SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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

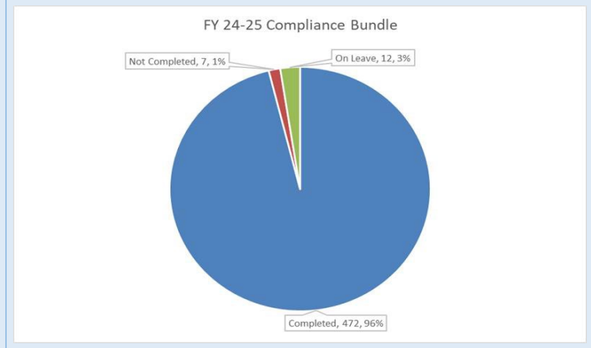
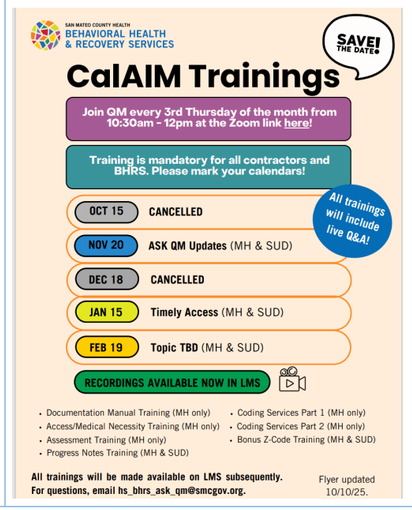
System (SYS)	
DMC	DMC-ODS
MHP	Mental Health
JT	Joint DMC-ODS and Mental Health Goal

Core QM Staff	
QM Manager	Betty Ortiz-Gallardo
QM Unit Chief	Claudia Tinoco-Elizondo
QM Program Specialist	Jessica Zamora WOC
QM Program Specialist	Annina Altomari
QM Program Specialist	Eri Tsujii
Medical Office Specialist	Mercedes Medal
Clinical Analyst	Laurie Bell

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

Core DMC-ODS Staff (as of 3/20/23)	
Deputy Director of SUD Services	Clara Boyden
SUD Clinical Services Manager	Mary Taylor Fullerton
SUD Supervisor	Desirae Walker
SUD Supervisor	Eliseo Amezcua
SUD Health Services Manager	Sheryl Uyan
SUD Program Specialist	Tracey Chan

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

SYS	CAT	#	Goal Description	Intervention	Measurement	Responsible Persons	Due Date	Outcomes
MH	QI	1	Maintain compliance with HIPAA, Fraud, Waste and Abuse (FWA), and Compliance training mandates.	Staff will complete online HIPAA, FWA & Compliance Training at hire and annually.	Track training compliance, HIPAA, & FWA of new staff and current staff. Current staff: Goal = or > 90% for each training. New Staff: Goal = 100% <u>Annual Required Compliance Bundle: BHRS Staff Only:</u> The assigned months for each training will be December • Annual: BHRS Compliance Mandated Training – December 2024 • Annual: BHRS Fraud, Waste, & Abuse Training – December 2024 • Annual: BHRS: Confidentiality & HIPAA for Mental Health and AOD– December 2024 • Annual: BHRS Critical incident Tracking – December 2024 • Annual: BHRS AB210 Brief Overview-December 2024	QM Staff	June 2025	**Status:** Met, continue for next year **Summary:** In FY 24-25 96 % of staff completed The Required Annual Compliance Bundle training. 100% of New Staff Completed the compliance bundle training. 
MH	QI	2	Improve clinical documentation and quality of care.	• Maintain clinical documentation training program for all current and new staff. • Train staff and contractor providers on new CalAIM requirements	Report on trainings provided via live webinar, specialty training, and online training modules Include attendance numbers where applicable.	QM Staff	June 2025	**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 Learning Management System (LMS) site, so all BHRS and CBO's were able to re-watch and access the webinars at any time. Power points were posted to the QM website. 

MH	CAT	3	Implement monthly internal audits to assess compliance with new CalAIM documentation requirement with an adherence of 90% by June of 2025	• Adhere to the new CalAIM documentation standards • Contractor Audit Team will conduct internal audits of BHRS providers and contractors.	Internal Chart audits Less than 10% disallowance per BHRS program and contractors.	Audit Team	June 2025	**Status:** **Summary:**
JT	QI	4	Create a Quality-of-Care Committee (QCC) to address system-wide quality of care issues that arise from client/beneficiary experience.	• Establish committee membership • Review quality of care concerns within committee follow-up with appropriate guidance and interventions • Review the results of these quality-of-care concerns at least annually	Create a tracker of the quality-of-care concerns raised for SOC. Annual Report to QIC and/or to the Executive Team.	Betty Ortiz-Gallardo	June 2025	**Status:** Not met **Summary:** Due to staff issues this committee was unable to be created.
JT	QI	5	Monitor staff satisfaction with QI activities & services	• Perform Annual Staff Satisfaction Survey: All staff will be sent a survey to rate level of satisfaction with Quality Management Department.	Percentage of staff reporting satisfied/somewhat satisfied with QM support = or > 90%. • Are you satisfied with the help that you received from the Quality Management staff person? • Baseline: ○ FY 23-24 Very Satisfied=38.87% Satisfied=43.55% Somewhat satisfied= 4.84%, Very Dissatisfied= 4.84% Total responses 62	Betty Ortiz-Gallardo QM Staff	June 2025	**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 45 responses **Answer Choices** / **Percentage** / **Responses** Very satisfied — 35.56% — 16 Satisfied — 31.11% — 14 Somewhat satisfied — 11.11% — 5 Neither satisfied nor dissatisfied — 11.11% — 5 Somewhat dissatisfied — 0% — 0 Dissatisfied — 4.44% — 2 Very dissatisfied — 6.67% — 3 **Total** — **45**
JT	QI	6	Create and update policies and procedures in BHRS for Mental Health and SUD	• Update current policies and procedures for new managed care rules. • Update policy Index. • Maintain internal policy committee to address needed policies and procedures. • Retire old/obsolete policies. • Create new, amend existing, and retire obsolete policies • Update policies and procedures to comply with CalAIM	• # of Policies Created • # of Policies Retired • # of Policies Amended	Policy Committee QM Staff DMC-ODS Staff	June 2025	**Status:** Met, continue for next year **Summary:** In FY 24-25, the QM Policy Committee made improvements to the policy tracking process and Policy Index through the use of Smartsheet. In addition, the QM Policy Committee standardized the protocol for updating and developing new policies though targeted training and templates to be rolled out in FY 25-26. These improvements in FY 24-25 to the policy process have supported the approval of the following number of policies so far: # of Policies Created: 5 # of Policies Retired: 0

								# of Policies Amended: 8 The QM Policy Committee continues to meet bi-monthly regarding policy related topics. QM is also collaborating with contracted consultants to support the prioritization and updating of policies, especially those relating to CalAIM.
JT	QI	7	Comply with QIC Policy and maintain voting membership that represents all parts BHRS	• Review/amend QIC Policy as necessary. • Maintain QIC membership that represents BHRS system	• Ensure compliance with QIC Policy: communicate with QIC members as necessary. • Verify and document QIC members that represents BHRS system by 6/2021 (continuous)	Betty Ortiz-Gallardo Annina Altomari QM Staff	June 2025	**Status:** Met, continue for next year **Summary:** In FY 24-25 the QM Policy Committee clarified the role of the QIC in the policy process to support the timely approval of policies. This change, which is outlined in Policy 08-02, removes the QIC as a voting body for policy approval, and rather utilizes the QIC for feedback regarding certain policies pertaining to client care, treatment, and client rights. Policies such as compliance and credentialing policies are not presented for feedback to the QIC, therefore allowing these policies to be implemented in a timelier manner. All new and amended policies, regardless of whether they warrant QIC feedback or not, are still shared with the QIC at bi-monthly meetings. QM continues to evaluate QIC membership and request additional members on an annual basis. QM will consider additional ways to increase outreach for membership. QIC currently has 31 members. The QIC could benefit from increased contractor and community membership.
JT	QI	8	Tracking Incident Reports (IR)	• Continue to monitor and track all Incident reports. • Report trends and current data.	Report to QIC	QM Staff	June 2025	**Status:** Partially met, continue for next year **Summary:** Quality Management (QM) reviews all submitted incident reports. Sentinel events, breaches of confidentiality, and high-risk incidents are escalated to the executive team for further review. In March 2025, BHRS implemented the SAFE incident reporting system, with all staff going live in July 2025. Staff can now submit incident reports directly through SAFE. QM reviews all reports entered into the system and also uploads PDF incident reports received from contracted agencies.
JT	QI	9	Tracking of timeliness data for Mental Health Plan (MHP) Substance Use (SUDS) and Foster Care (FC) clients. (see definition of a new client)	• Include data for BHRS and contract agencies serving SDMC clients. • Report to Executive Team and QIC, timeliness data annually.	• % of clients being offered or receiving an assessment appointment 10 days from request to first appointment. • % of new clients receiving Psychiatry Services within 15 days from request/assessment to first psychiatric service. • Track Timeliness from request for Urgent appointment to actual encounter. (48 hrs for non-authorized service; 96 hrs for pre- authorized services)	Betty Ortiz-Gallardo Eri Tsujii Chad Kempel	June 2025	**Status: Partially Met** **Summary:** • Performance on the % of appointments offered an assessment within 10 days exceeds the 80% DHCS 10 day standard. • An ad hoc work group met in Fall 2025 to assist in creating Avatar screens and workflows that will be consistent between MH and SUDS for tracking timely access to care. Staff will be trained on the new procedures in January 2026. The new process will enable tracking of psychiatry timeliness and urgent appointment timeliness. It will also allow the urgent/non-urgent status to be modified if the client's needs change.
JT	AC	10	Improve customer service and satisfaction for San Mateo County Access Call Center for MH/SUD	• Review and Revise, as needed, standards for answering calls • Provide training for Optum call center staff on standards for answering calls.	• Test calls and call logs 90% test call rated as positive	Access Call Center QM Staff	June 2025	**Status:** Met, continue for next year **Summary:** Out of 28 answered calls 24 callers felt like they were helped when the call was answered. Out of 28 answered calls, 24 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	11	Monitor 24/7 access to care through Call Center and Optum. 100% of calls will be answered. 100% of test callers will be provided information on how/where to obtain services if needed.	• Make 4 test calls quarterly to 24/7 toll-free number for AOD and Mental Health services. • Make 1 test call in another language and 1 for AOD services • QM will report to call center the outcome of test calls	• 95 % or more calls answered • 95 % or more test calls logged. • 100% of interpreters requested provided • 75% of call will be rated satisfactory (Caller indicated they were helped)	QM Staff	June 2025	**Status:** Met, continue for next year **Summary:** 100% of calls were answered, 96% of test calls were logged, 4 callers requested and were provided with interpreters, 11 all calls were made in another language, 4 AOD calls, and 96 % calls were rated satisfactory. Summary of Calls: • First Quarter: 10 calls • Second Quarter: 9 calls • Third Quarter: 4 calls • Fourth Quarter: 5 calls Total: 28 total calls
JT	GN	12	Grievances will be resolved within 90 days of receipt of grievance and appeals within 30-day timeframe, expedited appeals will be resolved within 72 hours after receipt of expedited appeal in 100% of cases filed.	• Grievance and appeals regularly addressed in Grievance and Appeal Team (GAT) Meeting.	• Annual reports on grievances, appeals, and State Fair Hearings to QIC. • Annual report with % of issues resolved to client/family member fully favorable or favorable. • Annual report with % grievances/appeals resolved within 90/30 days.	GAT Team	June 2025	**Status:** Met, continue for next year **Summary:** All grievances were investigated and resolved within 90 days and appeals within 30 days.
JT	GN	13	Ensure that providers are informed of the resolution of all grievances and given a copy of the letter within 90 days of the grievance file date. This will have documented in the GAT file 100% of the time.	• Audit the grievance resolution folders quarterly to ensure that there is evidence that providers have been informed of the resolution.	• 80% of providers will receive the grievance resolution at the time the client is informed. This will be documented in the GAT file. • (Baseline 50%)	GAT Team Claudia Tinoco	June 2025	**Status:** Met, continue for next year **Summary:** All providers were informed of the grievances resolutions and were provided with copies of the resolution letters. This was documented in the GAT files in 100% of the grievances.
JT	GN	14	Ensure that Grievance and NOABD process follow Policies and procedures for handling grievances.	• GAT will review all relevant revisions to the 2019 (Policy 19-01) Grievance Protocol and make any changes required. • Train BHRS staff and contractors on new grievance procedures • Track compliance with new Grievance and NOABD policy	• # of successfully issued NOABDs • # of Appeals completed with outcome % for favorable outcomes for client • # of successfully completed Grievances	GAT Team Claudia Tinoco	June 2025	**Status:** Partially Met, continue for next year **Summary:** 43 NOABD's were issued for this fiscal year. One grievance was logged after 24 hours (over a holiday weekend) and Acknowledgement letters were one day late for two grievances. 150 staff were trained in the Grievance Process. 1 appeal was received; the original decision was upheld. 100% of the 68 grievances received were successfully completed within the 90-day period
JT	GN	15	Decision for client's requested Change of Provider within 2 weeks	• Change of Provider Request forms will be sent to Quality Management for tracking.	Annual review of requests for change of provider: type of complaints and resolutions.	QM Staff	June 2025	**Status: Partially** Met, continue for next year

				• Review of complaints, resolutions, and COP requests				**Summary:** In FY 24-25, 35 total requests to change provider were received. 35 Request were approved, 1 request was denied, 2 were resolved without a change of provider. 82% of decisions were made within 14 days. Past data by fiscal year Total number of requests received. • 35 requests in FY 24-25 • 32 requests in FY 23-24 • 28 requests in FY 22-23 • 69 requests in FY 21-22 Percentage of Decisions made within 14 days. • 98% for FY 24-25 • 53% for FY 23-24 • 57% for FY 22-23 • 81% for FY 21-22
JT	CS	16	Providers will be informed of results of the beneficiary/family satisfaction surveys semi-annually.	• Inform providers/staff of the results of each survey within a specified timeline. (MHP = 2x per year, ODS = 1x per year)	• Notify programs, according to MHP/ODS requirements, consumer survey results • Presentation and notification of the results yearly.	QM Manager Scott Gruendl Clara Boyden	June 2025	**Status:** Met, continue for next year **Summary:** The DMC ODS Treatment Perception Survey (TPS) Data • Administered between 10/21/2024-10/25/2024 • 289 Adult Surveys completed, 16 treatment programs participated. • 16 Youth Surveys completed, 2 treatment programs participated. • 6.6% in Spanish, 93.4% in English. • 71.8 % completed via paper, 28.2% online completion. Presentation of TPS Results: • 6/5/2025: AOD Treatment Providers Meeting • 6/11/2025: AOD All Staff Meeting • 6/25/2025: BHRS Quality Improvement Committee • 8/13/2025: San Mateo County BH Commission
JT	CS	17	Improve cultural and linguistic competence	• "Working Effectively with Interpreters in Behavioral Health" refresher course training will be required for all direct service staff every 3 years.	• 100% of new staff will complete in-person "Working Effectively with Interpreters in Behavioral Health" • 75% of Existing staff who have taken the initial training will take the refresher training at lease every three years.	Maria Lorente-Foresti Doris Estremera Claudia Tinoco	June 2025	**Status:** Not met, continue for next year **Summary: 47% (252 out of 537)** of all BHRS staff have completed the Working with Interpreters training at least once. **<u>New BHRS Staff</u>** Among the **73** BHRS staff hired in FY 2024 2025, **26% (19)** completed Working with Interpreters, while **74% (54)** have not yet completed the required training. **<u>Existing BHRS Staff</u>** Among the **464** BHRS staff hired before FY 2024 2025, **51% (237)** is in compliance, while **49% (227)** is not in compliance.

								Summary: Among the **252** staff who have completed Working with Interpreters at least once, only **37%** currently remain in compliance. **63%** of trained staff are now out of compliance due to expired completion dates. Additional Information**:** After a pause while BHRS sought a new training provider, in Spring 2024 we secured a contract with the National Latino Behavioral Health Association to offer two updated trainings: one focused on working effectively with interpreters in behavioral health settings, and another designed to support bilingual staff currently serving within BHRS.
JT	CS	18	Improve Linguistic Access for clients whose preferred language is other than English	• Services will be provided in the clients preferred language	• % Of clients with a preferred language other than English receiving a service in their preferred language	Doris Estremera Maria Lorente-Foresti Chad Kempel Claudia Tinoco	June 2025	**Status:** Met, continue for next year **Summary: In** FY 2024-2025, BHRS had 3,983 unique requests for interpretation services. There were 2,933 requests for telephonic/Audio interpretation, 768 requests for in-person/onsite interpretation and 282 requests for video remote interpretation. In total, there were 35 unique requests for translation of written materials into San Mateo County threshold languages. In FY 24-25, language assistance services were offered in 99.05% of encounters (approximately 30,245 encounters) with clients with a preferred language other than English. Of these, 10% were assisted via our language services and 89% by our BHRS clinicians/staff.
JT	CS	19	Enhance Understanding and Use of Cultural Humility as an effective practice when working with diverse populations.	• All staff will complete mandatory training on cultural humility	• 65% of staff will complete the Cultural Humility training.	Doris Estremera Maria Lorente-Foresti Claudia Tinoco	June 2025	**Status:** Met, continue for next year **Summary:** In FY 2024–2025, 440 out of 537 BHRS staff have completed Cultural Humility 101, representing 82% of the workforce. There was a 6% increase from last year's 76% completion rate. To support this growth, 18 sessions were offered throughout the year, averaging two to three sessions each month. A total of 286 individuals participated in the training, including 126 BHRS staff and 174 contracted providers.
DMC	DMC	20	Continued utilization of Youth and Adult SUD Assessment tool.	• Work with clinical consultants and youth SUD treatment providers to develop an ASAM-based SUD Assessment tool specific to youth ages 12-17 and 18-21, and adults. Train contracted providers on its usage in Avatar EMR.	• Monitoring of youth and adult SUD Assessment tool. • Continuous training with providers serving youth 17 and under, with providers serving young people 18-21, and providers serving adults. • % of client charts audited with a completed Youth and completed Adult SUD Assessment tool.	DMC-ODS Staff IT Manager	June 2025	**Status:** Met **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. Full implementation occurred 11/2024.
DMC	DMC	21	Continued utilization of Youth Health Screening Tool	• Work with clinical consultants, youth SUD treatment providers, and medical directors to develop a youth health screening tool specific to youth ages 12-17 and 18-21.	• Monitoring of a youth health screening tool. • Continued training with providers serving youth 17 and	DMC-ODS Staff	June 2025	**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**.**

					under, and with providers serving young people 18-21. • % of client charts audited with a completed youth health screening tool.			
DMC	DMC	22	Care Coordination: Strategies to avoid hospitalizations and improve follow-up appointments. Clients discharged from residential detox services are referred and admitted follow-up care.	• ASAM evaluation and treatment referral completed prior to residential detox discharge. • Coordinate the detox discharge and subsequent admission/appointment to appropriate follow-up care.	• # of Res Detox discharges • % of clients admitted to a subsequent follow up appointment/treatment with 7 days of residential detox discharge • % of clients re-admitted to detox within 30 days	Eliseo Amezcua Mary Taylor Fullerton Sheryl Uyan	June 2025	**Status:** Partially Met, continued for next year **Summary:** In FY 24-25, there were a total of 450 client discharges from Residential Detox: • 420 – Horizon Palm Ave • 30 – First Chance Sobering Station (First Chance Sobering Station was closed as of 10/2024) • 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	23	Monitor Service Delivery System: Increase treatment provider compliance with DMC-ODS documentation regulations.	• Design and implement a plan for County review of SUD treatment provider Medi-Cal beneficiary charts to allow remote monitoring for COVID-19 safety practices. • Develop an audit tool and protocols in for remote chart audits in conjunction with QM; may include auditing in Avatar and scanning charts. • Pilot Audit with each of the DMC-ODS providers	• # of charts reviewed for each DMC-ODS providers	Sheryl Uyan Desirae Walker	June 2025	**Status:** Met **Summary:** FY 24-25, there were a total of **11 DMC-ODS substance use treatment providers reviewed, with 233 client charts audited. The CalMHSA-developed audit tool was utilized to review client charts.**
DMC	DMC	24	Develop and Implement a Training Plan for provider direct service staff that complies with DMC-ODS STC requirements around Evidenced-Based Practices (EBPs.)	• Review BHRS Standards of Care (SOC,) DMC-ODS Special Terms and Conditions (STC,) the Intergovernmental Agreement • Develop of an annual Training Plan that incorporates Evidenced-Based Practices. • Implement training plan	• Copy of training plan protocol • # of trainings offered	WET Director Sheryl Uyan Mary Fullerton Michelle Sudyka	June 2025	**Status:** Met **Summary:** There were **42** trainings offered to providers throughout FY24-25 on evidence based practices. There were **458** free trainings offered to providers on all topics including Peer Services, Documentation, Professional Responsibility, EBP's, Substance Education, Pregnant Populations, Cultural Humility and more. To support provider competency and ensure staff are trained in all County required topics, including at least two Evidence-Based Practices (EBPs), the county offers a comprehensive training approach that combines free external opportunities, tailored trainings, and ongoing communication. The strategy is designed to increase access, reduce barriers, and ensure consistent exposure to high-quality, evidence-based content. **Monthly Distribution of Training Opportunities** • Providers are given access to free online trainings offered by reputable third-party organizations. The Training Coordinator compiles and distributes a monthly training email to all providers. • Additional opportunities identified throughout the month are shared as needed.

								• Each training announcement clearly indicates whether the training qualifies as an EBP or other required training topic.
								• The monthly training email contains the list of required annual trainings, a training calendar, and a document containing free on-demand training opportunities on many different topics including: cultural competency, evidence-based practices, stigma, medication assisted treatment, and general substance education.
								• Many of these trainings include free Continuing Education Units (CEUs) to support professional development.
								County-Supported Personalized Training
								• San Mateo County contracts with a training provider to deliver customized or specialty trainings when topics are not available for free elsewhere or when tailored instruction is needed.
								• Evidence-Based Practices include:
								  ○ Motivational Interviewing
								  ○ Trauma 101
								  ○ Relapse Prevention
								Additional topics can be arranged based on provider needs.

DMC	DMC	25	80% of all provider direct service staff will be trained in at least 2 Evidenced-Based Practices as identified in the DMC-ODS STCs.	• Implement Training Plan for provider clinicians, counseling and supervisory staff. • Conduct personnel file reviews to confirm evidence of training on at least 2 EBPs. • Explore with BHRS Workforce Education and Training Coordinator and with Providers possible methods to improve access and compliance with EBP training requirements.	• % of all provider clinicians, counseling staff, and supervisors will be trained in at least 2 EBPs. • FY 18-19 performance is 28%	Sheryl Uyan WET Director Michelle Sudyka	June 2025	**Status:** Not Met, continued for next year. **Summary:** In FY 24-25, 75% of all providers (clinicians, counseling staff, and supervisors) were training in at least 2 Evidenced-Based Practice trainings. Based on the available data, 12 out of 16 provider organization direct service staff (75%) met this requirement. For the remaining four providers, documentation of EBP training was not available, so their status could not be verified. Because the percentage of providers confirmed to have met the training requirement is below the 80% goal, and incomplete documentation prevents verifying compliance for the remaining providers, the goal was not fully met.
DMC	DMC	26	All providers who are Licensed Practitioners of the Healing Arts (LPHA) clinicians will receive at least 5 hours of Addiction Medicine Training annually.	• Implement a Training Plan for provider clinicians.	• % of all provider LPHA clinicians will receive at least 5 hours of addiction medicine training annually. • FY 17/18 baseline is 35%. • FY 18/19 = 55%.	Sheryl Uyan	June 2025	**Status:** Not Met, continued for next year. **Summary:** In FY 24-25, 79.2% of all LPHA staff received at least 5 hours of addiction medication training annually. San Mateo County has designated staff responsible for identifying Addiction Medicine trainings and notifying all DMC-ODS substance use disorder (SUD) treatment providers of available opportunities via email. Notifications are distributed at least monthly throughout the fiscal year. In addition, SUD treatment providers receive reminders regarding training availability from their assigned program analysts. Compliance with this requirement is monitored through annual site visit audits to verify that LPHAs have completed a minimum of five hours of Addiction Medicine training.

DMC	DMC	27	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 2025	**Status:** Partially Met, continued for next year. **Summary:** • 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 New reports created by QM and BHRS IT for contractors to utilize. • SUD Progress Notes Report by Client • SUD Progress Notes Report by Clinician

DMC	DMC	28	Timeliness of first contact to first appointment:
			BHRS will track time from first request to first appointment for Outpatient SUD and Opioid Treatment Programs.
				• Develop a process to analyze timeliness data quarterly for:
				  ○ Outpatient SUD services (excluding Opioid Treatment Programs)
				  ○ Opioid Treatment Programs
				• Share data for BHRS programs and contractor agencies serving DMC-ODS clients
				• NRT providers will monitor and track timely access to services, from the time of first request to the time of first appointment.
				• Report timeliness data annually with NACT Submission on April 1, 2022.
					• % of client's receiving an Outpatient SUD Service within 10 days from request to first appointment.
					• % of clients admitted to treatment within 24 hours of making a request for Narcotic Replacement Therapy. (County Standard)
					• % of clients starting an Opioid Treatment Programs within 3 days from request to first appointment. (State measure/reference only; data not reported as County standard is more stringent).
						Chad Kempel
						Mary Taylor
						Fullerton
						Eri Tsujii
						Sheryl Uyan
						Alberto Ramos
							June 2025	**Status:** Met
								
								Summary:
								• 91% of those requesting an outpatient appointment received an appointment within 10 days.
								• 97% of those requesting Narcotic Replacement Therapy were admitted to treatment within 24 hours (County Standard)
								• 100% of those requesting Narcotic Replacement Therapy were admitted to treatment within 72 hours (State Standard)

DMC	DMC	29	Comply with SABG requirements for Pre-Award Risk Assessments	• Complete SABG Pre-Award Risk Assessment tools annually, prior to renewing or starting a new contract.	• % of contracted SUD treatment programs receiving SABG funding with a completed Risk Assessment prior to contract renewal.	Sheryl Uyan Desirae Walker	June 2025	**Status:** Met **Summary:** FY 24-25, 100% of all contracted SUD treatment programs receiving SUBG funding completed Risk Assessments prior to contract renewal.
DMC	DMC	30	Care Coordination: Care will be coordinated with physical health and mental health service providers.	• Implementing contract standard for physical health and mental health care coordination of services at the provider level • Audit charts to monitor compliance with standard • Develop system-wide coordination meeting with providers • Analyze TPS client survey data to monitor client satisfaction with care coordination	• % of audited client charts which comply with DMC ODS physical health examination requirements. • % of MD reviewed physical health examinations with a subsequent referral to physical health services. • % of audited client charts with a completed ACOK screening • % of positive AC OK Screens with a subsequent referral to mental health services.	Sheryl Uyan Desirae Walker Eliseo Amezcua Mary Fullerton	June 2025	**Status:** Partially met, continued for next year. **Summary:** FY 24-25, 11 DMC-ODS substance use treatment providers were reviewed, and a total of 233 client charts were audited. Of these, 135 client charts were compliant with DMC-ODS physical health examination requirements and reviewed by an MD, resulting in an overall compliance rate of 57.9%, however it is not known if a subsequent referral to physical health services was provided. 0% of audited charts had AC OK screening. This item was not monitored for FY 24-25 as the ASAM 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	31	Assess client experience of SUD services through annual survey.	• Conduct annual TPS Survey with all provider/beneficiaries	• % percent of clients surveyed who indicate “staff were sensitive to my cultural	Sheryl Uyan Desirae Walker	June 2025	**Status:** Met **Summary:**

				• Analyze TPS data and share findings with providers and stakeholders.	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	Mary Fullerton		FY 24-25 TPS Adult Client Survey Results • 89.2% (272 of 305) of adult clients surveyed indicated "staff were sensitive to my cultural background." • 86.6% (264 of 305) of adult clients surveyed indicated "I chose my treatment goals with my provider help." • 84.9% (259 of 305) 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 2025	**Status:** Met **Summary:** The MHP initiated two new PIPs: • Timely access to MH follow-up non-psychiatry appointments • Adherence to antipsychotic medications for clients with schizophrenia and schizoaffective disorder Documents were submitted to the EQRO in July and October 2025 with "pre-baseline data" representing CY 2024. Both PIPs received a "high confidence" rating. Baseline data will be submitted in July representing CY 2025. Interventions are due to begin in early 2026.
DMC	PIP	33	BHRS will continue to work on two on-going Performance Improvement Projects (PIP) for the DMC-ODS.	• Continue with second year of current clinical and non-clinical BHQIP PIPs (FUA and POD) • Analyze data to measure progress on the clinical and non-clinical PIPs. • Ensure that PIPs meet both EQRO and BHQIP requirements. • Identify additional interventions to address the identified problem(s).	• Development of 2 PIP's that are rated as active and meet EQRO standards • Committee Minutes	Eri Tsujii Clara Boyden Consultant	June 2025	**Status:** Met **Summary:** The DMC-ODS initiated two new PIPs: • Timely access to SUD residential treatment • Adherence to MAT treatment for clients with opioid use disorder Documents were submitted to the EQRO in July and October 2025 with "pre-baseline data" representing CY 2024. Both PIPs received a "high confidence" rating. Baseline data will be submitted in July representing CY 2025. Interventions are due to begin in early 2026.