing
	2. Will identify and make recommendations regarding all PIPS.	BHQIC Committee	Ongoing
	3. SUTS system issues will be identified at IP level.	QI Committee	4/31/20
	4. An Annual report will be published on a BHSD website	QI Committee/QIDS	12/31/20

2. ACCESS

A. **Description:** Track compliance with Medi-Cal time & distance standards, placement of clients within 14 days of screening, and the number of admissions DMC-ODS Requirement: Beneficiary must have timely access to treatment services: Admission to residential and outpatient services within 14 days (10 business days) and 3 days for NTP/OTP services

B. **Goal:** Ensure beneficiary's access to appropriate services with needed accommodations following prescribed Managed Care Plan (MCP) guidelines including CLAS standards.

Objectives	Actions	Responsible Staff (unit/group)	Current Status
1. Provide 24/7 telephone access for referral to services GW	1. Develop a procedure to collect calls data outside of business hours (evenings and weekends).	Gateway Call Center (GW)	6/30/20
	2. Add data elements in the Gateway Referral for Service form to capture dispositions of all referrals.	ROM	7/1/19
2. Track timeliness to first	1. Timeliness of first contact with Gateway to referral	ROM	Tracked quarterly since July 1 2017

appointment metrics	appointment date (IGA-Section 25).		
	2. The interval between the referral/appointment date in OP to actual intake date (% occur within 14 days)	ROM	Tracked quarterly since July 1 2017
	3. First contact with Gateway to referral date to intake date for residential	ROM	Tracked quarterly since July 1 2017
3. Timeliness of services of first dose of NTP services	1. Measure timeliness of first contact with Gateway to dose date.	ROM	Tracked quarterly since July 1 2017
4. Engagement	1. Percentage of outpatient clients receiving four face-to-face sessions in first 30 days	ROM	Tracked quarterly since July 1 2017

3. Utilization Management (UM)

- A. **Description:** QI authorizes all residential stays. QI provides daily utilization management to SUTS system of care. QIDS regularly monitors LOS data in all modalities and requires agency specific reporting for LOS data that is off the norm (outlier numbers). QIDS collects and monitors client specific utilization data and identifies atypical utilization patterns and intervenes to ensure treatment quality and efficient use of treatment capacity.
- B. **DMC-ODS Requirement:** Counties will have a UM program assuring that beneficiaries have appropriate access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and the level of care.
- C. **Goal:** Ensure seamless transitions for beneficiaries through SUTS continuum of care with the focus of providing high quality services to address beneficiaries' needs in the least intensive, but safe treatment setting.

Authorization

- A. **Description:** The QIDS has been authorizing extensions of lengths of stay (LOS) in residential treatment for nearly two decades. As part of the DMC-ODS, QIDS will continue using this LOS management strategy while also addressing Medi-Cal medical necessity requirements for residential treatment. QIDS will monitor integration effort with Mental Health and Physical Health services.
- B. **DMC-ODS Requirement:** Counties must provide prior authorization for residential services within 24 hours of the authorization request being submitted by the provider.
- i. Review DSM and ASAM criteria to ensure the requirements for residential services are met.
 - ii. Track the number/percentage of processed/approved/denied requests and timelines of authorization
- C. **Goal:** Ensure that beneficiaries have timely access to residential level of care (LOC) as indicated by ASAM criteria.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. Provide authorization of residential LOC requests within 24 hours of the receipt of the request.	1. Number of authorization requests received	QIDS/ Utilization Management	Quarterly
	2. Percentage approved	QIDS/ Utilization Management	Quarterly
	3. Percentage denied	QIDS/ Utilization Management	Quarterly
	4. Percentage authorized within 24 hrs.	QIDS/ Utilization Management	Quarterly
2. Assure ASAM criteria are used for LOC determinations of residential services.	1. Ratio of indicated ASAM LOC /approved LOC.	QIDS/ Utilization Management	Quarterly

	2. Review random selection percentage of charts to see if ASAM/DSM criteria are met for the level of care in the ALOC (Authorization and Assessment for Level of Care).	QIDS	Annually
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Care Coordination between the MCP and Mental & Physical health agencies

- A. The Substance Use Treatment System (SUTS) coordinates services with Mental Health and Primary Care to provide clients with integrated care for co-occurring conditions. The case management aspect of care coordination is monitored via annual medical records review and audit process. Measures for *care coordination* will involve identifying specific populations within the System of Care, such as frequent utilizers of high intensity services, and care coordination practices to improve treatment outcomes for this group. Business Operations developed MOUs with Santa Clara Family Health Plan and Anthem Blue Cross to reflect changes as a result of the DMC-ODS implementation.
- B. **DMC-ODS Requirement:** Coordination of Care with Physical Health (PH) Care and Mental Health (MH) to benefit SUD clients while protecting their rights. This is a mandatory performance measure required by EQRO.
- C. **Goal:** Develop plan for and demonstrate coordination to assist beneficiaries with PH and MH care to address barriers to SUD recovery and whole person care.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. Coordination with Santa Clara Family Health Plan (SCFHP) and Anthem Blue Cross.	1. Continue regular meetings with health plans to review collaboration outcomes and identify issues for improvement. Monitor Care Coordination referrals by way of an assigned QIC who will facilitate entry into SUTS.	Business Operation	Ongoing/ In process

	2. Monitor Care Coordination referrals by way of an assigned QIC who will facilitate entry into SUTS.	QIDS	Ongoing/ In process
2. Develop and monitor compliance with P&Ps for coordination with Physical Health Care (PHC) and Mental Health (MH) with releases as required.	1. Audit health care issues identified on Health Screening Questionnaire form to ensure translated to ASAM Dimension 2 or 3 on the Treatment Plan.	QIDS	6/30/20
3. Coordinate care for beneficiaries with co-occurring mental health and substance use disorders.	1. Develop and Implement an integrated screening tool for access into both SUTS and MH systems of care.	QIDS	6/30/20
	2. Coordinated Access workflow for concurrent MH and SUTS services at those sites certified to provide both services.	QIDS	6/30/20
4. Coordinate care for beneficiaries with high acuity.	1. Continue developing referral and placement workflows for integrated care initiatives with hospital discharges.	QIDS/Medical Collaboratives	Ongoing
	2. Continue developing referral and placement workflows for integrated care initiatives with other managed health care plan primary care staff.	QIDS	Ongoing
5. Emergency Psychiatric Services (EPS) to Withdrawal Management (WM)	1. Develop a tracking mechanism to capture referral date and admission date from EPS to Withdrawal Management. (Medical Collaborative)	QIDS	6/30/20

6. Transition of Care requests	1. Track Transition of Care requests and report as required by DHCS.	QIDS	Quarterly
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Strategies to Reduce Avoidable Emergency and Inpatient Services Use

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. Assure that residential beneficiaries at high risk for frequent intensive service utilization (high utilizers) are identified and receive timely care coordination.	1. Identify the population in need of care coordination services (receiving more than 2 residential episodes/admissions within the plan year beyond 9 days).	ROM	Annually
	2. Track transfer rate from Withdrawal Management (WM) to other levels of care.	ROM	Tracked quarterly since July 1 2017
	3. Report on referral data from Sobering Station.	ROM	As requested

4. Utilization Review

- A. **Description:** SUTS Providers implement quarterly internal peer utilization reviews. SUTS QI implements annual clinical record audits.
- B. **DMC-ODS Requirement:** MCP monitors the providers and their internal process of chart review for adherence to DMC regulations (IGA-Section 25).
- C. **Goal:** Ensure adherence to Title 22 and 9 regulations.

Objective	Actions	Responsible Staff	Current Status
1. Quarterly Internal Review	1. Monitor submittal of provider’s internal peer utilization review (UR) for drug Medi-Cal.	UM	30 days after the end of each quarter

	2. Monitor UR CAP and billing accountability submitted within 30 days.	UM	30 days to reply with a CAP
	3. Verify billing accountability submitted to finance and ensure completion of Corrective Action Plan (CAP).	QIDS	30 days from receipt of letter from QIDS
1. Annual Audit	1. Conduct annual drug Medi-Cal audit review of all providers with notation of regulatory compliance and billing accountability.	QIDS	Annually
	2. Providers submit CAPs within 30 days of audit findings.	QIDS/ROM	30 days from audit review
	3. Monitor CAPs for clinical review and offer technical assistance as needed.	QIDS	Ongoing
	4. Verify billing accountability submitted to finance and ensure completion of CAP.	QIDS	30 days from receipt of letter from QIDS

ASAM Fidelity Monitoring

ASAM Fidelity Monitoring

- A. **Description:** Fidelity to the spirit and content of ASAM criteria includes assuring that all clinicians are trained in applying ASAM criteria for LOC assessment, developing full scope continuum of levels of care to assure uninterrupted flow of services to meet beneficiaries' needs efficiently and effectively, and monitoring that care is individualized and not program-driven.
- B. **DMC-ODS Requirement:** In order to receive services through the DMC-ODS, the beneficiary "must meet the ASAM criteria definition of medical necessity" and the DSM 5 criteria for substance use diagnosis. "After establishing a diagnosis, the ASAM criteria will be applied to determine placement into the level of assessed services". (DMC-ODS and IGA program Specifications, January 27, 2017).

C. **Goal:** Assure that beneficiaries’ needs are met at the appropriate level of care to increase engagement and optimize cost-effectiveness and avoid unnecessary over- or under-matching of services.

D.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. Assure match between beneficiaries’ needs and LOC at which services are provided.	1. Use ALOC data to track and benchmark occurrences when “indicated” LOC is different from “actual” LOC to identify training needs and system gaps.	Data Support	Reported Biannually since 2017
	2. Audit annually medical records for appropriate LOC match with beneficiaries’ needs during annual review.	QIDS	6/30/20
	3. Develop procedures for UM and review of beneficiaries’ needs with extended lengths of stay in OS.	QIDS	December 31, 2020
	4. Audit Treatment Plan (TP) dosage aligns with appropriate level of care	QIDS	December 31, 2020

Long-term goal:

Monitor effects of current UM process on ASAM fidelity measures. Shift the UM process to monitor match of LOC with beneficiaries’ needs at any time during their stay.

5. Beneficiary and Family Satisfaction

Beneficiary/Family Satisfaction

A. Description: Providers will have Beneficiary Survey available to clients during treatment, to gather information regarding beneficiary’s experience.

B. DMC-ODS Requirement: The Plan shall monitor beneficiary satisfaction and inform providers of the results of beneficiary/family satisfaction activities. The Plan shall implement mechanisms to ensure beneficiary or family satisfaction. The Plan shall assess beneficiary satisfaction by:

- 1) Surveying beneficiary/family satisfaction with the plan’s services at least annually.

C. Goal: Monitor beneficiary/family satisfaction as frequently as possible.

Objective	Actions	Responsible Staff	Current Status
1. Survey all clients at discharge on multiple times during the year.	1. Ensure that providers offer a beneficiary survey to each individual leaving treatment and have surveys available at any time during treatment.	ROM	Has been administered throughout the year and an annual canvas
	2. Determine the rate of completed surveys using services and discharge data. Analyze satisfaction data, with the purpose using this data to drive improvement.	ROM	Bi-annually

Grievance/Appeals/Fair Hearings/Timely Interventions when Occurrences Raise Quality of Care Concerns

- A. **Description:** Evaluate beneficiary grievances, appeals, expedited appeals, fair hearings, and expedited fair hearings at least quarterly. The Quality Improvement Division coordinates a single point of access for patient rights and grievance process. The process consists of Quality Improvement Coordinators, who are clinicians trained as “client rights advocates,” and is overseen by a Clinical Standards Coordinator. Clients are able to report complaints anonymously and file grievances that will be investigated by the MCP. Advocates have full access to provider staff and pertinent records required to investigate client grievances. The Quality Improvement Division monitors and reviews the efficacy of interventions when incidents occur that raise quality of care concerns.
- B. **DMC-ODS Requirement:** Evaluate beneficiary grievances, appeals, and fair hearings at least annually.

The Contractor shall implement mechanisms to monitor appropriate and timely interventions of occurrences that raise quality of care concerns. The contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the interventions shall be evaluated by the Contractor at least annually.

- C. **Goal:** Ensure timely resolution of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, and incident reports. Identify system-wide patterns and implement corrective actions accordingly. Develop a process of monitoring and reviewing evidenced-based (EB) and promising interventions in response to incidents that raise quality of care concerns.

Objective	Actions	Responsible Staff	Current Status
1. Continue to review grievances, appeals, expedited appeals, fair hearings, and expedited fair hearings to identify system improvement issues.	1. Collect, analyze, and report trends in grievances and grievance resolutions, appeals, and fair hearings on a log and sent quarterly to the State.	QM- Beneficiary relations	6/30/20
	2. Submit quarterly reports to BHQIC committee for review and recommendation.	QM –Beneficiary relations	Upon request by Behavioral Health Quality Improvement Committee (BHQIC)
2. Develop systems to carefully track agency incident reports and grievances, their resolution times, and the corrective actions associated with those reports that raise quality of care concerns.	1. Identify patterns in IR reports, evaluate, and report out to BHQIC for their review and recommendations.	QIDS/BHSD QA/Risk Management	Bi-monthly
	2. If appropriate, conduct a root cause analysis after investigation, and work collaboratively with an individual agency or the system of care on a plan of corrective action.	QIDS/QA/Risk Management	As needed
	3. Identify any barriers to delays in response and resolution times and design a plan to address those delays.	QIDS	Bi-monthly

	4. Review corrective action plans and provide support to providers that aims at improving quality of care.	QIDS	Bi-monthly
3. Develop tracking mechanism of NOABD (Notice of Adverse Benefit Determination)	1. SUTS Providers are required to send copies of NOABDs to Clinical Standards Coordinator weekly.	Clinical Standards Coordinator	6/30/2020
	2. Report out different types of NOABDs and review possible improvement needs.	Clinical Standards Coordinator/QIDS	6/30/2020

6. Outcomes/Performance Measures

- A. **Description:** Routine reports are available for all providers to manage their operations. Quality Improvement staff run multiple reports on a regular basis to monitor both provider and system performance. Independent review of performance measures is conducted by the Research and Outcome Measurement unit.
- B. **DMC-ODS Requirement:** The Quality Management program shall conduct performance monitoring activities throughout the MCP operations, including beneficiary and system outcomes. The QI Plan shall monitor the system performance.
- C. **Goal:** Monitoring the quality of services.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. To report on client outcomes following treatment.	1. Create change measures for: Substance use, housing, employment status, income, and daily living activities.	ROM	180 Scan
2. To report on client perception of treatment	1. Develop a report based on client responses on the Client Feedback Survey.	ROM	Quarterly Report
3. To report on client completion of treatment	1. Develop a report on discharge status 	ROM	180 Scan

Mechanisms addressing clinical issues affecting Beneficiaries system wide:

I. PIPs

A. Description:

Performance improvement projects (PIPs) shall be designed to achieve significant improvement in clinical care and non-clinical care health outcomes and beneficiary satisfaction.

B. DMC-ODS Requirement:

The MCP shall establish an ongoing quality assessment and performance improvement program consistent with 42 CFR 438.240 [IGA Section 24].

C. Goal:

Maintain a minimum of two active PIPs, overseen by a QI Committee; one for a clinical area and one for an administrative area.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. Develop PIPs that measure performance using objective quality indicators.	1. IP will generate needed improvement project suggestions and forward them to the QI Committee.	IP	Ongoing
	2. BHQIC will offer recommendations for PIP proposals.	BHQIC	Ongoing
	3. QI Division works with Providers to comply with EQRO standards for PIP projects and report back to the BHQI Committee for review.	QIDS	Ongoing
2. Develop PIPs that support implementation of system interventions that aim to improve quality of care.	1. BHQI Committee to monitor the PIP outcomes.	BHQIC	Ongoing

	2. QI Committee to make recommendations for system wide implementation.	BHQIC	Ongoing
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7. Data Monitoring/Reporting

- A. **Description:** Quality Management Division monitors timely and accurate provider data elements for monthly County and State reports.
- B. **DMC-ODS Requirement:** MCP will collect, analyze and report timeliness and accuracy metrics of county and State reports.
- C. **Goal:** Ensure providers adhere to data reporting needed for MCP and data reporting mandated by the State.

Objectives	Actions	Responsible	Current Status
1. Data Monitoring / Reporting	1. Collect and review DATAR elements for timeliness and accuracy of submittals.	QIDS	By the 10 th of the month
	2. Collect and review Provider Monthly Reports (PMR) for timeliness, access, capacity, medical necessity, and determine the accuracy of data.	QICs/QIDS	After the 12 th of the month
2. CalOMS	1. Review EHR generated provider reports to ensure compliance with State requirements.	QIDS	Ongoing Monthly
3. All County and Contract Quality Assurance staff attend meetings.	1. Facilitate a “DMC-ODS meeting, Quality Assurance and Performance Improvement (QAPI).” to review reports and trends for systems improvements.	QIDS	Monthly

*** The ROM unit conducts other system monitoring functions and reports.**

8. DMC Trainings

- A. **Description:** QIDS provides trainings on DMC statutes and regulations on a regular basis.
- B. **DMC-ODS Requirement:** Contractor shall ensure that all subcontracts receive training on the requirements of Title 22 regulations and DMC program requirements at least annually.
- C. **Goal:** SUTS will provide required trainings and ensure compliance.

Objective	Actions	Responsible Staff (unit/group)	Current Status
1. All Providers will attend mandatory trainings required by DHCS and SUTS contract.	1. Provide annual Title 22 and Title 9. DMC-ODS training and DHCS required trainings.	QIDS	Annually
	2. Track attendance and match to staff rosters.	QIDS	Annually
1. All County and Contract program managers and clinical leads will attend regular Drug Medi-Cal meetings to receive updates.	1. Provide DMC-ODS Regulatory and Compliance training twice a year to MCP providers.	QIDS	2x/year

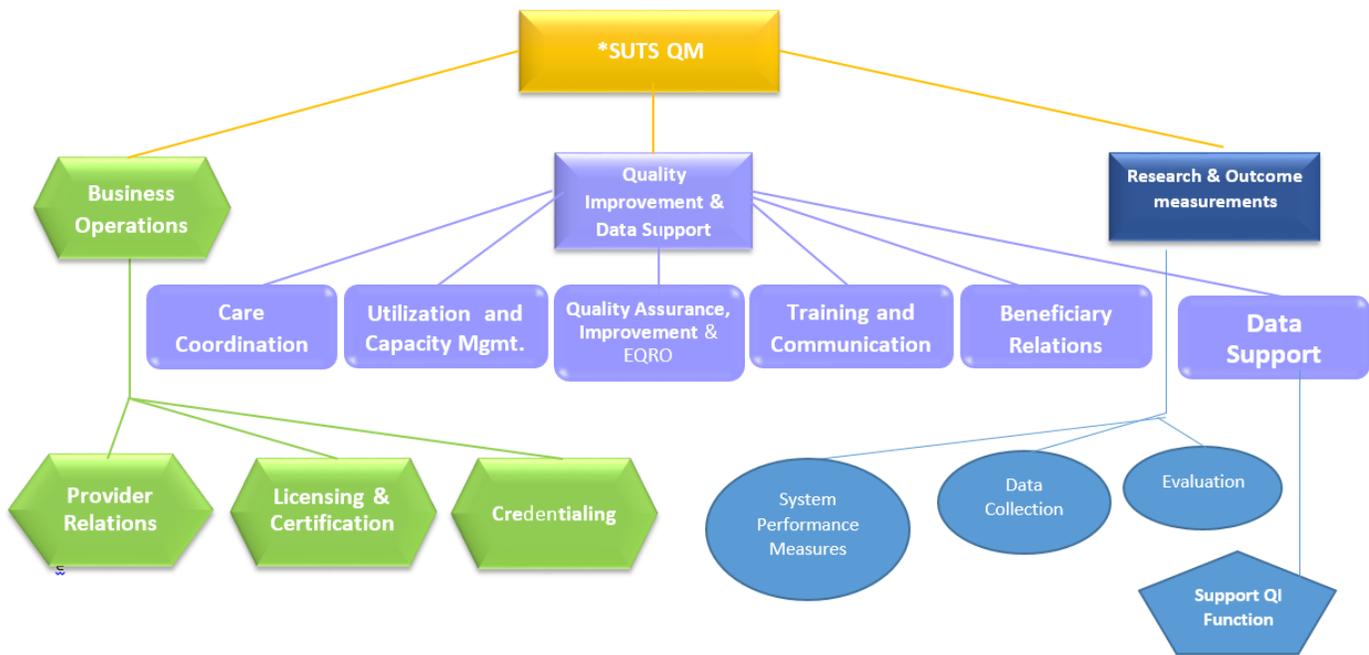
9. APPENDIX A. Acronyms Glossary

AOD:	Alcohol or Drug
ALOC:	Assessment and Authorization for Level of Care
ASAM:	American Society of Addiction Medicine
ASOC:	Adult System of Care
BHSD:	Behavioral Health Services Department
BHQIC:	Behavioral Health Quality Improvement Committee
BBS:	Board of Behavioral Science
CaIOMS:	California Outcome Measures System
CAP:	Corrective Action Plan
CLAS:	Culturally and Linguistically Appropriate Services
COC:	Continuum of Care
CPM:	Clinical Performance Measures
DHCS:	Department of Health Care Services
DMC:	Drug Medi-Cal
DMC-ODS:	Drug Medi-Cal Organized Delivery System
DS Unit:	Data Standards Unit
DSM:	Diagnostic and Statistical Manual
EBPs:	Evidenced Based Practices
EBT:	Evidenced Based Treatment
EHR:	Electronic Health Record
EQRO:	External Quality Review Organization
GW:	Gateway Call Center
HIPAA:	Health Insurance Portability Accountability Act
IGA:	Intergovernmental Agreement
IP:	Innovative Partnership
IR:	Incident Report
LOC:	Level of care
LOS:	Length of Stay
LPHA:	Licensed Practitioner of the Healing Arts
MAT:	Medically Assisted Treatment (Includes Methadone, Buprenorphine and Vivitrol)
MCP:	Managed Care Plan
MH:	Mental Health

MIS: Management Information System
MOU: Memorandum of Understanding
NTP: Narcotic Treatment Program
ODS: Organized Delivery System
PH: Physical Health
PHC: Physical Health Care
PIP: Performance Improvement Project
P&P: Policy and Procedures
PSAP: Perinatal Substance Abuse Program
Pro-Filer/Unicare: BHSD EHR
QA: Quality Assurance
QAPI: Quality Assurance and Performance Improvement
QI: Quality Improvement.
QIC: Quality Improvement Coordinator
QIDS: Quality Improvement and Data Support
QM: Quality Management
ROM: Research and Outcome Measurement Unit
RES: Shortened initials for Residential
RR: Recovery Residences (used to be called THU)
SAMHSA: Substance Abuse Mental Health Services Administration
SCC: County of Santa Clara
SOC: System of Care
SUD: Substance Use Disorder
SUTS: Substance Use Treatment Services
THU: Transitional Housing Unit
TP: Treatment Plan
UM: Utilization Management
UR: Utilization Review
VHP: Valley Health Plan
VMC: Valley Medical Center
WM: Withdrawal Management
YSOC: Youth System of Care

10. Appendix B.

MCP Organization Chart



- SUTS QM is comprised of a multidisciplinary process with three units: Business Operations, Quality Improvement and Data Support (QIDS), and Research & Outcome Measurements (ROM).

11. Appendix C.

Behavioral Health Quality Improvement Committee Members

- 1) Consumer
- 2) Family Member of Consumer
- 3) BHSD Executive
- 4) BHSD QI and QA
- 5) Stakeholder - CJS
- 6) Stakeholder - HHS
- 7) Stakeholder / RR
- 8) SUTS Stakeholders
- 9) MH Stakeholders
- 10) Cultural Competence Stakeholder
- 11) BHSD SUTS QI Director
- 12) Representatives from other MCPs
- 13) Subject Matter Experts (as needed)

APPROVAL OF BHS 2019-2020 QUALITY IMPROVEMENT WORK PLAN

The attached is Santa Clara Behavioral Health Services Substance Use Treatment Services (BHS SUTS) 2019-2020 Quality Improvement Plan has been reviewed and approved by the following undersigned, including the governing body responsible for the operations of Santa Clara Behavioral Health Services Department Substance Use

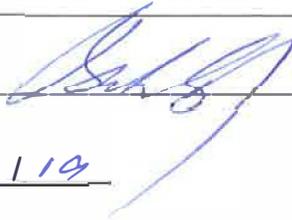
Treatment Services.

Toni Tullys, MPA
Director of Behavioral Health Services
County of Santa Clara Health System

Signature: 

Date 10 / 2 / 2019

Bruce Copley
Director of Alcohol, Drugs and Access Services
County of Santa Clara Health System – Substance Use Treatment Services (SUTS)

Signature: 

Date 10 / 7 / 19

Tianna Nelson, Ph.D, LMFT
Division Director Substance Use Treatment Services,
Quality Improvement and Data Support, County of Santa Clara Health System - Behavioral Health Services

Signature: 

Date 10 / 7 / 19