

**Quality Improvement Work Plan for  
 Mental Health & SUDS  
 July 2025 - June 2026  
 (Start July 2025)**

System (SYS)	
<b>DMC</b>	DMC-ODS
<b>MHP</b>	Mental Health
<b>JT</b>	Joint DMC-ODS and Mental Health Goal

Core QM Staff	
QM Manager	Vacant
QM Unit Chief	Claudia Tinoco-Elizondo
QM Program Specialist	Vacant
QM Program Specialist	Annina Altomari
QM Program Specialist	Eri Tsujii
QM Community Mental Health Nurse	Elaina Acosta Ford
QM Clinical Analyst	Laurie Bell

Category (CAT)	
<b>QI</b>	Quality Improvement Activities
<b>PIP</b>	Performance Improvement Projects
<b>UT</b>	Utilization and Timeliness to Service Measures
<b>AC</b>	Access and Call Center
<b>GN</b>	Monitoring Grievances, Notice of Adverse Benefits Determination and Appeals
<b>CS</b>	Client Satisfaction and Culturally Competent Services
<b>DMC</b>	DMC-ODS Pilot
<b>CAT</b>	Contractor Audit Team

Core DMC-ODS Staff	
Deputy Director of SUD Services	Clara Boyden
SUD Clinical Services Manager	Mary Taylor
SUD Supervisor	Vacant
SUD Supervisor	Eliseo Amezcua
SUD Health Services Manager	Sheryl Uyan
SUD Program Specialist	Tracey Chan

For additional staff listed in this document, please see BHRS Organization Chart

SYS	CAT	#	Goal Description	Intervention	Measurement	Responsible Persons	Due Date	Outcomes
MH	QI	1	Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.	Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.	<p>Track training compliance, HIPAA, &amp; FWA of new staff and current staff.</p> <p>Current staff: Goal = or &gt; 90% for each training. New Staff: Goal = 100%</p> <p><u>Annual Required Compliance Bundle: BHRS Staff Only:</u> The assigned months for each training course will be December</p> <ul style="list-style-type: none"> <li>• Annual: BHRS Compliance Mandated Training – December 2025</li> <li>• Annual: BHRS Fraud, Waste, &amp; Abuse Training – December 2025</li> <li>• Annual: BHRS: Confidentiality &amp; HIPAA for Mental Health and AOD– December 2025</li> <li>• Annual: BHRS Critical incident Tracking – December 2025</li> <li>• Annual: BHRS AB210 Brief Overview-December 2025</li> <li>•</li> </ul>	QM Staff	June 2026	
MH	QI	2	Improve clinical documentation and quality of care.	<ul style="list-style-type: none"> <li>• Maintain clinical documentation training program for all current and new staff.</li> <li>• Train staff and contractor providers on new CalAIM requirements</li> </ul>	Report on training provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.	QM Manager QM Staff	June 2026	
JT	QI	5	Monitor staff satisfaction with QI activities & services	<ul style="list-style-type: none"> <li>• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.</li> </ul>	<p>Percentage of staff reporting satisfied/somewhat satisfied with QM support = or &gt; 90%.</p> <ul style="list-style-type: none"> <li>• Are you satisfied with the help that you received from the Quality Management staff?</li> <li>• Baseline: <ul style="list-style-type: none"> <li>○ FY 24-25 Very Satisfied=35.56% Satisfied=31.11% Somewhat satisfied= 11.11%, Very Dissatisfied= 6.67% Total responses 45</li> </ul> </li> </ul>	QM Manager QM Staff	June 2026	
JT	QI	6	Create and update policies and procedures in BHRS for Mental Health and SUD	<ul style="list-style-type: none"> <li>• Update current policies and procedures for new managed care rules.</li> <li>• Update policy Index.</li> <li>• Maintain internal policy committee to address needed policies and procedures.</li> <li>• Retire old/obsolete policies.</li> <li>• Create new, amend existing, and retire obsolete policies</li> </ul>	<ul style="list-style-type: none"> <li>• # of Policies Created</li> <li>• # of Policies Retired</li> <li>• # of Policies Amended</li> </ul>	Policy Committee QM Staff DMC-ODS Staff	June 2026	

SYS	CAT	#	Goal Description	Intervention	Measurement	Responsible Persons	Due Date	Outcomes
				<ul style="list-style-type: none"> <li>Update policies and procedures to comply with CalAIM</li> </ul>				
JT	QI	7	Comply with QIC Policy and maintain voting membership that represents all parts BHRS	<ul style="list-style-type: none"> <li>Review/amend QIC Policy as necessary.</li> <li>Maintain QIC membership that represents BHRS system</li> </ul>	<ul style="list-style-type: none"> <li>Ensure compliance with QIC Policy: communicate with QIC members as necessary.</li> <li>Verify and document QIC members that represents BHRS system by 6/2021 (continuous)</li> </ul>	QM Manager Annina Altomari QM Staff	June 2026	
JT	QI	8	Strengthen staff proficiency with SAFE incident reporting system by establishing clear procedures, training, and support to ensure reliable and timely incident reporting. Tracking Incident Reports (IR)	<ul style="list-style-type: none"> <li>Implement a standardized SAFE incident reporting process that includes clear written procedures, staff training, and ongoing support</li> <li>Continue to monitor and track all Incident reports.</li> <li>Report trends and current data.</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of Incident Reports submitted without errors or missing required information.</li> <li>Report to QIC</li> </ul>	QM Staff	June 2026	
JT	QI	9	Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) as defined by DHCS under Network Certification Standard Requirements.	<ul style="list-style-type: none"> <li>Include data for BHRS and contract agencies serving Medi-Cal clients.</li> <li>Report to Executive Team and QIC, timeliness data annually.</li> </ul>	<ul style="list-style-type: none"> <li>% of clients being offered an initial appointment within 10 days of request for MH Non-Psychiatry, SUD Residential, and SUD OP/IOP services.</li> <li>% of new clients being offered a Psychiatry appointment within 15 days of request for a MH psychiatry service.</li> <li>% of clients starting an Opioid Treatment Programs within 3 days from request to first appointment.</li> <li>Track Timeliness from request for Urgent appointment to initial offered appointment. (48 hrs for non-authorized service; 96 hrs for pre- authorized services)</li> </ul>	QM Manager Eri Tsujii Maya Greene	June 2026	
JT	AC	10	Improve customer service and satisfaction for San Mateo County Access Call Center for MH/SUD	<ul style="list-style-type: none"> <li>Review and Revise, as needed, standards for answering calls</li> <li>Provide training for Optum call center staff on standards for answering calls.</li> </ul>	<ul style="list-style-type: none"> <li>Test calls and call logs 90% test call rated as positive</li> </ul>	Access Call Center QM Staff	June 2026	
JT	AC	11	Monitor 24/7 access to care through Call Center and Optum. 100% of calls will be answered. 100% of test callers will be provided with information on how/where to obtain services if needed.	<ul style="list-style-type: none"> <li>Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services.</li> <li>Make 1 test call in another language and 1 for AOD services</li> <li>QM will report to call center the outcome of test calls</li> </ul>	<ul style="list-style-type: none"> <li>95 % or more calls answered</li> <li>95 % or more test calls logged.</li> <li>100% of interpreters requested provided</li> <li>75% of calls will be rated satisfactory (Caller indicated they were helped)</li> </ul>	QM Staff	June 2026	
JT	GN	12	Grievances will be resolved within 30 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.	<ul style="list-style-type: none"> <li>Grievance and appeals are regularly addressed in Grievance and Appeal Team (GAT) Meeting.</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reports on grievances, appeals, and State Fair Hearings to QIC.</li> <li>Quarterly report with % of issues resolved to client/family member fully favorable or favorable.</li> <li>Quarterly report with % grievances/appeals resolved within 30/30 days.</li> </ul>	GAT Team	June 2026	
JT	GN	13	Ensure that providers are informed of the resolution of all grievances and given a copy of the letter within 30 days of the grievance	<ul style="list-style-type: none"> <li>Audit the grievance resolution folders quarterly to ensure that there is</li> </ul>	<ul style="list-style-type: none"> <li>80% of providers will receive the grievance resolution at the time the client is informed. This will be documented in the GAT file.</li> </ul>	GAT Team Claudia Tinoco	June 2026	

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			file date. This will be documented in the GAT file 100% of the time.	evidence that providers have been informed of the resolution.	<ul style="list-style-type: none"> <li>(Baseline 50%)</li> </ul>			
JT	GN	14	Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.	<ul style="list-style-type: none"> <li>GAT will review all relevant revisions to Policy 19-01 Grievance Protocol and make any changes required.</li> <li>Train BHRS staff and contractors on new grievance procedures</li> <li>Track compliance with Grievance and NOABD policy</li> </ul>	<ul style="list-style-type: none"> <li># of appeals completed with outcome % for favorable outcomes for client</li> <li># of successfully completed Grievances</li> <li># of successfully issued NOABDs</li> </ul>	GAT Team Claudia Tinoco	June 2026	
JT	GN	15	Ensure timely decision-making for all client-initiated Change of Provider requests within a 2-week timeframe.	<ul style="list-style-type: none"> <li>Change of Provider Request forms will be sent to Quality Management for tracking.</li> <li>Review of complaints, resolutions, and COP requests</li> </ul>	<ul style="list-style-type: none"> <li>Annual review of all change of provider including complaint categories, resolution outcomes, and adherence to the 14-day decision standard.</li> </ul>	QM Staff	June 2026	
JT	CS	16	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.	<ul style="list-style-type: none"> <li>Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)</li> </ul>	<ul style="list-style-type: none"> <li>Notify programs, according to MHP/ODS requirements, consumer survey results</li> <li>Presentation and notification of the results yearly.</li> </ul>	QM Manager Scott Gruendl Clara Boyden	June 2026	
JT	CS	17	Improve cultural and linguistic competence	<ul style="list-style-type: none"> <li>"Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.</li> </ul>	<ul style="list-style-type: none"> <li>100% of new staff will complete in-person "Working Effectively with Interpreters in Behavioral Health"</li> <li>75% of Existing staff who have taken the initial training will take the refresher training at least every three years.</li> </ul>	Maria Lorente-Foresti Doris Estremera	June 2026	
JT	CS	18	Improve Linguistic Access for clients whose preferred language is other than English	<ul style="list-style-type: none"> <li>Services will be provided in the clients preferred language</li> </ul>	<ul style="list-style-type: none"> <li>% Of clients with a preferred language other than English receiving a service in their preferred language</li> </ul>	Doris Estremera Maria Lorente-Foresti Chad Kempel	June 2026	
JT	CS	19	Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.	<ul style="list-style-type: none"> <li>All staff will complete mandatory training on cultural humility</li> </ul>	<ul style="list-style-type: none"> <li>65% of staff will complete the Cultural Humility training.</li> </ul>	Doris Estremera Maria Lorente-Foresti	June 2026	
DMC	DMC	20	Continued utilization of Youth and Adult SUD Assessment tool.	<ul style="list-style-type: none"> <li>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, and adults. Train contracted providers on its usage in Avatar EMR.</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring of youth and adult SUD Assessment tool.</li> <li>Continuous training with providers serving youth 17 and under, with providers serving young people 18-21, and providers serving adults.</li> <li>% of client charts audited with a completed Youth and completed Adult SUD Assessment tool.</li> </ul>	DMC-ODS Staff IT Manager	June 2026	
DMC	DMC	21	Care Coordination: Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.	<ul style="list-style-type: none"> <li>ASAM evaluation and treatment referral completed prior to residential detox discharge.</li> <li>Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.</li> </ul>	<ul style="list-style-type: none"> <li># of Res Detox discharges</li> <li>% of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge</li> <li>% of clients re-admitted to detox within 30 days</li> </ul>	Eliseo Amezcua Mary Taylor Sheryl Uyan	June 2026	
DMC	DMC	22	Monitor Service Delivery System: Increase treatment provider compliance with DMC-ODS documentation regulations.	<ul style="list-style-type: none"> <li>Design and implement a plan for County review of SUD treatment provider Medi-Cal beneficiary charts</li> </ul>	<ul style="list-style-type: none"> <li># of charts reviewed for each DMC-ODS providers</li> </ul>	Sheryl Uyan	June 2026	

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				<ul style="list-style-type: none"> <li>to allow remote monitoring for COVID-19 safety practices.</li> <li>Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts.</li> <li>Pilot Audit with each of the DMC-ODS providers</li> </ul>				
DMC	DMC	23	Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)	<ul style="list-style-type: none"> <li>Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement</li> <li>Develop of an annual Training Plan that incorporates Evidenced-Based Practices.</li> <li>Implement training plan</li> </ul>	<ul style="list-style-type: none"> <li>Copy of training plan protocol</li> <li># of trainings offered</li> </ul>	WET Director Sheryl Uyan Mary Fullerton Michelle Sudyka	June 2026	
DMC	DMC	24	80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs.	<ul style="list-style-type: none"> <li>Implement Training Plan for provider clinicians, counseling and supervisory staff.</li> <li>Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs.</li> <li>Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements.</li> </ul>	<ul style="list-style-type: none"> <li>% of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs.</li> <li>FY 18-19 performance is 28%</li> </ul>	Sheryl Uyan WET Director Michelle Sudyka	June 2026	
DMC	DMC	25	All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually.	<ul style="list-style-type: none"> <li>Implement a Training Plan for provider clinicians.</li> </ul>	<ul style="list-style-type: none"> <li>% of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually.</li> <li>FY 17/18 baseline is 35%.</li> <li>FY 18/19 = 55%.</li> </ul>	Sheryl Uyan Alberto Ramos	June 2026	
DMC	DMC	26	Monitor Service Delivery System: Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards	<ul style="list-style-type: none"> <li>Implement Avatar SUD enhancements to collect data for measures.</li> <li>Identified reports are created in Avatar</li> <li>Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system.</li> </ul>	<ul style="list-style-type: none"> <li>List of reports developed that meet reporting requirement for DMC-ODS</li> </ul>	Scott Gruendl Clara Boyden Sheryl Uyan Mary Taylor Eddie Lau Dave Williams Chad Kempel	June 2026	
DMC	DMC	27	Comply with SABG requirements for Pre-Award Risk Assessments	<ul style="list-style-type: none"> <li>Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.</li> </ul>	<ul style="list-style-type: none"> <li>% of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.</li> </ul>	Sheryl Uyan Alberto Ramos	June 2026	
DMC	DMC	28	Care Coordination: Care will be coordinated with physical health and mental health service providers.	<ul style="list-style-type: none"> <li>Implementing contract standard for physical health and mental health care coordination of services at the provider level</li> </ul>	<ul style="list-style-type: none"> <li>% of audited client charts which comply with DMC ODS physical health examination requirements.</li> <li>% of MD reviewed physical health examinations with a subsequent referral to physical health services.</li> </ul>	Sheryl Uyan Alberto Ramos Mary Taylor	June 2026	

SYS	CAT	#	Goal Description	Intervention	Measurement	Responsible Persons	Due Date	Outcomes
				<ul style="list-style-type: none"> <li>Audit charts to monitor compliance with standard</li> <li>Develop system-wide coordination meeting with providers</li> <li>Analyze TPS client survey data to monitor client satisfaction with care coordination</li> </ul>				
DMC	DMC	29	Assess client experience of SUD services through annual survey.	<ul style="list-style-type: none"> <li>Conduct annual TPS Survey with all provider/beneficiaries</li> <li>Analyze TPS data and share findings with providers and stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>% 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"> <li>FY 19/20: 88.8 % (N=228) – baseline</li> </ul> </li> <li>% 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"> <li>FY 19/20: 90.8 % (N=228) – baseline</li> </ul> </li> <li>% 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"> <li>FY 19/20: 90.8% (N=228) - baseline</li> </ul> </li> </ul>	Sheryl Uyan Mary Taylor Alberto Ramos	June 2026	
MH	PIP	30	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the MHP	<ul style="list-style-type: none"> <li>Continue development and data analysis of Clinical PIP (based on SAA HEDIS measure) and Non-Clinical PIP (based on Timeliness Standards included in DHCS Network Certification Requirements).</li> <li>Analyze data to measure progress on the clinical and non-clinical PIPs.</li> <li>Identify interventions to apply to address the identified areas of improvement.</li> </ul>	<ul style="list-style-type: none"> <li>Development of 2 PIP’s that are rated as active and meet EQRO standards</li> <li>Report of baseline measures, and reports of initial performance/process measures on a quarterly basis after implementation of intervention (Data Analysis of progress on attainment of improvement goals will be the focus of the next year).</li> </ul>	Eri Tsujii Ziomara Ochoa Talisha Racy Tasha Souter	June 2026	
DMC	PIP	31	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the DMC-ODS.	<ul style="list-style-type: none"> <li>Continue development and data analysis of Clinical PIP (based on POD HEDIS measure) and Non-Clinical PIP (based on Timeliness Standards included in DHCS Network Certification Requirements).</li> <li>Analyze data to measure progress on the clinical and non-clinical PIPs.</li> <li>Identify interventions to apply to address the identified areas of improvement.</li> </ul>	<ul style="list-style-type: none"> <li>Development of 2 PIP’s that are rated as active and meet EQRO standards</li> <li>Report of baseline measures, and reports of initial performance/process measures on a quarterly basis after implementation of intervention (Data Analysis of progress on attainment of improvement goals will be the focus of the next year).</li> </ul>	Eri Tsujii Maya Greene Mary Taylor Sheryl Uyan Clara Boyden	June 2026	