Department of Behavioral Health

Where Hope & Healing Unite

Calendar Year 2024
Quality Improvement Work Plan
(QIWP)

Living Final

Revised

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Department of Behavioral Health

The County of Fresno Department of Behavioral Health (DBH) Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) are committed to providing recovery oriented, culturally appropriate, data-driven, whole-person focused services to the Fresno County community.

Mission

The Fresno County Department of Behavioral Health, in partnership with our diverse community, is dedicated to providing quality, culturally responsive, and behavioral health services to promote wellness, recovery, and resiliency for individuals and families in our community.

Quadruple Aim

At Fresno County Department of Behavioral Health, we have four primary goals. We call this our Quadruple Aim:

- Deliver quality care
- Maximize resources while focusing on efficiency
- Provide an excellent care experience
- Promote workforce well-being

Guiding Principles of Care Delivery

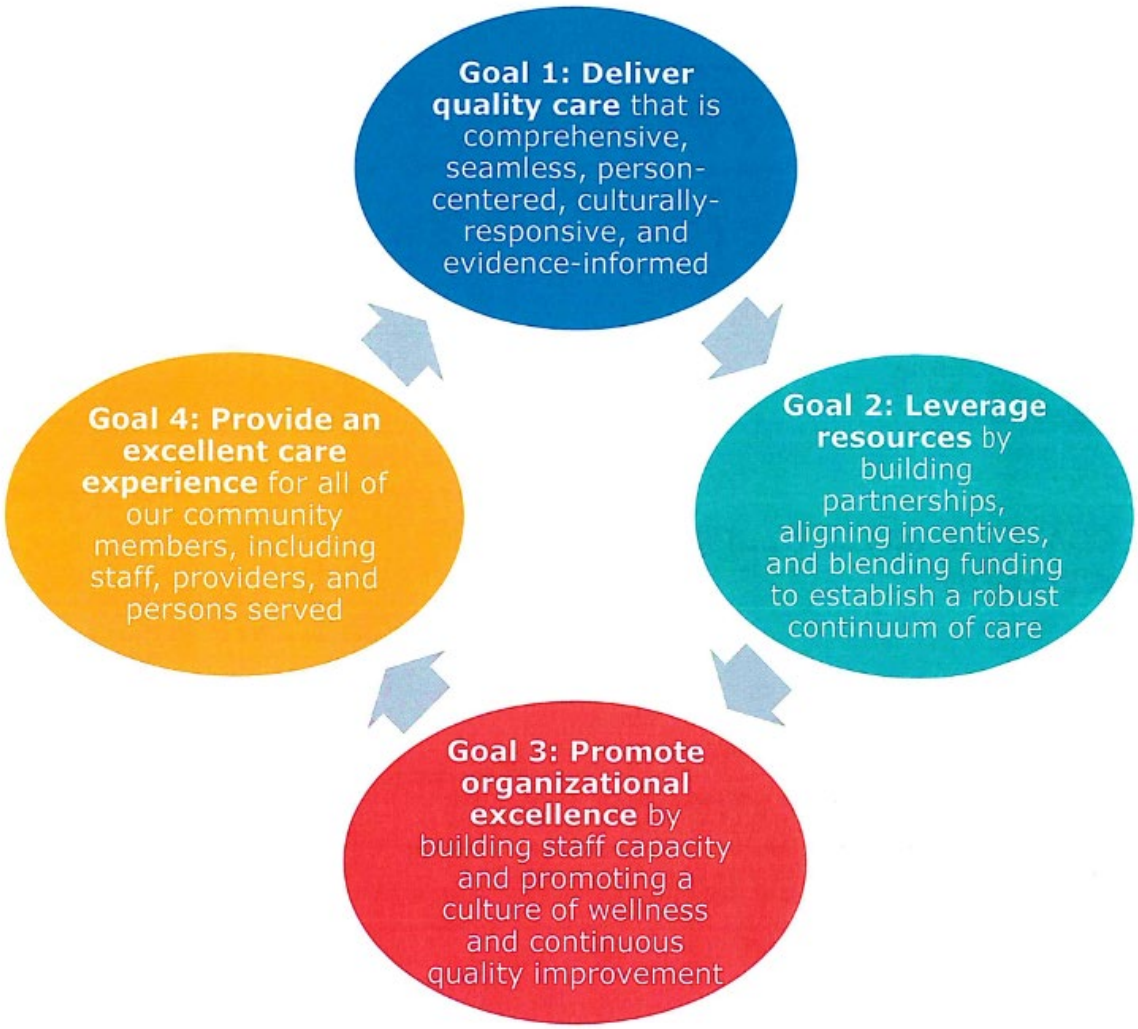
Our 11 principles of care delivery define and guide a system that strives for excellence in the provision of behavioral health services, where the values of wellness, resiliency and recovery are central to the development of programs, services and workforce. The principles provide the clinical framework that influences decision-making on all aspects of care delivery – including program design and implementation, service delivery, training of the workforce, allocation of resources and measurement of outcomes.

- Timely Access & Integrated Services
- Strengths-Based Services
- Person-Driven and Family-Driven Services
- Inclusion of Natural Supports
- Clinical Significance and Evidence-Based Practice (EBP)
- Culturally Responsive Services
- Trauma-Informed and Trauma-Responsive Services
- Co-Occurring Capable Services

- Stages of Change, Motivation, and Harm Reduction
- Continuous Quality Improvement and Outcomes-Driven
- Health and Wellness Promotion, Illness and Harm Prevention, and Stigma Reduction

DBH Strategic Plan

Fresno County DBH has developed a Strategic Plan for Calendar Years 2021 to 2031. Four key goals are outlined in the Strategic Plan, which provide a vision for creating and implementing the Quality Management Program. As shown below, the four Strategic Plan goals include: (1) Deliver quality care; (2) Leverage resources; (3) Promote organizational excellence; and (4) Provide an excellent care experience. The development, design and implementation incorporate the Departments strategic plan goals. The strategic plan can be found here: Strategic Plan



Diversity, Equity, and Inclusion

DBH is committed to culturally responsive and respectful services for all people in Fresno County. To that end, the Quality Improvement Program works in coordination with the DBH Diversity, Equity, and Inclusion (DEI) Committee (formerly known as the Cultural Humility Committee) to guarantee that services being provided are appropriate for the person served and that employees feel respected and safe at the workplace. The DBH Culturally Responsive Plan serves to guide every aspect of DBH as place of employment, as well as of the services that it provides.

County Profile

Demographics

The US Census Bureau identified that the population of Fresno County would be roughly 1,022,707 in 2023, with an estimated 324,640 households (Fresno County Health Improvement Partnership, 2023). The average household in Fresno County has a median income of $64,168 (Fresno County Health Improvement Partnership, 2023), with a per capita income of $30,130 (United States Census Bureau, 2023) and 19.9% of the population was born outside of the United States (United States Census Bureau, 2023). Of the eligible population, 4.7% are veterans of military service (United States Census Bureau, 2023).

Figure 3 utilizes the estimate information from the 2023 Healthy Fresno County Data website to identify age, race/ethnicity, and gender of the general population. The Fresno County population differs in some key areas from the California population. The Hispanic/Latino population is approximately 15 percentage points higher in Fresno County than in the State, and the Fresno County population is slightly younger as well (Fresno County Health Improvement Partnership, 2023).

Although approximately 5 percentage points lower than the California percentage (Fresno County Health Improvement Partnership, 2023), the Fresno County Asian population is unique due to the high percentage of Hmong individuals. Fresno County the second largest Hmong community in the United States. In the Hmong population in the United States, 44% of individuals live with poverty, which is the highest percentage among race/ethnic groups (PRRI, 2019).

Figure 3
Fresno County Residents
By Gender, Age, and Race/Ethnicity

Demographics	**Fresno County**	**California**
Total Population	1,022,707	39,455,491
Age	**% of Population**	**% of Population**
0 - 14 years	22.85%	18.11%
15 - 24 years	14.54%	13.05%
25 - 64 years	49.17%	52.79%
65+ years	13.44%	16.15%
Race	**% of Population**	**% of Population**
African American/ Black	4.56%	5.64%
American Indian/Alaskan Native	2.52%	1.69%
Asian	10.70%	15.64%
Native Hawaiian/Pacific Islander	0.22%	0.40%
Caucasian/ White	35.38%	39.59%
Other/Not Reported	29.64%	22.02%
2+ Races	16.98%	15.03%
Ethnicity	**% of Population**	**% of Population**
Hispanic/Latino	55.88%	40.91%
Gender Identity	**% of Population**	**% of Population**
Male	49.91%	49.73%
Female	50.09%	50.27%

Threshold Languages

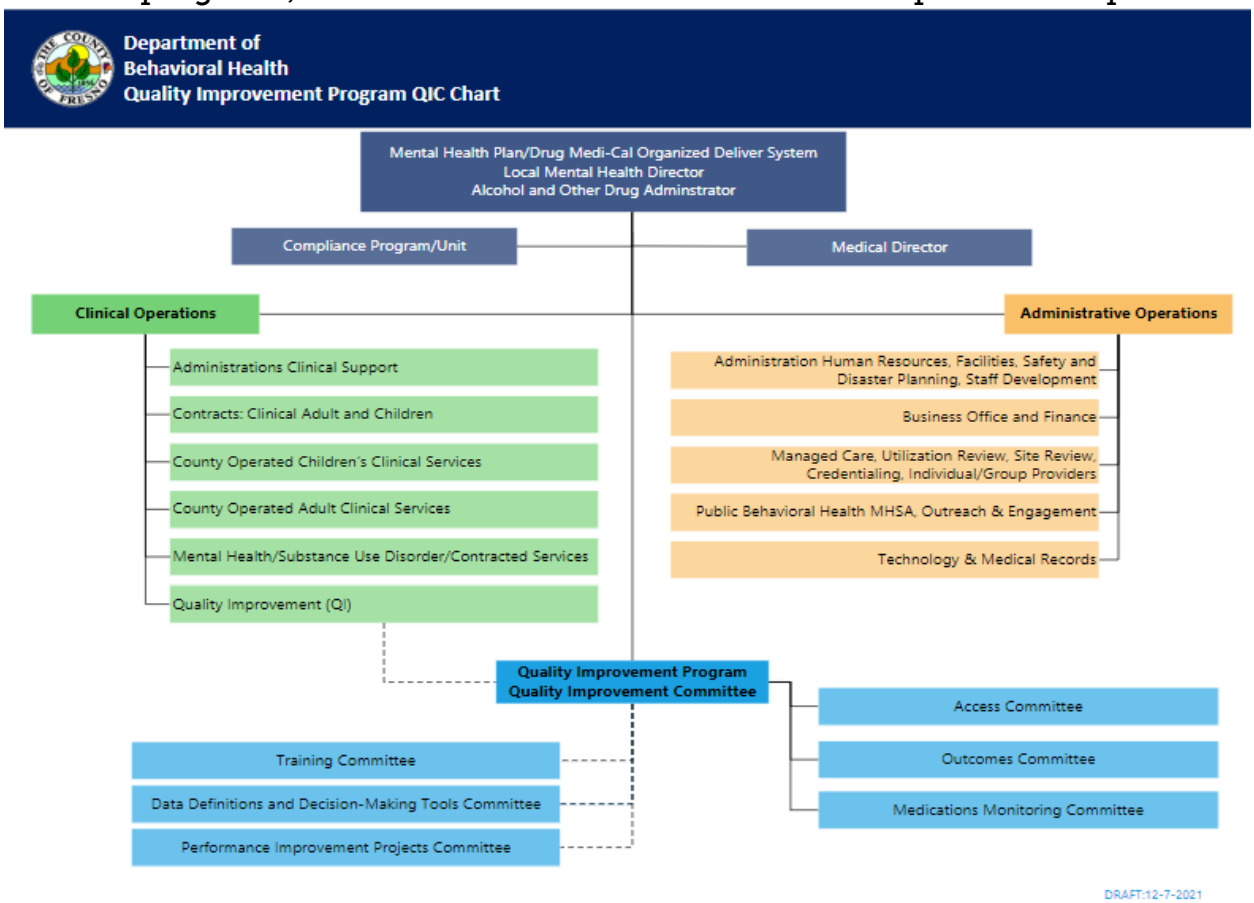
The threshold languages for Fresno County are English, Spanish, and Hmong. It is estimated that about 44.1% of the population of Fresno County speaks a language other than English at home. (United States Census Bureau, 2023)

DBH Quality Improvement Program

Fresno County DBH is dedicated to continuous quality improvement in all facets of care delivery and care support for both the MHP and DMC-ODS. The DBH Quality Improvement (QI) Team is responsible for developing a quality culture throughout the department by focusing on process improvement, data-driven decision making, and increased efficiency. A quality culture ensures that the responsibility of quality improvement does not reside solely with the QI professionals, but with every member of the DBH team.

Quality Improvement Team

The work of the QI Team is detailed in the annual Quality Improvement Work Plan. The QI Team is dedicated to ensuring that the County of Fresno DBH services are in compliance with the annual contract between DHCS and the department. Fresno County DBH contracts with numerous providers throughout the county to deliver a comprehensive array of mental health (MH) and substance use disorder (SUD) services at all levels of care and for all ages. Although they are not County of Fresno internal programs, DBH considers all its MHP and DMC-ODS providers as part of one



unified "family." The QI Team is committed to monitoring the performance of the entire system of care and providing programs with the tools they need to succeed in providing excellent care.

Management of the QI Team is the responsibility of the Quality Improvement Coordinator. The QI Coordinator position within DBH is required to be familiar with modern quality improvement practices outlined by the Certified Professional in Healthcare Quality (CPHQ) certification developed by the National Association of Healthcare Quality. The QI Coordinator reports directly to the Deputy Director of Clinical Operations in order to develop and maintain a significant relationship with the clinical programs throughout DBH.

Quality Performance Monitoring

To further align itself with State legislation and requirements, and to provide the best quality care to the people of Fresno County, DBH integrates quality management activities as outlined by the National Committee for Quality Assurance (NCQA). NCQA standards provide a backbone for current health legislation coming from the State of California and establish well-researched, thoroughly tested metrics and guidelines for the healthcare setting. Although not currently seeking accreditation, DBH is committed to achieving the quality standards outlined by NCQA.

Monitoring care performance is critical to ensuring that persons served are receiving the highest quality care achievable. Thus, the QI Team, in coordination with multiple DBH divisions, has developed multiple key performance categories throughout the system of care. These categories represent critical functions that contribute to the wellness and recovery of the individuals served. All performance metrics are developed to reaffirm DBH commitment to the Guiding Principles of Care Delivery. These categories are as follows:

- Access and Timeliness of Services
- Persons Served Satisfaction with Services
- Quality of Care for the Person Served
- Program Efficiency
- Care Coordination
- Employee Satisfaction, Health, and Wellbeing

Quality Improvement Work Plan

The Quality Improvement Work Plan (QIWP) outlines the structure, functions, and goals of quality improvement and quality management throughout DBH for both MHP

and DMC-ODS services. The QIWP meets all DHCS – DBH contract requirements, but also aligns with the high-quality standards outlined in the NCQA Managed Behavioral Health Organization accreditation guide. The QIWP will describe the QI structure in DBH, the QI Committee, the yearly activities and objectives, and the identification and monitoring of previous identified issues.

DBH strives to implement continuous quality improvement. As a result, the QIWP is a living document, with no "final" draft. At minimum, the QIWP is updated annually. If necessary, the QIWP can be updated at any time with QIC approval.

Quality Improvement Work Plan Evaluation

To evaluate the effectiveness of the QI activities described in the QIWP, DBH will produce a QIWP Evaluation. This document will identify the key quality performance metrics, the goals set on a yearly basis, and how DBH performed relative to those goals. In order to accurately describe DBH performance, the data will be presented with year-by-year comparisons. It is critical that data is presented in this format to ensure that the context of the performance is fully understood. The QIWP Evaluation will also track the completion of major quality improvement initiatives by indicating whether clearly defined target deadlines and milestones are met.

The QIWP Evaluation is developed with NCQA standards in mind and includes the following:

- Major Accomplishments
- Trended performance metrics
- Barriers encountered
- Recommended interventions
- Description of yearly activities and objectives
- Potential changes to program over the next year

Quality Improvement Committee

The QI program is responsible of establishing a Quality Improvement Committee (QIC). The QIC serves as the oversight body for all quality activities throughout DBH and is accountable to the DBH Director.

The QIC responsibilities are as follows:

- Serve as the oversight body for quality improvement activities.
- Oversee the QIC sub-committee activities.
- Planning, design, and execution of the quality improvement work.

- Review system data collection activities, grievance and complaint procedures, client outcomes, satisfaction, and other performance metrics.
- Provide input in development of an annual work plan to evaluate system objectives and activities and to address potential areas relating to quality improvement functions.
- As the need arises, recommend/designate the responsible party, workgroup, or ad hoc committee to execute the planned improvements.
- Monitor improvement activities.
- Monitor and evaluate the annual work plan's effectiveness.
- Assure quality improvement activities adhere to culturally responsive guidelines outlined by the cultural humility committee.

DBH ensures that all individuals participating in the QIC will not be subject to discrimination or any other penalty in their other relationships with DBH as a result of their role(s) in representing themselves and their constituencies. The QI Work Plan will provide the QIC and its subcommittees a roadmap to outline how the MHP/DMC-ODS will review the quality of specialty behavioral health services under its umbrella.

The structure of the QIC is designed to include participation from DBH staff, practitioners, service providers, beneficiaries and family members, legal guardians and people with lived experience accessing services from the MHP/DMC-ODS. QIC members and stakeholders provides input and suggested recommendation to the development and evaluation of the QIWP. The success of the QIC is critically dependent on the involvement of the Medical Director and the DBH Leadership team.

QIC Chair: Quality Improvement Coordinator

Meeting Frequency: Monthly

QIC Membership:

- Director
- Deputy Directors
- Medical Director
- Division Managers
- Quality Improvement
- Contracted Providers
- Program Managers
- Compliance Officer
- Managed Care
- Information Services
- Business Office
- Human Resources
- Staff Development
- Public Behavioral Health

QIC Subcommittees

The Quality Improvement Committee, is inclusive of QIC Subcommittees and are not limited to the following:

Subcommittee	Outcomes Committee
Composition	Chair: QI Senior Staff Analyst Members: Clinical Support, Quality Improvement, Contracts, Adult and Children's Services, IT, Contracted Provides by topic
Meeting Frequency	Monthly
Responsibilities	1. Provide a forum for inter-divisional discussion and analysis focusing on clinical and administrative outcomes 2. Review of program outcome reports 3. Identify improvement opportunities 4. Develop and implement new and improved outcomes measures 5. Report and make recommendations to QIC

Subcommittee	Training Committee
Composition	Chair: Training Coordinator Membership: Staff Development, other stakeholders
Meeting Frequency	At least quarterly
Responsibilities	The Training Committee is being renewed for FY2021-2022; Committee will include community agencies that are partners and allies in the areas of workforce development, education and training. In addition, the Committee currently has members from the Regional Workforce Investment Board, Fresno State (various departments), State Center Community College District (several departments), Fresno Pacific University (several departments), Contracted Service providers, Behavioral Health Board Members, DBH representatives, and Peer Support Staff/Family Members. The goal is to develop working projects to advance capacity building and target training and education to help achieve those and other goals, including reducing barriers to services, and building capacity within the existing workforce regarding core competencies.

Subcommittee	Performance Improvement Projects (PIPs) Committee
Composition	Chair: QI Senior Staff Analyst Membership: QI Coordinator, PIP project managers
Meeting Frequency	Monthly, as needed basis
Responsibilities	1. Provide Lead Project Management of PIPs 2. Provide technical support to monitor and track PIPs status 3. Mental Health PIPs Clinical/Non-Clinical 4. Substance Use Disorder PIPs Treatment/Non-Treatment

Subcommittee	Medication Monitoring Committee
Composition	Chair: QI Clinician Membership: Medical Director, Clinical Pharmacist, Psychiatrist, QI, Contracts, IT, Medical Records, Compliance, Nurse Manager
Meeting Frequency	Monthly
Responsibilities	1. Develop and Implement Medication Monitoring Tool(s) for reviewing medication prescribing and documentation practices 2. Review and analyze State Information Notices 3. SB 1291 – Foster Care, Implement Review Process 4. Review chart audits findings to identify trends in meeting Medi-Cal documentation standards 5. Review and monitor trends in audit findings

Subcommittee	Feedback and Improvement Groups
Composition	Chair: QI Clinicians Membership: QI Staff
Meeting Frequency	Monthly
Responsibilities	1. Implement monthly focus groups with persons served by mental health and substance use disorder programs 2. Solicit feedback from persons served about the quality, availability, and timeliness of services provided by DBH 3. Report feedback to QI team, QIC, and treatment programs

Subcommittee	Intensive Analysis (IAC)
Composition	Co-Chairs: QI Clinician, Compliance Officer Membership:
Meeting Frequency	Monthly
Responsibilities	1. Review incidents and identify those that require further review to determine possible cause

	2. Meet at least quarterly unless there are no incidents during the quarter. The IAC may meet more frequently, as needed 3. Make recommendations for changes in policy, procedure and practice 4. When necessary, the IAC may report personnel concerns to the appropriate Human Resources department; the IAC does not make or take disciplinary actions but obligated to share employee concerns. 5. Copies of Incident Reporting forms received and committee notes related to action items will be maintained by the IAC for 10 years.

DBH Quality Initiatives

Departmental Reorganization	
Objective	Reorganize the Department of Behavioral Health to meet needs of the Department and persons served
Goals	• Conceptualize the management of the work differently • Manage and balance workloads • Emphasize integration and care coordination • Maximize resources to create efficiency
Target Milestones	• 2023 – Establish divisions, assign Division Managers, draft concept • April 2024 – Finalize functions by division and org chart • July 1, 2024 - Reorganization complete

Lean Six Sigma Pilot Implementation	
Objective	Implement Lean Six Sigma principles and certification at all levels throughout the Department
Goals	• Certify 3 black belts and 12 green belts • Execute multiple successful Lean Six Sigma projects • Increase administrative and clinical efficiency • Reduce waste
Target Milestones	• Feb 2024 – begin Lean Six Sigma training for black and green belts • June 2024 – All twelve Department staff certified • June 2024 – Improvement project implemented and documented

Employee Engagement and Wellbeing Initiative	
Objective	To increase workplace engagement and improve wellness for all DBH employees
Goals	• Collect specific feedback from staff through focus groups • Conduct engagement surveys (Gallup, Great Place to Work) • Implement multiple improvement projects based on feedback
Target Milestones	• Summer 2023 – Non-Supervisory focus groups • Fall 2023 – Great Place to Work Survey (county-wide) • Fall/Winter 2023 – Supervisor focus groups • December/January 2024 – develop and report recommendations based on qualitative and quantitative data collected • January 2024 – Gallup engagement survey (DBH-specific) • May 2024 – LPI 360+ Survey pilot conducted • Spring 2024 multiple interventions implemented • Fall/Winter 2024/2025 – Remeasure engagement with Gallup and Great Place to Work Surveys

Key Performance Metrics

DBH uses data to assess performance and drive key decision-making. As a result, DBH has developed, and continues to develop, a suite of metrics that allow for performance monitoring and evaluation. The following section describes the key performance metrics utilized by DBH.

Mental Health

Mental Health

Access

Timeliness to First Offered/Kept Assessment for Non-Urgent Requests	
Metric	Individuals who request non-urgent SMHS services will be offered an appointment that occurs within 10 business days of the initial request. Individuals who request non-urgent SMHS services will receive a first service within 10 business days.
Goal	First Offered Assessment – 80% Kept Assessments – 80%

Timeliness to Kept Assessment for Urgent Requests	
Metric	Individuals who request urgent SMHS services will receive a first service within 48 hours.
Goal	Kept Assessments – 70%

Timeliness to First Offered/Kept Appointment for Psychiatric Services	
Metric	Individuals who request non-urgent psychiatry services will be offered an appointment that occurs within 15 business days of the initial request. Individuals who request non-urgent psychiatry services will receive an appointment within 15 business days.
Goal	Offered Psychiatric Assessment – 70% Kept Psychiatric Assessment – 70%

Enrollment by Service Line	
Metric	The total number of persons served enrolled in the product line, stratified by age.
Goal	N/A

Racial/Ethnic and Language Diversity of Membership	
Metric	An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Goal	N/A

Appointments Resulting in a No-Show or Cancellation	
Metric	The percentage of appointments for persons served that resulted in a no show or cancellation. No Show: an individual not attending a scheduled appointment Cancellation: an individual notifying DBH that they will not attend their appointment within 24 hours of the appointment
Goal	No Shows/Cancellations – below 20%

Access Line Test Calls	
Metric	The percentage of test calls that are recorded 100% accurately in the Access Line Call Log
Goal	Accuracy – 100%

Quality of Care

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
Metric	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Goal	First-Line Treatment Documented – 63%

Depression Screening and Follow-up for Adolescents and Adults	
Metric	• *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Goal	In Development

Social Need Screening and Intervention	
Metric	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Goal	In Development

Antidepressant Medication Management	
Metric	• The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • The percentage of members who remained on antidepressant medication for at least 180 days (26 weeks)
Goal	Acute - 55% Chronic – 32%

Readmission to Psychiatric Hospital Facilities (PHF)	
Metric	The percentage of individuals who are readmitted to PHFs within 7 and 30 days of discharge.
Goal	7-day readmission – <30% 30-day readmission – <20%

Person Served Satisfaction

Consumer Perception Survey (CPS)	
Metric	The percentage of persons served who received a service during the survey period who completed the survey
Goal	40% of individuals will complete the survey

Cultural Humility Survey	
Metric	The percentage of persons served who received a service during the survey period who completed the survey
Goal	40% of individuals will complete the survey

Feedback and Improvement Groups (FIG)	
Metric	The average number of persons served that attend the FIG focus groups.
Goal	Average of 4 or more individuals

Efficiency

Claims Denied	
Metric	The percentage of DBH claims denied for Med-Cal billable services.
Goal	< 2% of total claims

Care Coordination

Follow-Up After Hospitalization for Mental Illness	
Metric	• The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within 7 days after discharge.
Goal	• 30 days - 90% • 7 days - 70%

Follow-Up After Emergency Department Visit for Mental Illness	
Metric	• The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Goal	• 30 days - 90% • 7 days - 70%

Employee Satisfaction and Experience

Gallup Employee Engagement Survey	
Metric	DBH will provide the Gallup Employee Engagement Survey to its staff.
Goal	70% completion rate

Lived Experience Survey	
Metric	DBH will provide a lived experience survey to employees to determine the percentage of individuals who have direct or indirect MH lived experience.
Goal	66% completion rate

Employee Cultural Humility Survey	
Metric	DBH will provide a cultural humility survey to its employees in order to gain a greater understanding of the diversity of experience and culture in the workplace
Goal	50% completion rate

Substance Use Disorder

Access

Initiation and Engagement of Substance Use Disorder Treatment	
Metric	• *Initiation of SUD Treatment*. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • *Engagement of SUD Treatment*. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Goal	Initiation – 25% Engagement – 12%

Timeliness to Non-Urgent Services	
Metric	Individuals who request non-urgent SUD services will be offered an appointment that occurs within 10 days of the initial request. Individuals who request non-urgent SUD services will receive a service within 10 business days.
Goal	First Offered Service – 90% Kept Service – 90%

First Offered Non-Urgent Narcotic/Opioid Treatment Program	
Metric	Individuals who request non-urgent NTP/OTP services will be offered an appointment that occurs within 3 business days of the initial request.
Goal	First Offered Service – 90%

Timeliness to Urgent Service	
Metric	Individuals who request urgent SUD services will receive a service within 48 hours.
Goal	Kept Service – 90%

No-Show/Cancellation	
Metric	The percentage of appointments for persons served that resulted in a no show or cancellation. No Show: an individual not attending a scheduled appointment Cancellation: an individual notifying DBH that they will not attend their appointment within 24 hours of the appointment
Goal	No Shows/Cancellations – below 20%

Access Line Test Calls	
Metric	The percentage of test calls that are recorded 100% accurately in the Access Line Call Log
Goal	Accuracy – 100%

Racial/Ethnic and Language Diversity of Membership	
Metric	An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Goal	N/A

Enrollment by Service Line	
Metric	The total number of persons served enrolled in the product line, stratified by age.
Goal	N/A

Quality of Care

Readmission to Withdrawal Management	
Metric	The percentages of persons served who return to Withdrawal Management services within 30 days of discharge.
Goal	Readmission rate - below 20%

Diagnosed Substance Use Disorder	
Metric	The percentage of members 13 years of age and older who were diagnosed with a substance use disorder during the measurement year. Four rates are reported: 1. The percentage of members diagnosed with an alcohol disorder. 2. The percentage of members diagnosed with an opioid disorder. 3. The percentage of members diagnosed with a disorder for other or unspecified drugs. 4. The percentage of members diagnosed with any substance use disorder.
Goal	*N/A*

Social Need Screening and Intervention	
Metric	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive
Goal	100% of persons served will be screened

Pharmacotherapy for Opioid Use Disorder	
Metric	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
Goal	28% of OUD pharmacotherapy events will last at least 180 days.

Person Served Satisfaction

Treatment Perception Survey (TPS)	
Metric	The percentage of persons served who received a service during the survey period who completed the survey
Goal	40%

Cultural Humility Survey	
Metric	The percentage of persons served who received a service during the survey period who completed the survey
Goal	40%

Feedback and Improvement Groups (FIG)	
Metric	The average number of persons served that attend the FIG focus groups.
Goal	Average of 4 or more individuals

Efficiency

Claims Denied	
Metric	The percentage of DBH claims denied for Med-Cal billable services.
Goal	< 2% of total claims

Care Coordination

Follow-Up After High-Intensity Care for Substance Use Disorder (Acute inpatient hospitalization, residential treatment, or withdrawal management)

Metric	• The percentage of visits or discharges for which the member received follow-up for SUD within the 30 days after the visit or discharge. • The percentage of visits or discharges for which the member received follow-up for SUD within the 7 days after the visit or discharge.
Goal	• 30 Days – 35% • 7 Days – 30%

Follow-Up after Emergency Department Visit for Substance Use	
Metric	• The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Goal	• 30 Days – 34% • 7 Days – 30%

Employee Satisfaction and Experience

Gallup Employee Engagement Survey	
Metric	DBH will provide the Gallup Employee Engagement Survey to its staff.
Goal	70% completion rate

Lived Experience Survey	
Metric	DBH will provide a lived experience survey to employees to determine the percentage of individuals who have direct or indirect MH lived experience.
Goal	66% completion rate

Employee Cultural Humility Survey	
Metric	DBH will provide a cultural humility survey to its employees in order to gain a greater understanding of the diversity of experience and culture in the workplace
Goal	66% completion rate