SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Quality Improvement Work Plan for Mental Health & SUDS July 2023 - June 2024 (Start July 2023) - YEAR END SUMMARY

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

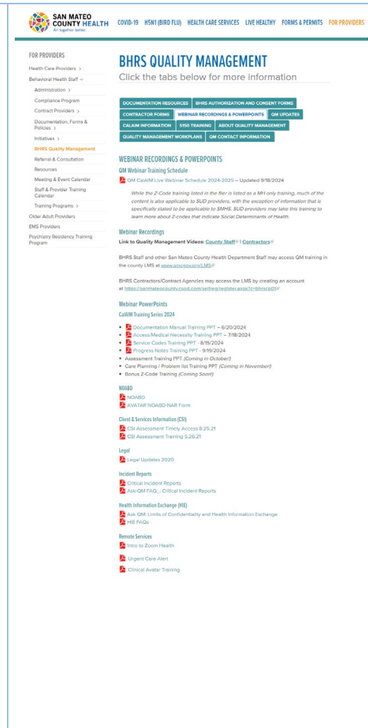
Core QM Staff (as of 3/20/23)	
QM Manager	Betty Ortiz-Gallardo
QM Unit Chief	Claudia Tinoco-Elizondo
QM Program Specialist	Jessica Zamora WOC
QM Program Specialist	Annina Altomari
QM Program Specialist	Eri Tsujii
Medical Office Specialist	Mercedes Medal

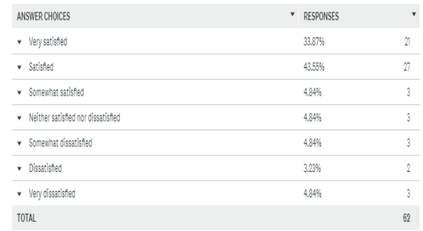
Category (CAT)	
QI	Quality Improvement Activities
PIP	Performance Improvement Projects
UT	Utilization and Timeliness to Service Measures
AC	Access and Call Center
GN	Monitoring Grievances, Notice of Adverse Benefits Determination and Appeals
CS	Client Satisfaction and Culturally Competent Services
DMC	DMC-ODS Pilot
UM	Utilization Management
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 Supervisor	Christine O'Kelly
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 2023 • Annual: BHRS Fraud, Waste, & Abuse Training – December 2023 • Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD: All BHRSv3.3 – December 2023 • BHRS Critical incident Tracking – December 2023	QM Staff	June 2024	**Status:** Unable to determine, continue for next year **Summary:** Due to a clerical issue, we were unable to obtain accurate and comparable data for the fiscal year. The issue has been resolved, and we will be able to collect the data needed for next fiscal year.
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 2024	**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 uploaded to our Learning Management System (LMS) site, so all BHRS and CBOs were able to re-watch and access the webinars at any time. The power points were posted to the QM website. QM also collaborated with our SUD team on webinars. For this fiscal year the average median for BHRS staff and CBOs was 250 staff. 

								
MH	UM	3	Implement concurrent review which will include utilization management and utilization review.	• Create processes and concurrent authorization review procedures. • Update Policy 20-06 to reflect concurrent review procedures.	Measurement will be having a concurrent review tracking mechanism. Establish a baseline at the beginning of FY 23-24 and compare #'s by the end of the FY 23-24	UM Staff	June 2024	**Status:** **Summary:**
MH	CAT	4	Identify overutilizing or underutilization of services by conducting internal audits.	• Adhere to the new CalAIM documentation standards • Contractor Audit Team will conduct internal audits of BHRS providers and contractors.		Audit Team	June 2024	**Status:** **Summary:**
JT	QI	5	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.	QM Staff	June 2024	**Status:** Not met, continue for next year **Summary:** Due to staffing issue this committee was unable to be created.

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.	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 2022- Dec 2022 ○ Very Satisfied=41.94% Satisfied=41.94% Somewhat satisfied= 6.45%, Very Dissatisfied= 3.23% Total responses 31 Yes 74.29%, Somewhat 18.57% = 92.86%, No = 7.14% Total	QM Manager	June 2024	**Status:** Not met, continue for next year **Summary:** This survey is open to BHRS staff and contracted agencies. As determined from the survey results, we had a total of 63 response.  ANSWER CHOICES / RESPONSES Very satisfied 33.87% 21 Satisfied 43.55% 27 Somewhat satisfied 4.84% 3 Neither satisfied nor dissatisfied 4.84% 3 Somewhat dissatisfied 4.84% 3 Dissatisfied 3.23% 2 Very dissatisfied 4.84% 3 TOTAL 62
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 Staff DMC-ODS Staff	June 2024	**Status:** Met, continue for next year. • 2 Polices Created • 0 Policies Retired • 14 Policies Amended **Summary:** Policies continue to be created, amended, and retired as needed based on information notices from DHCS and BHRS practices and procedures. QM continues to oversee the policy process and has developed an improved procedure to be implemented in FY 24-25 to monitor and address the development of new policies and the ongoing updates to existing policies through collaboration with the Executive Team. Improvements to the monitoring and updating of compliance related policies have also been made by QM. The policy index continues to be updated on a regular basis.
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 2024	**Status:** Met, continue for next year. **Summary:** Emphasis on attendance, policy review and voting, and reporting outcomes have been the focus of FY 23-24. Member participation has improved, and new voting members have joined. The QIC policy continues to be followed and updated as needed. Ongoing

								recruitment for additional members (especially from Clients/Consumers/ Community/Family Members and Contracted Community-Based providers) continues.
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 2024	**Status:** Partially 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.

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
							June 2024	**Status:**
								Not Met, Continue for next year.
								
								Summary:
								Due to staffing limitations, we are unable to calculate for the full fiscal year. However, we do have partial year analysis based on NACT TADT findings (reporting period July 1, 2022–March 31, 2023), which will be guiding our improvement efforts and will be reported below:
								• SUD
								  ○ 94% Adults were initial offered Outpatient Services
								  ○ 100% Youth were offered initial offered Outpatient Services
								  ○ Psychiatry is not tracked for SUD Timely Access.
								  ○ Urgent Appointments were not included in the TADT findings.
								• MH
								  ○ 79% Adults Non-Urgent Non-Psychiatry initial offered appt
								  ○ 58% Youth Non-Urgent Non-Psychiatry
								  ○ 47% Adults Non-Urgent Psychiatry initial offered appt
								  ○ 58% Youth Non-Urgent Non-Psychiatry initial offered appt
								  ○ 78% Adult Urgent Psychiatry initial offered appt
								  ○ 71% Youth Urgent Psychiatry initial offered appt
								  ○ No urgent psychiatry appts were reported
								• BHRS continues to have difficulties calculating timeliness to psychiatry services and urgent appointments. Calculation was able to be done for

								purposes of the NACT TADT. • There were no urgent requests for services that require pre-authorization. BHRS did receive a conditional CAP for timely access for SMHS based on NACT TADT findings. Findings for the reporting period was below the standard for MH but met the standard for DMC-ODS. BHRS has selected Timely Access as the non-clinical PIP for both MH and DMC-ODS so that we can continue to refine our workflows and data collection to improve timely access for clients and to also improve our data collection for more accurate analysis of our system health with regards to timely access.
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 2024	**Status:** Met, continue for next year **Summary**: Out of 11 answered calls, all 11 callers felt like they were helped when the call was answered. Out of 11 answered calls, all 11 callers felt like the staff that answered the call 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 QM Staff	June 2024	**Status**: Partially met, continued for next year. 100% of calls were answered 81% of test calls were logged No callers requested interpreters, all calls were made in English **Summary of Calls** • First Quarter: 3 calls • Second Quarter: 3 calls • Third Quarter: 1 call • Fourth Quarter: 4 calls Total: 11 total calls
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 2024	**Status:** Met, continue for next year **Summary:** 100% of grievances and appeals were resolved within 90 days. The average length was 41.2 days, the shortest resolution took 0 days and the longest 89 days. Every grievance was discussed during bi-weekly Grievances & Appeals Team (GAT) meetings.

								GAT has members who are managers from the Alcohol & Other Drugs division and representatives from QM and the Office of Consumer & Family Affairs.
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 2024	**Status:** Met, continue for next year **Summary:** Providers involved in 100% of grievances were informed about the grievance resolutions within 90 days, as documented on the Grievances Log and the individual grievance folders. The Log includes a column to document the date the notification was written and mailed to providers. The folders include a cover letter and a copy of the resolution letter sent to the client.
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 2024	**Status:** Met, continue for next year **Summary**: 62 NOABD's were issued for this fiscal year. 2 Appeals completed for this fiscal year. Even though 1 appeal was overturned, and the other was upheld, 100% of the outcomes were positive since the upheld appeals was resolved including providing the Client with the services they had requested through a single case contract. 24 grievances were successfully completed.
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 2024	**Status:** Partially Met, continued for next year. **Summary:** In FY 23-24, 32 total requests to change provider were received. 20 requests were approved, 1 request was denied, 11 requests were resolved without a change of provider. 53% of decisions were made within 14 days. **Past data by fiscal year** Total amount of requests received. • 32 requests in FY 23-24 • 28 requests in FY 22-23 • 69 requests in FY 21-22 • 47 requests in FY 20-21 Percentage of Decisions made within 14 days. • 53% for FY 23-24 • 57% for FY 22-23 • 81% for FY 21-22 • 87% for FY 20-21

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 2024	**Status:** **Summary:**
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 lease every three years.	Maria Lorente-Foresti Doris Estremera Claudia Tinoco	June 2024	**Status:** Not met, continue for next year **Summary:** No trainings were provided in FY 23-24. BHRS' facilitator was not available to renew their contract. BHRS worked to identify and contract another provider to facilitate this training. BHRS has secured a contract with the National Latino Behavioral Health Association (NLBHA) to provide these trainings in FY 24-25. Additional trainings will be added to support staff that did not have this training opportunity last FY.
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 2024	**Status:** Met, continue for next year **Summary:** In FY 2023-2024 the BHRS saw unique 3,984 requests for interpretation services. There were 3,424requests for telephonic/Audio interpretation, 460 requests for in-person/onsite interpretation and 100 requests for video remote interpretation. In total, there were 36 unique requests for translation of written materials into San Mateo County threshold languages. According to FY 23-24 data, 82.73% of BHRS services were conducted in the preferred language of the client. In 99.46% of services (approximately 28,894 encounters), language services were offered by the provider or interpretation services
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 2024	**Status:** Met, continue for next year **Summary:** In FY 23-24, 46% of New Hires completed the Cultural Humility training requirement within 90 days. 78% of all BHRS staff have

								completed the Cultural Humility training requirement. To enhance compliance with the 90-day Cultural Humility training mandate for new hires, the WET team is proactively exploring strategies such as direct messaging to staff and offering advanced notifications about upcoming training sessions.
DMC	DMC	19	Develop and implement a Youth 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. Train contracted providers on its usage and implement in Avatar EMR.	• 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.	DMC-ODS Staff IT Manager	June 2024	**Status**: **Met, continued for next year** **Summary:** DMC ODS has developed a Youth Assessment modeled after the ASAM. Youth providers have been instructed to complete the assessment and scan the form into the associated Avatar episode. A memo was sent 7/15/24 to providers in addressing the development and use of the Youth ASAM. In FY 23-24, the total of youth served is 52 (for ages 12-17 years old). 9 out of 11 (82%) of youth treatment charts reviewed had a completed youth ASAM in Avatar. Youth AUD ASAM Data: • # of Youth Clients currently enrolled in program o El Centro: 13 o StarVista: 27 o HR360: 25 ▪ Total: 52 • # of Clients charts audited o El Centro: 4 o StarVista: 5 o HR360: 2 ▪ Total: 11 • # of Clients charts audited with a completed Youth SUD assessment tool o El Centro: 2 (50%) o StarVista: 5 (100%) o HR360: 2 (100%) ▪ Total: 9 (82%) • Was Assessment tool uploaded into Avatar or EHR o El Centro: Yes o StarVista: Yes o HR360: Yes

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.	DMC-ODS Staff	June 2024	**Status: Met** **Summary:** The Youth ASAM was rolled out and integrated into AvatarNX on November 2024. The County with BHRS IT support provided the contractors trainings how to use the ASAM in AvatarNX.
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 with 7 days of residential detox discharge • % of clients re-admitted to detox within 30 days	Eliseo Amezcua Mary Taylor Fullerton Sheryl Uyan	June 2023	**Status: Partially Met, continued for next year.** • In FY23-24, there were a total of 653 client discharges from Residential Detox: • 639 – Horizon Palm Ave • 14 – First Chance Sobering Station • Unknown at this time the percentage that were admitted to subsequent treatment within 7 days. • Unknown at this time 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	Sheryl Uyan Desirae Walker Christine O'Kelly	June 2024	**Status: Met** **Summary:** FY 23-24, there were a total of 109 client charts reviewed for DMC-ODS providers. The # of charts reviewed for each DMC-ODS provider: • BAART/ART: 8 • El Centro: 10 • FAL: 7 • Horizon: 5 • HR360: 20 • OCG: 12 • P90: 8 • Sitike: 5 • Service League: 5 • StarVista: 13 • TLC: 16
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.)	• 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 2024	**Status: Met** **Summary:** For FY 23-24, San Mateo County BHRS provided contracted treatment provider staff with a total of **527** training opportunities. Training categories include: ASAM, Cultural Humility, De-Escalation, Elder Abuse, Human

								Trafficking, Social Determinants of Health, Harm Reduction, Evidence Based Practices, DMC-ODS service trainings, Infectious Diseases, Mental Health, Ethics, Relapse Prevention, Stigma, Telehealth, Trauma Informed Care, Co-Occurring Disorders, Professional Development and General Education. Under the topic of Evidence Based Practices, including relapse prevention and trauma informed care there were **49** training opportunities offered to staff. There were **61** trainings offered on DMC-ODS services.
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%	Sheryl Uyan WET Director Michelle Sudyka	June 2024	**Status: Partially Met, continued for next year** **Summary:** In FY 23-24, 55.9% of all providers (clinicians, counseling staff, and supervisors) were training 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 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 Desirae Walker	June 2024	**Status: Partially Met, continued for next year.** **Summary:** In FY 23-24, 61.5% of all LPHA staff 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 Sheryl Uyan Mary Fullerton Eddie Lau Dave Williams Chad Kempel	June 2024	**Status: Partially Met, continued for next year** • 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 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
					• % 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
						Chad Kempel
						Mary Taylor Fullerton
						Eri Tsujii
						Sheryl Uyan
							June 2024	**Status: MET:**
								
								• 94% of those requesting an outpatient appointment received an appointment within 10 days
								• 100% of those requesting Narcotic Replacement Therapy were admitted to treatment within 24 hours (County Standard)

				• 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.	measure/reference only; data not reported as County standard is more stringent).		• 100% of those requesting Narcotic Replacement Therapy were admitted to treatment within 72 hours (State Standard)
DMC	DMC	28	Comply with SUBG requirements for Pre-Award Risk Assessments	• Complete SUBG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.	• % of contracted SUD treatment programs receiving SUBG funding with a completed Risk Assessment prior to contract renewal.	Sheryl Uyan Desirae Walker	June 2024	**Status: Met** **Summary:** FY 23-24, 100% of all contracted SUD treatment programs receiving SUBG funding completed Risk Assessments 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.	Sheryl Uyan Desirae Walker Eliseo Amezcua Mary Fullerton	June 2024	**Status: Partially Met, continued for next year.** **Summary:** FY 23-24: • the TPS client survey data showed 68.1% of youth and adult clients were satisfied with care coordination. • 68.8% of audited client charts complied with DMC-ODS physical health examination requirements. • 0% of audited charts had AC OK screening. This item was not monitored for FY 23-24 as the ASMA assessment contains trauma and co-occurring components that are similar to the AC OK screening. To prevent duplication of services, treatment providers are no longer obligated to conduct the AC OK screening, they may still choose to do so.
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. o FY 19/20: 88.8 % (N=228) – baseline	Sheryl Uyan Alberto Ramos Mary Fullerton	June 2024	**Status: Met** Summary: FY 23-24 TPS Adult Client Survey Results

					• % 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
								• 92.7% of adult clients surveyed indicated "staff were sensitive to my cultural background."
								• 83.3% of adult clients surveyed indicated "I chose my treatment goals."
								• 83.1% of adults surveyed indicated "as direct result of the services I am receiving, I am better able to do things that I want to do."

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 2024	**Status: Partially Met, continue for next year.** **Summary:** The Equity focused clinical PIP and BHQIP FUM non-clinical PIP were submitted for EQRO FY23-24. EQRO PIP validation results indicated that both PIPs were in the implementation phase. BHRS will need to continue to develop these PIPs as barriers related to staff bandwidth as well as barriers related to technology of the FUA intervention has delayed implementation of the FUA intervention. Additionally, barriers to data collection for both PIPs have made analysis of intervention process and outcomes difficult to determine. BHRS is also experiencing delays in contracting with a trainer to provide clinical training for the clinical intervention for the Equity PIP. BHRS will continue to work to address these barriers and develop a cohesive data collection and intervention implementation plan for these areas of focus. However, it is unclear if these areas of focus will be continued as PIPs for FY24-25 because a new EQRO process will be in place for FY24-25. Once BHRS obtains more information about the new PIP requirements from the new EQRO, we will update the new workplan with the information about the PIP topics.
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.	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii Clara Boyden	June 2024	**Status: Partially Met, continue for next year.** **Summary:** BHQIP FUA non-clinical PIP and POD clinical PIP were submitted for EQRO FY23-24. EQRO PIP validation results indicated that our FUA

				• Identify additional interventions to address the identified problem(s).				PIP was in the planning phase and the POD PIP was in the implementation phase. Will need to continue to develop these PIPs 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 areas of focus. However, it is unclear if these areas of focus will be continued as PIPs for FY24-25 because a new EQRO process will be in place for FY24-25. Once BHRS obtains more information about the new PIP requirements from the new EQRO, we will update the new workplan with the information about the PIP topics.