SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Quality Improvement Work Plan for Mental Health & SUDS July 2022 - June 2023 (Start July 2022) - YEAR END SUMMARY

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

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

Core QM Staff (as of 3/20/23)	
QM Manager	Betty Ortiz-Gallardo
QM Unit Chief	Claudia Tinoco-Elizondo
QM Program Specialist	Tracey Chan
QM Program Specialist	Annina Altomari
QM Program Specialist	Eri Tsujii
Medical Office Specialist	Mercedes Medal

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 Miller
SUD Supervisor	Eliseo Amezcua
SUD Supervisor	Christine O'Kelly
SUD Health Services Manager	Sheryl Uyan
SUD Management Analyst	Matt Boyle

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

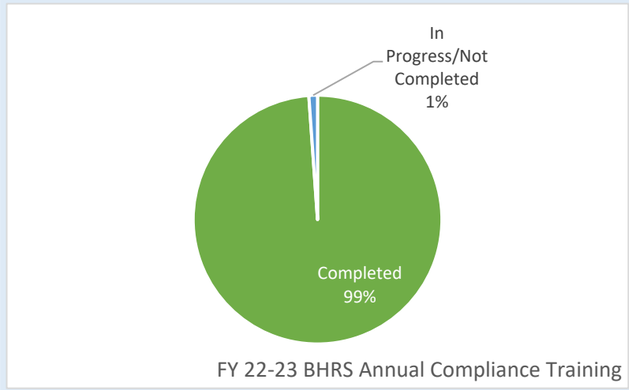
<table>
<tr><th>SYS</th><th>CAT</th><th>#</th><th>Goal Description</th><th>Intervention</th><th>Measurement</th><th>Responsible Persons</th><th>Due Date</th><th>Outcomes</th></tr>
<tr><td>MH</td><td>QI</td><td>1</td><td>Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.</td><td>Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.</td><td>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

• Annual: BHRS Compliance Mandated Training – October 2023
• Annual: BHRS Fraud, Waste, & Abuse Training – October 2023
• Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD: All BHRSv3.3 – November 2023
• BHRS Critical incident Tracking – November 2023</td><td>QM Staff</td><td>June 2023</td><td>Status: Met, continue for next year

Summary: In FY 22-23 99 % of staff completed The Required Annual Compliance Bundle trainings. 100% of New Staff Completed the compliance bundle trainings.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<tr><td>MH</td><td>QI</td><td>2</td><td>Improve clinical documentation and quality of care.</td><td>Maintain clinical documentation training program for all current and new staff.</td><td>Report on trainings provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.</td><td>QM Staff</td><td>June 2023</td><td>Status: Met, continue for next year

Summary: QM provided live training on CalAIM requirements that were attended by BHRS staff and CBO staff. They were then posted to our website so all BHRS and CBO’s were able to re-watch and access the webinars at any time. QM also provided information on CalMHSA LMS training videos and instructions on how to access their site.

<table>
<tr><th>Training Title Live WEBINAR FY 22-23</th><th>Training Date</th><th>Total Attended</th></tr>
<tr><td>CalAIM Overview</td><td>8/25/23</td><td>146</td></tr>
<tr><td>CalAIM Access to Services</td><td>9/22/23</td><td>73</td></tr>
<tr><td>CalAIM Assessment</td><td>10/27/22</td><td>137</td></tr>
<tr><td>CalAIM Diagnosis and Problem List</td><td>12/1/23</td><td>126</td></tr>
<tr><td>CalAIM Informational Webinar</td><td>6/7/23</td><td>427</td></tr>
<tr><td>CalAIM Progress Notes</td><td>6/21/23</td><td>480</td></tr>
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https://www.smchealth.org/bhrs/qm</td></tr>
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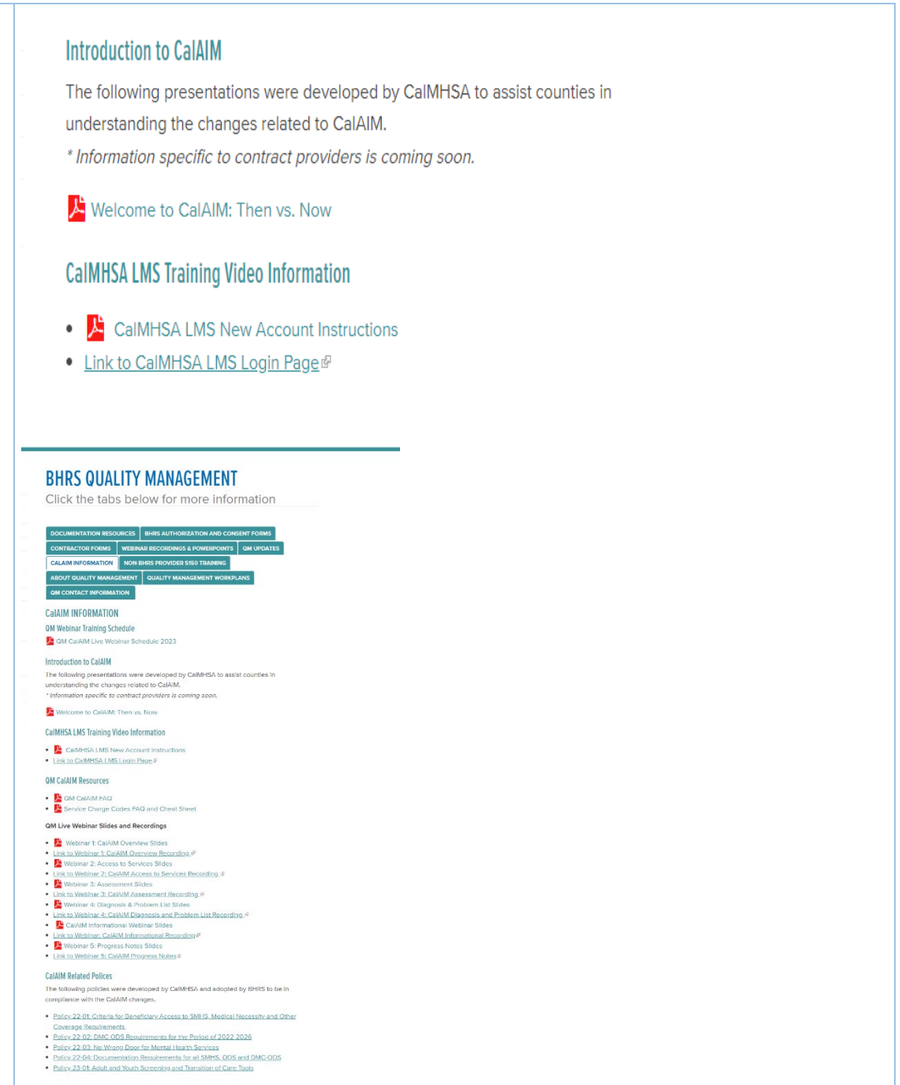
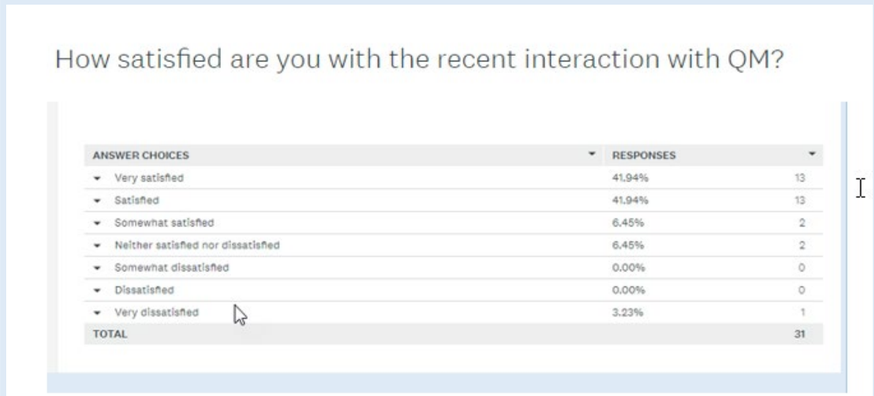
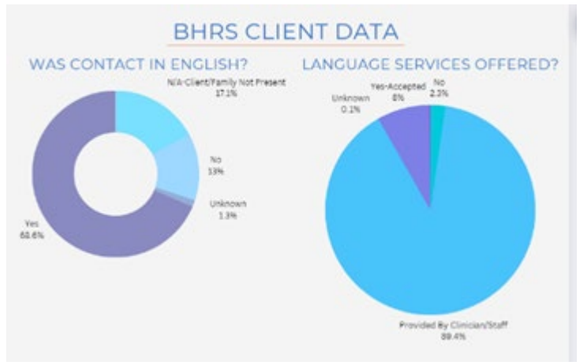
								
JT	QI	3	Monitor staff satisfaction with QI activities & services	• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department. • Determine Optimal timing for conducting survey	Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%. • Are you satisfied with the help that you received from the Quality Management staff person? • Baseline: Nov 2018- ○ 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	QM Manager	June 2023	**Status:** Not met, continue for next year **Summary:** This survey was open to BHRS staff and contracted agencies. As determined from the survey results, we had a total of 31 responses.

								 • QM will continue to explore and determine best time of the year to conduct this survey.
JT	QI	5	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 Manager Annina Altomari QM Staff Clara Boyden – AOD Deputy Director Diana Hill – AOD Health Services Manager Mary Taylor Fullerton – AOD Clinical Services Manager	June 2023	**Status:** Met, continue for next year 10 Policies created. 7 Polices retired. 10 Policies amended/updated. **Summary:** Policies continued to be created, amended, and retired as needed based on information notices from DHCS and BHRS practices and procedures. BHRS has adopted new CalAIM polices completed by CalMHSA. The QM policy committee meets monthly to review policies, procedures, make updates, and provide guidance to other units developing policies. QM and DMC ODS work collaboratively to review SUD related polices and make updates as needed. The policy index is updated on an ongoing basis as changes occur with policies. The QM policy committee maintains the index and all mast copies of BHRS policies.
JT	QI	6	Comply with QIC Policy and maintain voting membership that represents all parts BHRS	• Review/amend QIC Policy as necessary. • Maintain QIC voting membership that represents BHRS system	• Ensure compliance with QIC Policy: communicate with QIC members as necessary. • Verify and document QIC Voters that represents BHRS system by 6/2021 (continuous)	QM Manager Annina Altomari QM Staff	June 2023	**Status:** Partially Met, continue for next year **Summary:** Our QIC membership is currently at 28 members. **Quality Improvement Committee policy states a goal of 35 voting members. Our committee is also lacking additional community involvement with currently 2 community members. Outreach is needed to recruit additional members (especially from Clients/Consumers/Community/Family Members and Contracted Community-Based providers). QIC policy was last updated 6/25/2019. Policy is still current and communication with QIC occurs as necessary.**
JT	QI	7	Tracking Incident Reports (IR)	• Continue to monitor and track all Incident reports. • Present data to Executive Team • Report trends and current data to QIC and leadership	• Annual Reports to Executive Team and QIC	QM Staff Tracey Chan	June 2023	**Status:** Met, continue for next year **Summary:** QM reviews all submitted incident reports. Sentinel Events, breaches of confidentiality, and high-risk incident reports are emailed to the Executive Team for their review. QM presented data at QIC meeting, 10/25/2023.

JT	QI	8	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)	QM Manager Eri Tsujii Chad Kempel Matt Boyle	June 2023	MHP • % of clients being offered or receiving an assessment appointment 10 days from request to first appointment. – 80% of those offered were offered a first appt within the 10 day standard (82.5% for Foster Care); 71.7% of those who attended an appt attended (received) within the 10 day standard (64.9% for Foster Care) • % of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service. – 38% of those offered an appt were offered within 15 days; 53% of those who attended an appointment attended within the 15 day standard. (5/5 of Foster Care who requested Psychiatry services received an offered appt within 15 days and 3/4 attended within 15 days). • Track Timeliness from assessment to first treatment appointment – Average 35.88 days from date of request (44.35 for Foster Care) • Track Timeliness from request for Urgent appointment to actual encounter. (48 hrs for non-authorized service; 96 hrs for pre- authorized services) – 44% for those that do not require pre-authorization, 100% of those that require preauthorization received services within 96 hours. (4/4 Foster Care who had an urgent request received services within the 48-hour time frame). DMC • % of clients being offered or receiving an appointment within 10 days of first request: 91% of those requesting an appointment were offered a first appt within the 10-day standard. • % of clients receiving delivered service within 10 days of service request: 84% of those requesting a service received the service within 10 days. • % of urgent requests for services that were offered an appointment within 48 hours: 98.5% of the requests for urgent appointments were offered an appointment within 48 hours.
JT	AC	9	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 2023	**Status:** Partially Met, continue for next year **Summary:** Out of 10 answered calls, 9 callers felt like they were helped equaling about 90% of test callers felt like they were helped when the call was answered. Out of 10 answered calls, 9 callers felt like the staff that answered the call was knowledgeable equaling that about 90% of the test callers felt the staff was knowledgeable when the call was answered. Access Call Center staff and Optum will continue to meet quarterly to review resources, the Call Center script, discuss technical issues and consumer experience.
JT	AC	10	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)	Annina Altomari	June 2023	**Status:** Partially met, continued for next year. 100% of calls were answered 90% or more test calls logged No callers requested interpreters 90% of call will be rated satisfactory Summary of Calls • First Quarter: 2 calls • Second Quarter: 3 calls • Third Quarter: 4 calls • Fourth Quarter: 1 calls

								• Total: 10 total calls • All calls were made in English
JT	GN	11	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 2023	**Status: Met** **Summary:** 100% of grievances resolved in accordance with regulations. 71 of 72 grievances were resolved within 90 days. 1 grievance was resolved in 103 days following a 14-day extension which was conducted in accordance with BHRS Policy19-01. BHRS considers all grievance resolutions to be favorable to the client. QIC presentation scheduled for October 25, 2023.
JT	GN	12	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 Annina Altomari Claudia Tinoco	June 2023	**Status: Met** **Summary:** 100% of grievances resolved in accordance with regulations. 71 of 72 providers were informed of the grievance resolution within 90 days of filing date. 1 provider was informed 103 days after filing date following 14-day extension which was conducted in accordance with BHRS Policy19-01. On 65 of 72 (90.2%) grievances providers were informed the same day clients were informed. Of the remaining 7 grievances, 3 were informed the following day, 2 five days later and 2 nine days later. All within 90 days of clients filing. Timeline of when providers were informed were documented in all grievances.
JT	GN	13	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 Tracey Chan	June 2023	**Status: Met** **Summary:** 98.6% of grievances resolved in accordance with regulations. 1 grievance in which a letter was sent late. There were 46 grievances and 0 appeals. 71 grievances filed, 100% completed following all requirements. 1 grievance was promptly logged, investigated and resolved, but the Acknowledgement letter was late. No Appeals. 19 NOABD's were issued for this fiscal year.
JT	GN	14	Decision for client's requested Change of Provider within 2 weeks	• Change of Provider Request forms will be sent to Quality Management for tracking. • Obtain baseline/develop goal.	Annual review of requests for change of provider.	Tracey Chan QM Staff	June 2023	**Status: Partially Met, continued for next year.** In FY 22-23, 28 total requests to change provider were received. • 69 requests in FY 21-22 • 47 requests in FY 20-21 • 62 requests in FY 19-20 • 69 requests in FY 18-19 • 105 requests in FY 17-18 57% of decisions were made within 14 days. • 81% for FY 21-22 • 87% for FY 20-21 • 82% for FY 19-20 • 73% for FY 18-19 • 76% for FY 17-18 25 requests were approved, 3 requests were resolved without a change of provider.

JT	CS	15	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 2023	**Status: MET** The DMC ODS Treatment Perception Survey (TPS) Data • Administered between 10/17-10/21/2022 • 120 Adult Surveys completed, 14 treatment programs participated, • 19.2% in Spanish, 80.8% in English; • 65% administered via paper, 35% only completion. • 11 youth TPS Surveys were completed • Presentation of TPS Results: • 4/25/23: BHRS AOD Leadership Presentation • 4/26/23: BHRS Quality Improvement Committee • 5/1/23: Treatment Provider AOD Leadership Meeting • 5/4/23: AOD Treatment Provider General Meeting • 5/4/23: Presentation of TPS Results emailed to all AOD Treatment Provider and BHRS AOD Staff
JT	CS	16	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 least every three years.	Maria Lorente-Foresti Doris Estremera Claudia Tinoco	June 2023	**Status: Partially Met** **231:** BHRS Active Staff Completed: **241:** BHRS Active Staff Not Completed **49%** Completed **51%** Not Completed **Summary:** In FY 2022-2023 a total of 46 (38 staff and 8 contractors) BHRS staff completed our biannual "Working Effectively with Interpreters and Limited English Proficient Clients in a Behavioral Health Setting" training. A virtual and in-person training was offered. This is a mandatory training for all BHRS staff providing direct service every three (3) years. Due to this being a reoccurring training and staff being hired throughout the year, it is difficult to measure when we've reached a total of 100%. Since inception a total of **455** have been trained. New staff are informed of the requirement to attend this training during the New Hire Orientation. The Office of Diversity & Equity hired a new Workforce Education Director and supporting staff that is working to improve outreach and training completion. Additionally, in FY 23-24 this training is projected to be updated, and a training of trainers will be provided to expand the number of facilitators available to support implementation.
JT	CS	17	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 2023	**Status: Met** **Summary:** In FY 2022-2023 the BHRS saw unique 3,794 requests for interpretation services. There were 3,345 requests for telephonic/Audio interpretation, 364 requests for in-person/onsite interpretation and 85 requests for video remote interpretation. In total, there were 25 unique requests for translation of written materials into San Mateo County threshold languages.

								According to FY 22-23 data,13% of BHRS encounters (represents approximately 3,817 clients) were conducted in a non-English language. Of those encounters, 97% received language assistance via language matching with provider or interpretation serivces. 
JT	CS	18	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 2023	**Status: Partially Met** **Summary:** **592 Staff Completed CH 101 YTD** (Break Down: 430 BHRS Staff, 162 BHRS Contracted Providers) **237:** BHRS Active Staff Completed: **235:** BHRS Active Staff Not Completed **51%** Completed **49%** Not Completed Trainings have continued to be provided virtually, which has presented challenges with facilitator availability, staff engagement and zoom fatigue. Another barrier to meeting our current measurement was the experience of high staff turnover and current teams being short staffed, limiting availability to participate. A cohort of Cultural Humility facilitators meets monthly to troubleshoot issues and continue to improve the training experience. This year a training of trainers was provided, and an additional set of facilitators will now be available to support trainings. This upcoming fiscal year the cohort will be working on Cultural Humility 2.0 an expansion on the concepts of this training. Finally, the Office of Diversity & Equity hired a new Workforce Education Director and supporting staff that is working to improve outreach and training completion. Including, working with Human Resources to require new staff to take this training within 90 days of hire.
DMC	DMC	19	Develop and implement a Youth SUD Assessment tool.	• Work with clinical consultants and youth SUD treatment providers to develop an	• The development of a youth SUD Assessment tool. • Import tool into Avatar.	SUD Staff IT Manager	June 2023	**Status: Partially MET, continued for next year** The DMC ODS has developed a Youth Assessment modeled after the ASAM. The tools was previewed with the SUD Treatment Providers during the July 11, 2022. Provider AOD

				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.	• 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.			Treatment Leadership meeting. The Youth ASAM Assessment has not yet been integrated into Avatar. Youth providers have been instructed to complete the assessment and scan the form into the associated Avatar episode. In FY 22/23, the total of youth served is 39. Six (15%) of youth treatment charts with a completed youth ASAM were scanned into Avatar.
DMC	DMC	20	Develop and Implement a 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.	• 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.	SUD Staff	June 2023	Status: Not met. This tool was not developed.
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.	• 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 within 7 days of residential detox discharge • % of clients re-admitted to detox within 30 days	Eliseo Amezcua Giovanna Bonds Mary Taylor Fullerton Health Services Manager Matt Boyle	June 2023	**Status: Partially Met, continued for next year.** • In FY22-23, there were 473 discharges from Residential Detox • Unknown at this time the percentage that were admitted to subsequent treatment within 7 days • 18.7% of the Residential Discharges were re-admitted to detox within 30 days
DMC	DMC	22	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	Health Services Manager Desirae Miller Christine O'Kelly	June 2023	**Status: MET** • In FY 22-23, there were a total of 121 charts reviewed for DMC-ODS providers. # of charts reviewed for each DMC-ODS providers: • BAART/ART: 8 • El Centro de Libertad: 14 • Free at Last: 14 • Horizon: 4 • HealthRight 360: 21 • American Health Services: 2 • Our Common Ground: 18 • Project Ninety: 8 • Sitike Counseling Center: 7 • Service League: 6 • StarVista: 9 • The Latino Commission: 10
DMC	DMC	23	Develop and Implement a Training Plan for provider direct service	• Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,)	• Copy of training plan protocol • # of trainings offered	WET Director Health Services Manager	June 2023	**Status: MET** • During FY 22-23, San Mateo County Behavioral Health & Recovery Services provided contracted treatment provider staff with a total of 271 online training opportunities.

			staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)	the Intergovernmental Agreement • Develop of an annual Training Plan that incorporates Evidenced-Based Practices. • Implement training plan		Mary Fullerton Christine O'Kelly Michelle Sudyka		Training topics included: confidentiality, ethics, cultural competency, de-escalation, evidence-based practices, harm reduction, human trafficking, medication assisted treatment, relapse prevention, special populations, special topics, staff wellness, stigma, substance education, substances & STI's, telehealth, tobacco, trauma informed care, and treatment planning. Within the topic of evidence-based practices, including relapse prevention, and trauma informed care, there were 41 trainings offered throughout the year. San Mateo County sponsored three of these offerings and others were available as live webinars that were scheduled by other organizations but available to our treatment providers and their staff free of charge with many offering CEUs.
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.	• 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%	Health Services Manager Christine O'Kelly WET Director Michelle Sudyka	June 2023	**Status: Partially MET, continued for next year.** • In FY 22-23, 56.76% of all provider clinicians, counseling staff, and supervisors were trained in at least 2 Evidenced-Based Practice trainings.
DMC	DMC	25	All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at <u>least 5 hours of Addiction Medicine Training annually.</u>	• 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%.	Health Services Manager	June 2023	**Status: Partially MET, continued for next year.** • In FY 22-23, 38.89% of all provider LPHA clinicians received at least 5 hours of addiction medication training annually.
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	• 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.	• List of reports developed that meet reporting requirement for DMC-ODS	Scott Gruendl Clara Boyden Health Services Manager Mary Fullerton Eddie Lau Dave Williams Chad Kempel	June 2023	**Status: MET** • DMC ODS Svcs by Date and RRG; • SUD Timely Access Report; • AOD Summary Svcs by Prgrm and Svcs Code; • AOD Residential Treatment Auth Report; • ASAM Evaluation Report
DMC	DMC	27	Timeliness of first contact to first appointment: BHRS will track time from first request to first appointment for	• Develop a process to analyze timeliness data quarterly for: o Outpatient SUD services (excluding Opioid Treatment Programs)	• % 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	Chad Kempel Mary Taylor Fullerton Matt Boyle Diana Campos Gomez	June 2023	**Status: MET** In FY 22-23: • 91% of those requesting an outpatient appointment received an appointment within 10 days • 91.1% of those requesting Narcotic Replacement Therapy were admitted to treatment within 24 hours (County Standard)

			Outpatient SUD and 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.	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).	Eri Tsujii		• 100% of those requesting Narcotic Replacement Therapy were admitted to treatment within 72 hours (State Standard)
DMC	DMC	28	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.	Diana Hill Christine O'Kelly Desirae Miller	June 2023	**Status: MET** In FY 22-23, 100% of all contracted SUD treatment programs receiving SABG funding completed Risk Assessment prior to contract renewal.
DMC	DMC	29	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.	Diana Hill Christine O'Kelly Desirae Miller Eliseo Amezcua Mary Fullerton	June 2023	**Status: Partially MET, continued for next year** • In FY 22-23, the TPS client survey data shows 83% of youth and adult clients were satisfied with care coordination. • In FY22-23, 72.28% of audited client charts complied with DMC ODS physical health examination requirements. • In FY 22-23, 89.11% of audited client charts completed AC OK screening.
DMC	DMC	30	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 ○ FY 20/21: 92.9% ○ FY 21/22: 89.3% • % 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 ○ FY 20/21: 93.5% ○ FY 21/22: 89.5% • % of clients surveyed who indicated, "As a direct result of the services I am	Diana Hill Christine O'Kelly Desirae Miller Mary Fullerton	June 2023	**Status: Met** FY 22/23: TPS Adult Client Survey Results (N=120) • 91.2% of adult clients surveyed indicated "staff were sensitive to my cultural background." • 90.4% of adult clients surveyed indicated "I chose my treatment goals..." • 87.9% of adult clients surveyed indicated "as a direct result of the services I am receiving, I am better able to do the things that I want to do."

					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 ○ FY 20/21: 89.4% ○ FY 21/22: 89.3%			
MH	PIP	31	BHRS will develop two Performance Improvement Projects (PIP) for the MHP	Ensure that CalAIM BHQIP PIP for FUM meets EQRO requirements. Develop second MH PIP outside of the BHQIP structure. Possibly one on decreasing benzodiazepine prescriptions.	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii Clara Boyden Desirae Miller Mary Taylor Fullerton Diana Hill	June 2023	• Barriers regarding staff bandwidth is delaying development of a second MH PIP. • BHQIP FUM PIP was submitted for EQRO FY22-23. Will need to continue to develop this PIP as barriers related to staff bandwidth as well as barriers related to technology of intervention has delayed implementation of intervention. BHRS will continue to work to address these barriers and develop a cohesive data collection and intervention implementation plan for this PIP.
DMC	PIP	32	BHRS develop two Performance Improvement Projects (PIP) for the DMC-ODS.	Ensure that CalAIM BHQIP PIPs for FUA and POD meet EQRO requirements.	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii Clara Boyden Desirae Miller Mary Taylor Fullerton Diana Hill	June 2023	• BHQIP FUA and POD PIPs were submitted for EQRO FY22-23. Will need to continue to develop there PIP as barriers related to staff bandwidth as well as barriers related to technology of intervention has delayed implementation of the FUA intervention, and barriers to data collection have made analysis of intervention process and outcomes difficult to determine. BHRS will continue to work to address these barriers and develop a cohesive data collection and intervention implementation plan for these two PIPs.