Fresno County

Department of Behavioral Health

Where Hope & Healing Unite

Fiscal Year 2022/2023
Quality Improvement Work Plan
(QIWP)

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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 behavioral health services to promote wellness, recovery, and resiliency for individuals and families in our community.

Quadruple Aim

At Fresno County DBH, 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: program design and implementation, service delivery, workforce training, resources allocation and performance measurement.

- 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 Decisions
- 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 2021-2031, which provides in part a vision for creating and implementing the Quality Management Program. As shown below, the Strategic Plan goals are: (1) Deliver quality care, (2) Leverage resources, (3) Promote organizational excellence, and (4) Provide an excellent care experience. The development, design, and implementation incorporate DBH's strategic plan goals. The strategic plan can be found here: Strategic Plan

Diversity, Equity, and Inclusion

DBH is committed to providing 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 are appropriate for the person served and that employees feel of all backgrounds respected and safe at the workplace. The DBH Culturally Responsive Plan guides every aspect of DBH services, and as a place of employment.

County Profile

Demographics

Fresno County has a population of 1,008,654, with an estimated 307,906 households (United States Census Bureau, 2020). The average household in Fresno County has a median income of $53,969, with a per capita income of $24,422 (United States Census Bureau, 2019); 20.6% of the population was born outside of the United States and 4.9% of the eligible population are military veterans (United States Census Bureau, 2019).

Table 1 shows information from the 2021 Healthy Fresno County Data website on age, race/ethnicity, and gender of the general population. Fresno County differs in some key areas from the California population. The Hispanic/Latinx population is 15% points higher in Fresno County than in the State, and the Fresno County population is slightly younger (Fresno County Health Improvement Partnership, 2021).

Although 5% points lower than the California percentage (Fresno County Health Improvement Partnership, 2021), the Fresno County Asian population is unique due to the high percentage of Hmong individuals. Fresno County has the second largest Hmong community in the United States. In the Hmong population in the United States, 44% of individuals live with poverty, the highest among race/ethnic groups (PRRI, 2019).

Table 1

Fresno County Residents by Gender, Age and Race/Ethnicity

Demographics	Fresno County	California
Total Population	1,012,748	39,740,046
Age	% of Population	% of
0 - 14 years	23.46%	18.62%
15 - 24 years	14.54%	13.18%
25 - 64 years	49.14%	52.97%
65+ years	12.86%	15.23%
Race	% of Population	% of
African American/ Black	4.97%	5.80%
American Indian/Alaskan Native	1.70%	0.98%
Asian	10.40%	15.17%
Native Hawaiian/Pacific Islander	0.17%	0.40%
Caucasian/ White	52.04%	53.91%
Other/Not Reported	25.64%	18.25%
2+ Races	5.08%	5.48%
Ethnicity	% of	% of
Hispanic/Latinx *	55.37%	40.57%
Gender Identity*	% of Population	% of
Male	49.9%	49.7%
Female	50.1%	50.3%

*Gender Identity categories reflect the options presented by the US Census results summary.

Threshold Languages

Fresno County's threshold languages are English, Spanish, and Hmong. It is estimated that about 45% of the population of Fresno County speaks a language other than English at home, with 19.4% of the population speaking English "less than very well" (United States Census Bureau, 2019).

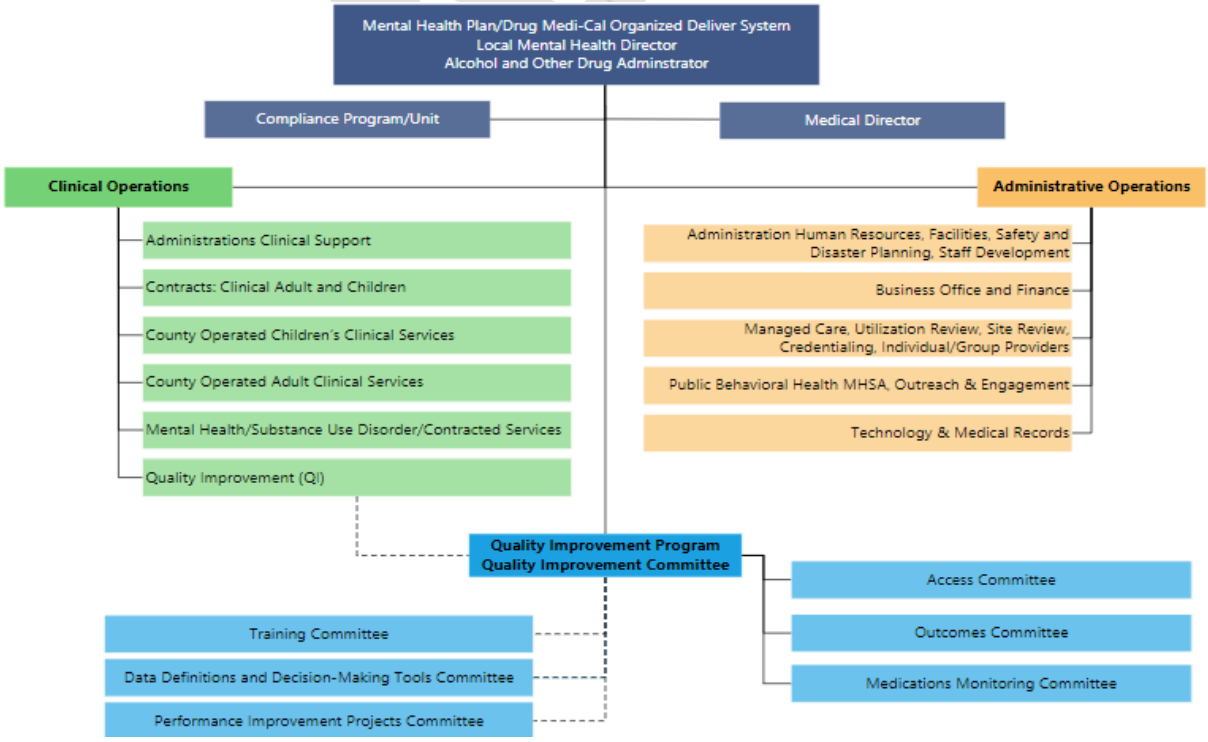
DBH Quality Improvement Program

Fresno County DBH is dedicated to continuous quality improvement in all facets of care delivery and support for the MHP and DMC-ODS. The DBH Quality Improvement (QI) Team is responsible for developing a quality culture throughout the DBH system of care 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 QI professionals, but with every member of the DBH team.

Quality Improvement Team

The QI Team is dedicated to ensuring that all services are in compliance with its annual DHCS contract. Fresno County DBH contracts with numerous programs throughout the county to deliver a comprehensive array of mental health and substance use disorder 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.

The QI Team is managed by the Quality Improvement Coordinator. The QI Coordinator 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 to the Deputy Director of Clinical Operations in order to develop and



maintain a significant relationship with 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, the QI Team and DBH quality management performs 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
- Satisfaction of Persons Served
- 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 previously 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, annual goals, 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:

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

Quality Improvement Committee

The QI program is responsible for establishing a Quality Improvement Committee (QIC), the oversight body for all quality activities in DBH. It is accountable to the DBH Director.

The QIC responsibilities are:

- Serve as the oversight body for quality improvement activities
- Oversee the QIC subcommittee activities
- Planning, design, and execution of 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 needed, 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 DEI 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 QIWP 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 QIC is designed to include participation from DBH staff, practitioners, service providers, beneficiaries, legal guardians, family members, and people with lived experience accessing services from the MHP/DMC-ODS. QIC members and stakeholders provide 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

QIC Subcommittees

The QIC is inclusive of QIC subcommittees and are not limited to the following:

Subcommittee	Access Committee
Composition	Chair: QI Analyst Membership: Staff with access related responsibilities, QI, IT, Contracts, Adult and Children's Services, contracted providers
Meeting Frequency	Monthly
Responsibilities	1. Serve as the oversight body for access to care process 2. Review data regarding access to care 3. Develop new and improved access measures 4. Identify areas of improvement 5. Report and make recommendations to the QIC

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 the QIC

Subcommittee	Training Committee
Composition	Chair: Training Coordinator Membership: Staff Development; community partners in workforce development, education and training; other stakeholders
Meeting Frequency	Monthly
Responsibilities	The Committee partners with several agencies 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. It has members from the Regional Workforce Investment Board, Fresno State, State Center Community College District, Fresno Pacific University, contracted service providers, Behavioral Health Board Members, DBH representatives, and Peer Support Staff/Family Members.

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) to review 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	At least quarterly, unless there are no incidents during the quarter
Responsibilities	1. Review incidents and identify those that require further review to determine possible cause 2. Recommend changes in policy, procedure and practice 3. When necessary, report personnel concerns to the appropriate Human Resources department; the IAC does not make or take disciplinary actions but obligated to share employee concerns 4. Confidentially maintain Incident Reporting forms received and committee notes related to action items for 10 years

Quality Improvement Activities

Performance Metric Development	
Objective	DBH is dedicated to data-driven decision making and continuously improving outcomes for individuals receiving services. In order to accomplish this, the QI team developing a comprehensive suite of performance metrics for system monitoring, program evaluation, and outcomes improvement.
Goals	• Develop comprehensive performance metrics related to access, timeliness, recovery, satisfaction, care coordination, program efficiency, clinical effectiveness, and medication monitoring • Develop data visualization dashboards for distribution to treatment providers and programs • Develop a consistent flow of data to and from treatment providers • Develop a greater understanding of the relationship between program expenditures and clinical outcomes • Create a system of program evaluation that allows for "apples-to-apples" comparison. • Implement HEDIS metrics
Target Milestones	• 7/1/2022 Begin development a data collection gap analysis • 10/1/2022 – Begin planning for new EHR (see CalMHSA multi-county EHR initiative activity) data collection strategies. • 2/1/2023 Complete development of data collection strategy for new HER • 6/30/2023 Prepare data visualization software for new measures
Membership	Project Manager: QI Coordinator • Clinical Leadership • Quality Improvement • Business Office • Information Services Division • Managed Care • Contracts Division

Emergency Department (ED) Care Coordination	
Objective	Create and implement a system for local EDs to identify and refer individuals who qualify for DBH services to the appropriate entry program.
Goals	• Create a system utilizing the 24/7 Access Line that allows EDs to determine individuals who may already be receiving services with DBH, as well as individuals in need of an initial referral to DBH services • Develop a referral process for individuals in the ED who are making an initial request for MH and/or SUD DBH services • Develop a tracking mechanism for referrals coming to DBH from local EDs

Target Milestones	• 8/01/2022 – complete first year of intervention. Analyze results. Determine need for additional interventions
Membership	Project Manager: QI Coordinator • Local ED representatives • DBH access point clinical supervisors (HIOP, UCWC) • Division Managers • 24/7 Access Line provider

Level of Care Development and Implementation	
Objective	DBH has developed a framework and implementation plan for Levels of Care throughout the MHP. These levels of care will allow for program planning, evaluation, and clarity of purpose. DBH will train staff to understand the principles of the Levels of Care and how they will apply to treatment.
Goals	• Develop and implement Levels of Care for Fresno County DBH Mental Health Plan in order to gain a full understanding of all treatment programs place in the system • Create apples-to-apples comparisons for data analysis purposes.
Target Milestones	• 8/1/2022 – develop Levels of Care and education material (complete) • 11/1/2022 – implementation into clinical workflow
Membership	

Multi-County EHR Implementation	
Objective	DBH has joined the CalMHSA multi-county EHR initiative and will continuously prepare its administrative and technical staff for implementation on July 1, 2023.
Goals	• Attend CalMHSA trainings and how-to's • Assist with implementation
Target Milestones	• 10/2022 – attend CalMHSA Training • 7/1/2023 – EHR Go-Live • Beyond 7/1/2023 – test, train, troubleshoot, utilize, refine
Membership	Membership from all DBH Divisions

Monitor Pharmacotherapy for Opioid Use Disorder (OUD)	
Objective	As a part of CalAIM implementation DBH will, under the authority of its medical director, develop a medication monitoring process for adults who have been receiving pharmacotherapy for Opioid Use Disorder for over 180 days.
Goals	• Develop monitoring dashboard for pharmacotherapy for OUD • Establish a baseline performance for DBH • Identify areas of improvement
Target Milestones	9/1/2022 – Develop performance monitoring dashboard (complete) 10/1/2022 – Establish baseline (complete)

	12/31/2022 – Incorporate into consistent monitoring practice and discussion with providers.
Membership	• QI Sr. Substance Abuse Specialist • Medication Monitoring Committee members

SUD Outpatient Orientation Before Residential Discharge Pilot	
Objective	When a person served is approaching discharge from SUD residential treatment, they will receive an orientation from the outpatient program that they are being referred to in order to increase the likelihood that the person served will successfully transition to the next level of care.
Goals	• Develop an early orientation process • Establish the outpatient provider - person served treatment bond before residential discharge • Increase the percentage of individuals who successfully transition to the outpatient level of care. • Increase the timeliness with which an individual enters outpatient services following discharge
Target Milestones	• 4/1/2022 Begin pilot (complete) • 10/1/2022 – expand the number of participating residential programs
Membership	• Residential providers • Quality Improvement Staff • DBH Contracts Staff

Clinical Feedback Initiative	
Objective	The QI team will solicit feedback from clinical staff in order to determine possible areas of improvement clinically and organizationally.
Goals	• Create a feedback loop with DBH staff to ensure that all voices are heard • Create an ongoing process that can be repeated at yearly or bi-yearly intervals.
Target Milestones	Year 1 – • Collect feedback. • Categorize similar responses • Develop action plans for improvement work • Develop repeatable processes. Year 2 – • Implement improvements • Refine processes • Plan next cycle
Membership	Quality Improvement Team

Zero Suicide Initiative	
Objective	Explore the possibility of implementing Zero Suicide principles into the DBH organization
Goals	• Implement evidence-based suicide prevention actions based on Zero Suicide principles and guidelines. • Adjust organizational culture to a Zero Suicide approach
Target Milestones	12/31/2022 – Determine DBH capability to implement Zero Suicide methodology 3/1/2023 – Develop implementation plan for selected Zero Suicide activities 2024 – Selected activities fully implemented.
Membership	Quality Improvement Staff Public Behavioral Health Division Staff Various Cross-Divisional Staff

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. The QIWP Evaluation (LINK HERE) outlines DBH performance over the previous two fiscal years.

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 an assessment within 10 business days.
Goal	First Offered Assessment – 90% Kept Assessments – 90%

Timeliness to Kept Assessment for Urgent Requests	
Metric	Individuals who request urgent SMHS services will receive an assessment within 48 hours.
Goal	Kept Assessments – 90%

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	Kept Psychiatric Assessment – 90%

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	

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	Develop Analysis Methodology and Establish Baseline

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	• 100% screened • 90% of individuals receive a timely follow-up

Utilization of the PHQ-9 to monitor Depression Symptoms for Adolescents and Adults	
Metric	The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.
Goal	90% will have an outpatient encounter with the PHQ-9 score present in their record in the same assessment period as the encounter.

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

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 (6 weeks)
Goal	Develop data collection capabilities. Establish baseline

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-day readmission – 20%

Person Served Satisfaction

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

Cultural Humility Survey	
Metric	The percentage of person's 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	Below 2% of claims denied

Direct Service Productivity	
Metric	The percent of the workday that treatment providers are providing direct service to persons served.
Goal	LPHAs will engage with persons served for more than 50% of their total work hours.

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	66% 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 it's employees in order to gain a greater understanding of the diversity of experience and culture in the workplace
Goal	66% 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	Develop Data Analysis Methodology and Establish Baseline

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	30% of OUD pharmacotherapy events will last at least 180 days.

Person Served Satisfaction

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

Cultural Humility Survey	
Metric	The percentage of person's 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	Below 2% of claims denied

Direct Services Productivity	
Metric	The percent of the workday that treatment providers are providing direct service to persons served.
Goal	LPHAs will engage with persons served for more than 50% of their total work hours.

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 substance use disorder within the 30 days after the visit or discharge. • The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.
Goal	• 30 Days – 90% • 7 Days – 70%

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 – 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	66% 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 it's employees in order to gain a greater understanding of the diversity of experience and culture in the workplace
Goal	66% completion rate