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## 1. Quality Improvement Activities

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>Staff will complete online HIPAA, FWA &amp; Compliance Training at hire and annually.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
<td>Track training compliance, HIPAA, &amp; FWA of new staff and current staff.</td>
</tr>
<tr>
<td></td>
<td>Current staff: Goal = or &gt; 90% for each training.</td>
</tr>
<tr>
<td></td>
<td>New Staff: Goal = 100%.</td>
</tr>
<tr>
<td><strong>Annual Required Compliance Bundle: BHRS Staff Only:</strong></td>
<td>The assigned months for each training will be November</td>
</tr>
<tr>
<td></td>
<td>• Annual: BHRS Compliance Mandated Training – October 2021</td>
</tr>
<tr>
<td></td>
<td>• Annual: BHRS Fraud, Waste, &amp; Abuse Training – October 2021</td>
</tr>
<tr>
<td></td>
<td>• Annual: BHRS: Confidentiality &amp; HIPAA for Mental Health and AOD: All BHRSv3.3 – November 2021</td>
</tr>
<tr>
<td></td>
<td>• BHRS Critical incident Tracking – November 2021</td>
</tr>
<tr>
<td><strong>Responsibility</strong></td>
<td>Tracey Chan</td>
</tr>
<tr>
<td></td>
<td>Jeannine Mealey</td>
</tr>
<tr>
<td><strong>Due Date</strong></td>
<td>June 2022</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Improve clinical documentation and quality of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>Maintain clinical documentation training program for all current and new staff.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
<td>Report on trainings provided via live webinar, specialty training, and online training modules include attendance numbers where applicable.</td>
</tr>
</tbody>
</table>
| Responsibility | Clinical Documentation Workgroup  
| QM Manager  
| Jeannine Mealey  
| Claudia Tinoco  
| Tracey Chan |
| Due Date | June 2022 |

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Program staff to improve overall compliance with timelines and paperwork requirements.</th>
</tr>
</thead>
</table>
| Intervention | • Maintain system-wide, yearly-audit program.  
• Send monthly emails with documentation compliance rates to all county program managers and directors to monitor teams’ compliance with requirements. |
| Measurement | Reports sent to programs Monthly |
| Responsibility | Jeannine Mealey  
| Tracey Chan  
| A.B. Limin |
| Due Date | June 2022 |

<table>
<thead>
<tr>
<th>Goal 4</th>
<th>Maintain disallowances to less than 5% of sample.</th>
</tr>
</thead>
</table>
| Intervention | • Monitor adherence to documentation standards/completion throughout AVATAR (EMR) System.  
• Send progress reports to county programs. |
| Measurement | • Audit 10% of SDMC System of Care client charts annually  
• Decrease disallowances, Target: Medi-Cal Audit: <5% |
| Responsibility | Jeannine Mealey  
| QM Audit Team |
| Due Date | June 2022 |

<table>
<thead>
<tr>
<th>Goal 5</th>
<th>Monitor staff satisfaction with QI activities &amp; services.</th>
</tr>
</thead>
</table>
| Intervention | • Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.  
• Determine Optimal timing for conducting survey |
| Measurement | 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-  
o  Yes 75.47%, Somewhat 16.98% = 92.45%, No = 3.77% Total responses 61 |
<p>| Responsibility | QM manager |
| Due Date | June 2022 |</p>
<table>
<thead>
<tr>
<th>Goal 6</th>
<th>Create and update policies and procedures in BHRS for Mental Health and SUD</th>
</tr>
</thead>
</table>
| **Intervention** | • Update current policies and procedures for new managed care rules.  
Update policy Index.  
• Maintain internal policy committee to address needed policies and procedures.  
• Retire old/obsolete policies.  
• Create new, amend existing, and retire obsolete policies |
| **Measurement** | # of Policies Created  
# of Policies Retired  
# of Policies Amended |
| **Responsibility** | Policy Committee  
QM Manager  
Annina Altomari  
Clara Boyden – AOD Deputy Director  
Diana Hill – AOD Health Services Manager  
Mary Taylor Fullerton – AOD Clinical Services Manager |
| **Due Date** | June 2021 |

<table>
<thead>
<tr>
<th>Goal 7</th>
<th>Comply with QIC Policy and maintain voting membership that represents all parts BHRS</th>
</tr>
</thead>
</table>
| **Intervention** | • Review/amend QIC Policy as necessary.  
• Maintain QIC voting membership that represents BHRS system |
| **Measurement** | • Ensure compliance with QIC Policy: communicate with QIC members as necessary.  
• Verify and document QIC Voters that represents BHRS system by 6/2021 (continuous) |
| **Responsibility** | QM Manager  
Annina Altomari |
| **Due Date** | June 2022 |

<table>
<thead>
<tr>
<th>Goal 9</th>
<th>Tracking Incident Reports (IR)</th>
</tr>
</thead>
</table>
| **Intervention** | • Continue to monitor and track all Incident reports.  
• Present data to Executive Team  
• Report trends and current data to QIC and leadership |
| **Measurement** | Annual Reports to Executive Team and QIC |
| **Responsibility** | Tracey Chan |
| **Due Date** | June 2022 |

<table>
<thead>
<tr>
<th>Goal 10</th>
<th>Develop protocol for eligibility screening for ICC and IHBS services for youth services</th>
</tr>
</thead>
</table>
| **Intervention** | • Develop Policy and Procedures for screening for ICC/IHBS services  
• Develop a universal screening form to be completed by direct service staff  
• Develop training for direct service staff. |
| **Measurement** | Completed Policy and Procedure  
Sample Forms |
| **Responsibility** | QM Manager  
Annina Altomari |
| **Due Date** | June 2022 |

**Goal 10** | Develop a process to identify and report on Health disparities for services by site, region and population served |
2. Performance Improvement Projects (PIP)

Goal 1
BHRS will develop two ongoing Performance Improvement Projects (PIP) for the MHP

| Intervention | • Gather baseline data from BHRS sources to identify improvement areas.  
  • Form a PIP committee to select improvement areas to focus on for a clinical PIP and a non-clinical PIP based on data gathered.  
  • Identify interventions to address the identified problem(s).  
  • Identify a population (Adult and/or Youth) for the PIP. |
| Measurement  | • Development of 2 PIP’s that are rated as active and meet EQRO standards  
  • Committee Minutes |
| Responsibility | Eri Tsujii |
| Due Date | June 2022 |

Goal 2
Identify new or revised PIP interventions for the current fiscal year.

| Intervention | • Review current PIPs in light of COVID-19 and assess viability for continuation.  
  • Review recent DMC ODS data, client feedback data, grievances, and other data to identify possible clinical and administrative improvement areas.  
  • Work with the DMC ODS QI subcommittee for input into direction and selection of clinical and administrative PIPs. |
| Measurement  | • Meeting Minutes  
  • Developed PIPs |
| Responsibility | Clara Boyden  
  Diana Hill  
  Mary Fullerton  
  Ingall Bull  
  Eri Tsujii  
  Eliseo Amezcua  
  Desirae Miller |
| Due Date | June 2022 |
### 3. Utilization and Timeliness to Service Measures

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client)</th>
</tr>
</thead>
</table>
| **Intervention** | • Include data for BHRS and contract agencies serving SDMC clients.  
• Report to Executive Team and QIC, timeliness data annually. |
| **Measurement** | • % of clients being offered or receiving an assessment appointment 10 days from request to first appointment.  
• % of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service.  
• Track Timeliness from assessment to first treatment appointment  
• Track Timeliness from request for Urgent appointment to actual encounter. (48 hrs for non-authorized service; 96 hrs for pre-authorized services) |
| **Responsibility** | QM Manager  
Eri Tsujii |
| **Due Date** | June 2022 |

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Develop reporting capability for disaggregating data for Youth and Foster Care for tracking medication use. (SB1291)</th>
</tr>
</thead>
</table>
| **Intervention** | Develop a process for capturing data for the following HEDIS measures  
• Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)  
• Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)  
• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)  
• Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)  
Revise JV 220 oversight process to incorporate these measures  
Identify and update policies as needed |
| **Measurement** | Creation of a protocol and process for oversite  
Updated policies |
| **Responsibility** | Quality Manager  
Eri Tsujii |
| **Due Date** | June 2022 |

### 4. Access and Call Center

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Improve customer service and satisfaction for San Mateo County Access Call Center</th>
</tr>
</thead>
</table>
| **Intervention** | • Review and Revise, as needed, standards for answering calls  
• Provide training for Optum call center staff on standards for answering calls. |
| **Measurement** | Test calls and call logs 90% test call rated as positive |
| **Responsibility** | Selma Mangrum  
Tracey Chan  
Claudia Tinoco |
| **Due Date** | June 2022 |
### Goal 2
**Monitor 24/7 access to care through Call Center and Optum. 100% of calls will be answered. 100% of test callers will be provided information on how/where to obtain services if needed.**

**Intervention**
- Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services.
- Make 1 test call in another language and 1 for AOD services.
- QM will report to call center the outcome of test calls.

**Measurement**
- 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)

**Responsibility**
Tracey Chan

**Due Date**
June 2022

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

#### Goal 1 (required)
**Grievances will be resolved within 90 days of receipt of grievance and appeals within 30-day timeframe, expedited appeals will be resolved within 72 hours after receipt of expedited appeal in 100% of cases filed.**

**Intervention**
Grievance and appeals regularly addressed in Grievance and Appeal Team (GAT) Meeting.

**Measurement**
- Annual reports on grievances, appeals, and State Fair Hearings to QIC.
- Annual report with % of issues resolved to client/family member fully favorable or favorable.
- Annual report with % grievances/appeals resolved within 90/30 days.

**Responsibility**
GAT Team

**Due Date**
June 2022

#### Goal 2
**Ensure that providers are informed of the resolution of all grievances and given a copy of the letter within 90 days of the grievance file date. This will have documented in the GAT file 100% of the time.**

**Intervention**
Audit the grievance resolution folders quarterly to ensure that there is evidence that providers have been informed of the resolution.

**Measurement**
- 80% of providers will receive the grievance resolution at the time the client is informed. This will be documented in the GAT file. (baseline 50%)

**Responsibility**
GAT Team
Claudia Tinoco

**Due Date**
June 2022

#### Goal 3
**Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.**

**Intervention**
- GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required.
- Train BHRS staff and contractors on new grievance procedures.
- Track compliance with new Grievance and NOABD policy.
### Measurement
- # of successfully issued NOABD
- # of Appeals completed with outcome % for favorable outcomes for client
- # of successfully completed Grievances

### Responsibility
Tracey Chan  
GAT Team

### Due Date
June 2022

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### Goal 4
Decision for client’s requested Change of Provider within 2 weeks

### Intervention
- Change of Provider Request forms will be sent to Quality Management for tracking.
- Obtain baseline/develop goal.

### Measurement
Annual review of requests for change of provider.

### Responsibility
Tracey Chan

### Due Date
June 2022

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### 6. Client Satisfaction and Culturally Competent Services

#### Goal 1
Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.

### Intervention
Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)

### Measurement
- Notify programs, according to MHP/ODS requirements, consumer survey results
- Presentation and notification of the results yearly.

### Responsibility
QM Manager  
Scott Gruendl  
Diana Hill

### Due Date
June 2022

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### Goal 2
Improve cultural and linguistic competence

### Intervention
“Working Effectively with Interpreters in Behavioral Health” refresher course training will be required for all direct service staff every 3 years.

### Measurement
- 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.

### Responsibility
Claudia Tinoco  
Maria Lorente-Foresti  
Doris Estremera

### Due Date
June 2022

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### Goal 4
Improve Linguistic Access for clients whose preferred language is other than English

### Intervention
Services will be provided in the clients preferred language

### Measurement
% of clients with a preferred language other than English receiving a service in their preferred language
| Responsibility | Claudia Tinoco  
|               | Doris Estremera  
|               | Maria Lorente-Foresti  
|               | Chad Kempel  
| Due Date       | June 2022 |

**Goal 5**
Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.

**Intervention**
All staff will complete mandatory training on cultural humility.

**Measurement**
65% of staff will complete the Cultural Humility training.

| Responsibility | Claudia Tinoco  
|               | Doris Estremera  
|               | Erica Britton  
|               | Desirae Miller  
| Due Date       | June 2022 |

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7. **DMC-ODS Pilot**

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Develop and implement a Youth SUD Assessment tool.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>Work with clinical consultants and youth SUD treatment providers to develop an ASAM-based SUD Assessment tool specific to youth ages 12-17 and 18-21. Train contracted providers on its usage and implement in Avatar EMR.</td>
</tr>
</tbody>
</table>
| **Measurement** | • The development of a youth SUD Assessment tool.  
|               | • Import tool into Avatar.  
|               | • Training and implementing with providers serving youth 17 and under, and with providers serving young people 18-21.  
|               | • % of client charts audited with a completed Youth SUD Assessment tool. |
| **Responsibility** | Diana Hill  
|               | Christine O'Kelly  
|               | Desirae Miller  
|               | Kim Pijma  
|               | Mary Taylor Fullerton  
|               | Stephanie Coate  
|               | Eliseo Amezcua  
| **Due Date**       | June 2022 |

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Develop and implement a Youth Health Screening tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Measurement** | • The development of a youth health screening tool.  
|               | • Import into Avatar.  
|               | • Training and implementing with providers serving youth 17 and under, and with providers serving young people 18-21.  
|               | • % of client charts audited with a completed youth health screening tool. |
| **Responsibility** | Diana Hill  
|               | Christine O'Kelly  
|               | Desirae Miller  
|               | Kim Pijma  
|               | Mary Taylor Fullerton  
<p>| <strong>Due Date</strong>       | June 2022 |</p>
<table>
<thead>
<tr>
<th>Goal 3</th>
<th><strong>Care Coordination:</strong> Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.</th>
</tr>
</thead>
</table>
| **Intervention** | • ASAM evaluation and treatment referral completed prior to residential detox discharge.  
• Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care. |
| **Measurement** | • # of Res Detox discharges  
• % of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge  
• % of clients re-admitted to detox within 30 days |
| **Responsibility** | Eliseo Amezcua  
Giovanna Bonds  
Melina Cortez  
Mary Taylor Fullerton |
| **Due Date** | June 2022 |

<table>
<thead>
<tr>
<th>Goal 4</th>
<th><strong>Monitor Service Delivery System:</strong> Increase treatment provider compliance with DMC-ODS documentation regulations.</th>
</tr>
</thead>
</table>
| **Intervention** | • Design and implement a plan for County review of SUD treatment provider Medi-Cal beneficiary charts to allow remote monitoring for COVID-19 safety practices.  
• Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts.  
• Pilot Audit with each of the DMC-ODS providers |
| **Measurement** | # of charts reviewed for each DMC-ODS providers |
| **Responsibility** | Diana Hill  
Desirae Miller  
Christine O'Kelly |
| **Due Date** | June 2022 |

<table>
<thead>
<tr>
<th>Goal 5</th>
<th>Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)</th>
</tr>
</thead>
</table>
| **Intervention** | • Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement  
• Develop of an annual Training Plan that incorporates Evidenced-Based Practices.  
• Implement training plan |
| **Measurement** | • Copy of training plan protocol  
• # of trainings offered |
<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Diana Hill</th>
<th>Mary Fullerton</th>
<th>Christine O’Kelly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due Date</td>
<td>June 2022</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Goal 6**

80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs.

**Intervention**

- 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.

**Measurement**

- % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs.
- FY 18-19 performance is 28%

**Responsibility**

- Diana Hill
- Christine O’Kelly
- Erica Britton

**Due Date**

- June 2022

**Goal 7**

All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually.

**Intervention**

- Implement a Training Plan for provider clinicians.

**Measurement**

- % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually.
- FY 17/18 baseline is 35%.
- FY 18/19 = 55%.

**Responsibility**

- Diana Hill
- Christine O’Kelly
- Mary Taylor Fullerton

**Due Date**

- June 2022

**Goal 8**

Monitor Service Delivery System:
Create AVATAR reports needed to monitor and evaluate DMC-ODS in relation to established performance measures and standards

**Intervention**

- Implement Avatar SUD enhancements to collect data for measures.
- Identified reports are created in Avatar
- Reports are reviewed quarterly for monitoring system quality and performance as sufficient data is available within the system.

**Measurement**

- List of reports developed that meet reporting requirement for DMC-ODS

**Responsibility**

- Clara Boyden
- Diana Hill
- Mary Fullerton
- Kim Pijma (contract monitor)
- Dave Williams

**Due Date**

- June, 2022

**Goal 9**

Timeliness of first contact to first appointment:
<table>
<thead>
<tr>
<th>BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>• Develop a process to analyze timeliness data quarterly for:</td>
</tr>
<tr>
<td>o Outpatient SUD services (excluding Opioid Treatment Programs)</td>
</tr>
<tr>
<td>o Opioid Treatment Programs</td>
</tr>
<tr>
<td>• Share data for BHRS programs and contractor agencies serving DMC-ODS clients</td>
</tr>
<tr>
<td>• NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment.</td>
</tr>
<tr>
<td>• Report timeliness data annually with NACT Submission on April 1, 2022.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
</tr>
<tr>
<td>• % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.</td>
</tr>
<tr>
<td>• % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard)</td>
</tr>
<tr>
<td>• % 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).</td>
</tr>
<tr>
<td><strong>Due Date</strong></td>
</tr>
<tr>
<td>June 2022</td>
</tr>
</tbody>
</table>

**Goal 10**  
**Comply with SABG requirements for Pre-Award Risk Assessments**

| **Intervention**  |
| Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.  |
| **Measurement**  |
| % of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.  |
| **Responsibility**  |
| Diana Hill  |
| Christine O’Kelly  |
| Desirae Miller  |
| **Due Date**  |
| June 2022  |

**Goal 11**  
**Care Coordination:**  
Care will be coordinated with physical health and mental health service providers.

<p>| <strong>Intervention</strong>  |
| 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  |
| <strong>Measurement</strong>  |
| % 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  |</p>
<table>
<thead>
<tr>
<th>Goal 12</th>
<th>Assess client experience of SUD services through annual survey.</th>
</tr>
</thead>
</table>
| **Intervention** | • Conduct annual TPS Survey with all provider/beneficiaries  
• Analyze TPS data and share findings with providers and stakeholders. |
| **Measurement** | • % percent of clients surveyed who indicate “staff were sensitive to my cultural background (race, religion, language, etc.)” on an annual treatment perceptions survey.  
  o 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.  
  o 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  
  o FY 19/20: 90.8% (N=228) - baseline |
| **Responsibility** | Diana Hill  
Christine O’Kelly  
Desirae Miller  
Eliseo Amezcuia  
Mary Fullerton |
| **Due Date** | June 2022 |