SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Quality Improvement Work Plan for Mental Health & SUDS July 2024 - June 2025 (Start July 2024)

System (SYS)	
DMC	DMC-ODS
MHP	Mental Health
JT	Joint DMC-ODS and Mental Health Goal

Core QM Staff (as of 3/20/23)	
QM Manager	Betty Ortiz-Gallardo
QM Unit Chief	Claudia Tinoco-Elizondo
QM Program Specialist	Jessica Zamora WOC
QM Program Specialist	Annina Altomari
QM Program Specialist	Eri Tsujii
Medical Office Specialist	Mercedes Medal
Clinical Analyst	Laurie Bell

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

Core DMC-ODS Staff (as of 3/20/23)	
Deputy Director of SUD Services	Clara Boyden
SUD Clinical Services Manager	Mary Taylor Fullerton
SUD Supervisor	Desirae Walker
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.	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 December • Annual: BHRS Compliance Mandated Training – December 2024 • Annual: BHRS Fraud, Waste, & Abuse Training – December 2024 • Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD– December 2024 • Annual: BHRS Critical incident Tracking – December 2024 • Annual: BHRS AB210 Brief Overview-December 2024	QM Staff	June 2025	
MH	QI	2	Improve clinical documentation and quality of care.	• Maintain clinical documentation training program for all current and new staff. • Train staff and contractor providers on new CalAIM requirements	Report on trainings provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.	QM Staff	June 2025	
MH	CAT	3	Implement monthly internal audits to assess compliance with new CalAIM documentation requirement with an adherence of 90% by June of 2025	• Adhere to the new CalAIM documentation standards • Contractor Audit Team will conduct internal audits of BHRS providers and contractors.	Internal Chart audits Less than 10% disallowance per BHRS program and contractors.	Audit Team	June 2025	
JT	QI	4	Create a Quality-of-Care Committee (QCC) to address system-wide quality of care issues that arise from client/beneficiary experience.	• Establish committee membership • Review quality of care concerns within committee follow-up with appropriate guidance and interventions • Review the results of these quality-of-care concerns at least annually	Create a tracker of the quality-of-care concerns raised for SOC. Annual Report to QIC and/or to the Executive Team.	Betty Ortiz-Gallardo	June 2025	
JT	QI	5	Monitor staff satisfaction with QI activities & services	• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.	Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%. • Are you satisfied with the help that you received from the Quality Management staff person? • Baseline:	Betty Ortiz-Gallardo QM Staff	June 2025	

					○ FY 23-24 Very Satisfied=38.87% Satisfied=43.55% Somewhat satisfied= 4.84%, Very Dissatisfied= 4.84% Total responses 62			
JT	QI	6	Create and update policies and procedures in BHRS for Mental Health and SUD	• 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 • Update policies and procedures to comply with CalAIM	• # of Policies Created • # of Policies Retired • # of Policies Amended	Policy Committee QM Staff DMC-ODS Staff	June 2025	
JT	QI	7	Comply with QIC Policy and maintain voting membership that represents all parts BHRS	• Review/amend QIC Policy as necessary. • Maintain QIC membership that represents BHRS system	• Ensure compliance with QIC Policy: communicate with QIC members as necessary. • Verify and document QIC members that represents BHRS system by 6/2021 (continuous)	Betty Ortiz-Gallardo Annina Altomari QM Staff	June 2025	
JT	QI	8	Tracking Incident Reports (IR)	• Continue to monitor and track all Incident reports. • Report trends and current data.	Report to QIC	QM Staff	June 2025	
JT	QI	9	Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client)	• Include data for BHRS and contract agencies serving SDMC clients. • Report to Executive Team and QIC, timeliness data annually.	• % 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)	Betty Ortiz-Gallardo Eri Tsujii Chad Kempel	June 2025	
JT	AC	10	Improve customer service and satisfaction for San Mateo County Access Call Center for MH/SUD	• Review and Revise, as needed, standards for answering calls • Provide training for Optum call center staff on standards for answering calls.	• Test calls and call logs 90% test call rated as positive	Access Call Center QM Staff	June 2025	
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 information on how/where to obtain services if needed.	• 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	• 95 % or more calls answered • 95 % or more test calls logged. • 100% of requested interpreters provided • 75% of call will be rated satisfactory (Caller indicated they were helped)	QM Staff	June 2025	

JT	GN	12	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.	• Grievance and appeals regularly addressed in Grievance and Appeal Team (GAT) Meeting.	• 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.	GAT Team	June 2025	
JT	GN	13	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.	• Audit the grievance resolution folders quarterly to ensure that there is evidence that providers have been informed of the resolution.	• 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%)	GAT Team Claudia Tinoco	June 2025	
JT	GN	14	Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.	• 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	• # of successfully issued NOABDs • # of Appeals completed with outcome % for favorable outcomes for client • # of successfully completed Grievances	GAT Team Claudia Tinoco	June 2025	
JT	GN	15	Decision for client's requested Change of Provider within 2 weeks	• Change of Provider Request forms will be sent to Quality Management for tracking. • Review nature of complaints, resolutions, and COP requests	Annual review of requests for change of provider: type of complaints and resolutions.	QM Staff	June 2025	
JT	CS	16	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.	• Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)	• Notify programs, according to MHP/ODS requirements, consumer survey results • Presentation and notification of the results yearly.	QM Manager Scott Gruendl Clara Boyden	June 2025	
JT	CS	17	Improve cultural and linguistic competence	• "Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.	• 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.	Maria Lorente-Foresti Doris Estremera Claudia Tinoco	June 2025	
JT	CS	18	Improve Linguistic Access for clients whose preferred language is other than English	• Services will be provided in the clients preferred language	• % Of clients with a preferred language other than English receiving a service in their preferred language	Doris Estremera Maria Lorente-Foresti Chad Kempel Claudia Tinoco	June 2025	
JT	CS	19	Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.	• All staff will complete mandatory training on cultural humility	• 65% of staff will complete the Cultural Humility training.	Doris Estremera Maria Lorente-Foresti Claudia Tinoco	June 2025	
DMC	DMC	20	Continued utilization of Youth and Adult SUD Assessment tool.	• 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.	• Monitoring of youth and adult SUD Assessment tool. • Continuous training with providers serving youth 17 and under, with providers serving young people 18-21, and providers serving adults. • % of client charts audited with a completed Youth and completed Adult SUD Assessment tool.	DMC-ODS Staff IT Manager	June 2025	

DMC	DMC	21	Continued utilization of Youth Health Screening Tool	• 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.	• Monitoring of a youth health screening tool. • Continued training 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.	DMC-ODS Staff	June 2025	
DMC	DMC	22	Care Coordination: Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.	• ASAM evaluation and treatment referral completed prior to residential detox discharge. • Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.	• # 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	Eliseo Amezcua Mary Taylor Fullerton Sheryl Uyan	June 2025	
DMC	DMC	23	Monitor Service Delivery System: Increase treatment provider compliance with DMC-ODS documentation regulations.	• 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	• # of charts reviewed for each DMC-ODS providers	Sheryl Uyan Desirae Walker	June 2025	
DMC	DMC	24	Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)	• 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	• Copy of training plan protocol • # of trainings offered	WET Director Sheryl Uyan Mary Fullerton Michelle Sudyka	June 2025	
DMC	DMC	25	80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs.	• Implement Training Plan for provider clinicians, counseling and supervisory staff. • Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs. • Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements.	• % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs. • FY 18-19 performance is 28%	Sheryl Uyan WET Director Michelle Sudyka	June 2025	
DMC	DMC	26	All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually.	• Implement a Training Plan for provider clinicians.	• % 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%.	Sheryl Uyan	June 2025	
DMC	DMC	27	Monitor Service Delivery System: Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to	• Implement Avatar SUD enhancements to collect data for measures.	• List of reports developed that meet reporting requirement for DMC-ODS	Scott Gruendl Clara Boyden Sheryl Uyan	June 2025	

			established performance measures and standards	• Identified reports are created in Avatar • Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system.		Mary Fullerton Eddie Lau Dave Williams Chad Kempel		

DMC	DMC	28	Timeliness of first contact to first appointment:
			BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs.
				• Develop a process to analyze timeliness data quarterly for:
				  ○ 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.
					• % 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
						Mary Taylor Fullerton
						Eri Tsujii
						Sheryl Uyan
						Alberto Ramos
							June 2025	

DMC	DMC	29	Comply with SABG requirements for Pre-Award Risk Assessments	• Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.	• % of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.	Sheryl Uyan Desirae Walker	June 2025	
DMC	DMC	30	Care Coordination: Care will be coordinated with physical health and mental health service providers.	• 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	• % 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.	Sheryl Uyan Desirae Walker Eliseo Amezcua Mary Fullerton	June 2025	

DMC	DMC	31	Assess client experience of SUD services through annual survey.	• Conduct annual TPS Survey with all provider/beneficiaries
				• Analyze TPS data and share findings with providers and stakeholders.
					• % percent of clients surveyed who indicate “staff were sensitive to my cultural background (race, religion, language, etc.)” on an annual treatment perceptions survey.
					  ○ 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.
					  ○ 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
					  ○ FY 19/20: 90.8% (N=228) - baseline
						Sheryl Uyan
						Desirae Walker
						Mary Fullerton
							June 2025	

MH	PIP	32	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the MHP	• Continue with second year of current non-clinical PIP (BHQIP FUM PIP) • Develop an additional clinical MH PIP • Analyze data to measure progress on the clinical and non-clinical PIPs. • Ensure that FUM PIP meets both EQRO and BHQIP requirements. • Identify additional interventions to address the identified problem(s).	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii	June 2025	
DMC	PIP	33	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the DMC-ODS.	• Continue with second year of current clinical and non-clinical BHQIP PIPs (FUA and POD) • Analyze data to measure progress on the clinical and non-clinical PIPs. • Ensure that PIPs meet both EQRO and BHQIP requirements. • Identify additional interventions to address the identified problem(s).	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii Clara Boyden Consultant	June 2025	