sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN

FISCAL YEAR 2025-2026

ADOPTED ON: 8/1/2025

The Quality Improvement Plan is a required element of the Quality Assessment and Performance Improvement (QAPI) Program, as specified by DHCS MHP contract, Exhibit A Attachment 5 (relevant section: 2G), DMC-ODS contract Exhibit A, Attachment 1 (relevant section III. SS 5.), Cal. Code Regs., Tit. 9, § 1810.440(a)(5), and 42 C.F.R. § 438.416(a).

PURPOSE AND INTRODUCTION

Sonoma County Department of Health, Behavioral Health Division (DHS-BHD) is committed to a culture of continuous quality improvement, in support of our goal to offer high quality behavioral healthcare services to Sonoma County beneficiaries. The Quality Assessment and Performance Improvement (QAPI) program, within DHS-BHD, serves as the unifying structure for quality improvement and quality assurance across the behavioral health system. The operation of the QI program and QAPI workplan is overseen and involves substantial involvement by a licensed mental health professional. **The purpose of the QAPI Work Plan is to promote continuous improvement in the quality of specialty mental health and substance use disorder services provided by DHS-BHD**. Through the QAPI Work Plan, DHS-BHD will implement quality improvement activities that:

- Ensure service delivery is consumer-focused, clinically appropriate, cost effective, data-driven, and culturally responsive;
- Increase the capacity of DHS-BHD leadership and QAPI staff to track key indicators addressing beneficiary outcomes, program development, and system change;
- Support decision-making based on performance improvement measures; and
- Increase quality of beneficiary services across the Behavioral Health Plan.

MISSION, VISION, AND VALUES

The mission of the Department of Health Services, Behavioral Health Division (DHS-BHD) is to promote recovery and wellness to Sonoma County residents.

DHS-BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or a substance use disorder to live a meaningful life in a community of their choosing, while striving to achieve their full potential. The principles of a recovery-focused system include: *

- Self-Direction
- Individualized and Person-Centered Care
- Empowerment and Shared Decision-Making
- Holistic Approach that Encompasses Mind, Body, Spirit, and Community
- Strengths-Based
- Peer Support
- Focus on Respect, Responsibility, and Hope.

DHS-BHD fosters a collaborative approach by partnering with clients, family members, and the community to provide high quality, culturally responsive services. ***Services are provided in all languages.*** DHS-BHD directly administers behavioral health treatment services to Sonoma County residents whose behavioral health needs are determined to be medically necessary as defined by CCR Title 9 and W&I Code 5600.

**adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)*

ALIGNMENT WITH OTHER ORGANIZATIONAL PLANS

DHS-BHD QAPI Work Plan objectives and activities align with and support the Sonoma County Department of Health Services (DHS) Strategic Plan in the following ways:

DHS Strategic Plan Goal 1: All residents and community environments are healthy and safe	
DHS Objective and Strategy: Improve quality of life outcomes by advancing cross-sector partnerships, networks, collaboration, and community engagement to improve community and individual determinants of health	**QAPI Work Plan Alignment:** The Quality Improvement Committee (QIC) is comprised of DHS-BHD Leadership, Staff, Community Providers, Clients, and Family Members of Clients; this cross-sector team collaborates to improve community and individual determinants of behavioral health.
DHS Strategic Plan Goal 2: Individuals, families, and communities access high quality and coordinated services for health, recovery, well-being, and self-sufficiency	
DHS Objective and Strategy: Increase access to safety net services by strengthening coordination of services with emphasis on high-need residents	**QAPI Work Plan Alignment:** Objective 1 of the workplan addresses improving access to and accessibility of behavioral health services; objective 6 is designed to integrate mental health and substance use disorder services.
DHS Strategic Plan Goal 3: The Department of Health Services is a high achieving, high functioning organization	
DHS Objective and Strategy: Build a highly competent, effective, and engaged workforce by improving communication and collaboration	**QAPI Work Plan Alignment:** Objective 4 addresses improving communications and processes within the system of behavioral health care and Objective 5 addresses maintaining workforce that is empowered to provide quality care.

More information on the DHS Strategic Plan can be found at this link:
https://healthstrategicplan.sonomacounty.ca.gov/

DHS-BHD QAPI Work Plan objectives and activities align with and support the Sonoma County Department of Health Services (DHS) 2024-25 Community Health Assessment (CHA) and Improvement Plan (CHIP) in the following ways:

DESIRED OUTCOMES	STRATEGIES	INDICATORS	Workplan Alignment
4.1. The DHS Behavioral Health division is fully staffed	• Use strategies such as job fairs, outreach to schools/ colleges, recruitment postings, and hiring bonuses as strategies to attract qualified staff reflecting the communities which DHS serves. • Utilize best practices (e.g., flexible healthy work life balance, employee recognition, competitive salary/ benefits, and training and career advancement opportunities) to reduce staff stress and turnover. • Seek funding to hire culturally and linguistically responsive peer support specialists to expand mental health support services	• By 2026, reduce staff vacancy rate by half (from 27% to 14%).	Objective 5 addresses building and sustaining a sufficient, trained, and empowered workforce by maintaining vacancy rates at or below 9%, strengthening staff retention, and expanding peer support services.

4.2. Service gaps in the behavioral health landscape are identified through data analysis and community engagement	• Assess trends in the number, demographics, and wait-times of people arriving at emergency departments with psychiatric needs. • Conduct a transitional recovery analysis of individuals who are conserved to inform preventative and recovery services needed. • Monitor internal behavioral health quality improvement metrics to inform staffing and programming needs. • Learn from continuous feedback shared in community forums (e.g., MHSA workgroups), the 2024 evaluation around community needs and assets, and bidirectional communication through mechanisms such as Community Health Worker engagement.	• By 2026, data and community input are used to inform resource planning for mental health and substance use.	Objective 1 aims to use data on enrollment, wait times, and service capacity to identify and address gaps in the behavioral health system. Monitoring demand and client flow ensures that network capacity planning reflects both community needs and internal performance trends. Objective 4 addresses hospital follow-up, transitions of care, and readmission trends to strengthen continuity of care. This ensures that identified service gaps are tied directly to improvements in follow-up, discharge planning, and coordination across service settings.
4.3. Prevention, maintenance, and harm reduction services are prioritized to reduce drug overdose deaths, infectious disease transmission, and the need for crisis-oriented care	• Support youth mental health and substance use prevention through programs such as the Behavioral Health School Partnership. • Increase availability of naloxone (“Narcan”) in County facilities. • Train and provide naloxone to all DHS field staff. • Help train community-based organizations and schools to administer naloxone to prevent drug overdose deaths and encourage all pharmacies to distribute naloxone.	• By 2026, the rate of deaths of despair in Sonoma County will decrease as compared to baseline.	Objective 5 aims to increase peer services and Objective 6 aims to improve coordination of care for SUD services for individuals with co-occurring needs to connect more clients to SUD programs.

	• Promote awareness of and participation in syringe services and medications take-back programming. • Implement Drug MediCal Organized Delivery System (DMC-ODS) plan to support a robust continuum of services. Expand mental health preventative and maintenance-oriented outpatient services including certified peer support specialists, group-based therapy, and telehealth options.		
4.4. Substance use treatment and treatment/housing options for individuals with co-occurring needs are expanded	• Expand residential and outpatient youth and adult substance use disorder and co-occurring treatment options through funds such as Measure O, BHCIP Round 5, and implementation of DMC-ODS plan. • Implement interim housing through Behavioral Health Bridge Housing (BHBH) grant for adults experiencing both serious mental health challenges and homelessness. • In collaboration with area service providers, the DHS Homelessness Services Division will identify the approximate number of homeless clients in Sonoma County who have severe needs above the level of care that Permanent Supportive Housing (PSH) can provide and describe and quantify the need to area decision makers. • Seek funds and/or partnership opportunities to expand treatment facilities qualified to treat patients with co-occurring needs (substance use [methamphetamine, opioids, alcohol, etc.], mental health, neurodiversity, homelessness, medical needs). • Support network of providers to increase flexible housing and treatment options to serve clients with co-occurring needs.	• By 2026, the Bridge Housing location(s) serving unhoused adults experiencing serious mental health challenges will be delivering services. • By 2026, at least two additional service agencies will be providing substance use and co-occurring treatment for Sonoma County community members.	Objective 6 aims to improve coordination of care for SUD services for individuals with co-occurring needs.

More information on the plan can be found at this link: [Sonoma County Community Health and Assessment Plan 2023]

Cultural Responsiveness is critical to promoting equity, reducing health disparities, and improving access to high-quality behavioral health services that are delivered in a manner which is respectful of and responsive to the needs of diverse clients. In support of this value, the QI Plan aligns with the Cultural Competence Plan by monitoring client satisfaction survey results pertaining to cultural responsiveness of staff, which then inform improvement goals for the service system. The QI Team analyzes and disseminates these results to Division Leadership, the Ethnic Services, Inclusion & Training Coordinator, and the Quality Improvement Committee to assist in identifying disparities and developing strategies toward cultural responsiveness.

DHS-BHD QUALITY IMPROVEMENT PROGRAM

Quality is an organization-wide commitment in which all members of the system play a vital role. The Quality Improvement team within QAPI delineates the structure and methods used to monitor and evaluate quality improvement. A division-wide array of teams and committees exist in partnership with QI, and provide overall structure for quality management as well as oversight responsibilities of DHS-BHD. To accomplish objectives of the QI workplan, QI collaborates closely with Responsible Partners within several organizational units and committees, including:

- Division Management Team (DMT)
- Quality Assessment & Performance Improvement Section (QAPI)
- Quality Improvement Unit within QAPI Section
- Quality Improvement Committee (QIC) and various QIC workgroups
- Behavioral Health Plan Administration (BHPA)
- Sentinel Events Committee
- Credentialing Committee
- Quality Improvement Project Workgroups

QUALITY IMPROVEMENT PROCESS

The QI Unit utilizes a variety of tools and resources to assess system performance issues and plan quality interventions and projects. The over-arching process utilized is the Plan-Do-Study-Act (PSDA) Model for Quality Improvement.

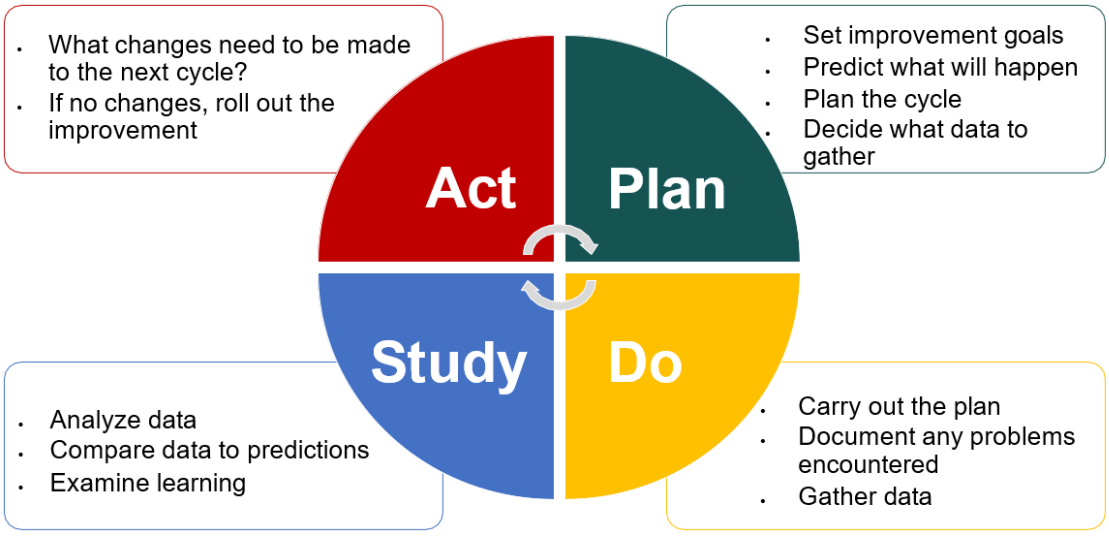
PLAN-DO-STUDY-ACT MODEL FOR QUALITY IMPROVEMENT

Plan: Investigate the current situation, fully understand the nature of any problem to be solved, and develop potential solutions to the problem.

Do: Implement the action plan on a test basis.

Study: Compare data results of the new process with those of the previous one.

Act: Decide, based upon the data, whether to adopt the new process, make slight changes to the process, or to abandon the process and start over. For decisions to adopt or adapt the improvement process, monitor the gains going forward. For decisions to abandon the process, determine a new course.



QAPI WORK PLAN CHANGES FOR FISCAL YEAR 2025-26

The Fiscal Year (FY) 2025-26 QAPI Work Plan will include the following structural changes from previous work plans, based on discussion and consensus from Quality Improvement Committee (QIC) members during the April and May 2025 meetings.

Quality Improvement objectives were restructured to multiple measures as part of a Results Based Accountability (RBA) framework that looks help answer: How much did we do? How well did we do it? and is anyone better off? Some objectives that were not met in the last work plan evaluation and not carried over as objectives in this work plan will continue to be worked on as Performance Monitoring Activities within the QAPI work plan, or within other plans that are in alignment with the QAPI Work Plan. These changes are described in the status list below that includes the objectives from the FY 2024-25 work plan.

1. For Medi-Cal beneficiaries with Emergency Department (ED) visits for mental health conditions, increase the percentage of follow-up mental health service connections from 53% to 58% within 7 days, and from 66% to 71% in 30 days (FUM).

   For Medi-Cal beneficiaries with ED visits for substance use disorder increase the percentage of follow-up SUD services to 11% within 7 days, 14% within 30 days (FUA).

   (Non-Clinical PIP)

   a. Objective Partially Met
   b. 2% year-over-year improvement was seen, but rates dropped due to data sources and definition changes.
   c. No data available for FUA.
   d. FUM carried over to FY 2025-26 QAPI Workplan.

2. Decrease the wait time for new/post-crisis services to an average of 10 business days.

   a. Objective Met
   b. This objective will be carried over to FY 2025-26 QAPI Workplan with adjustments to the measure definition.

3. Reduce High-Cost Beneficiary (HCB) count by 10% and HCB utilization of CSU by 20% over a 2-year period; Reduce HCB average actionable ANSA scores items by 15%.

   a. Objective Partially Met
   b. Unable to measure this objective due to transition to SmartCare.
   c. Clinical PIP has been shifted to FUM for 2025-2027 as directed by DHCS.
   d. ANSA scores and acute service utilization measures are present in other objectives for FY 2025-26 QAPI Workplan.

4. Improve communications and processes for clinical care coordination through the implementation of a care coordination policy and workflow.

   a. Objective Met
   b. Policies and procedures were put in place to standardize coordination processes. Data infrastructure developed to actively monitor measures, including timeless for new clients and program enrollment times.
   c. Coordination of care monitoring measures added to FY 2025-26 QAPI Workplan.

5. Expand/integrate Substance Use Disorder Services to meet all SUD DMC-ODS service requirements for FY 2025-26.

   a. Objective Partially Met
   b. Contracts executed to cover essential services and increase capacity within Santa Rosa, but state-wide shortages of Youth SUD services remain.
   c. Efforts to meet this objective will continue but will not be tracked in this workplan.

6. Decrease vacancy rate for BH county workforce, both County and CBOs:
   - Decrease BH workforce vacancy rate from 19% to less than 15%.
   - Identify baseline and decrease CBO workforce vacancy rate.
   - Create job descriptions and positions for Medi-Cal certified and non-certified peer support specialists.
     a. Objective Met
     b. Surpassed goal with DHS-BHD vacancy rate moving from 19% to 13%.
     c. DHS-BHD was unable to implement systems to monitor CBO vacancies.
     d. DHS-HR is in process of developing positions for Medi-Cal certified and non-certified peer support specialists.
     e. Vacancy rate continued in the FY 2025-26 QAPI Workplan.

SECTION I. PERFORMANCE MONITORING ACTIVITIES

DHS-BHD Quality Improvement staff work closely with QAPI staff and other stakeholders to monitor the following activities regularly to ensure meaningful improvement in clinical care and beneficiary service:

Area Monitored	Data Reviewed	Responsible Partners	FY 2025-26 Aims
Accessibility of Services	Timeliness service data, Beneficiary Access Call Database, Optum Call logs, Quarterly Test Call Reports	Quality Improvement;	DHS-BHD will regularly assess responsiveness for the Contractor's 24-hour toll-free telephone number, evaluate timeliness and accessibility of service performance across the system, and will address quality or performance issues within the QIC. This includes the following: 1) Decrease the average length of time from initial request to first offered appointment. 2) Increase the percentage of initial requests originating from Access Line that receive services within the benchmark for the urgency and type of service. 3) Monitor residential Treatment Authorization Requests authorizations within 24 hours.
Appeals & Expedited Appeals	Grievance & Appeals Log	Quality Assurance; Quality Improvement	DHS-BHD will continue monitoring appeals and analyzing trends.
Beneficiary Grievances	Grievance & Appeals Log	Quality Assurance; Quality Improvement	DHS-BHD will continue monitoring grievances and analyzing trends.
Clinical Records Review	Federal, State, and County Audit reports, Utilization Review (authorization findings)	Quality Assurance; Utilization Review (pre-billing audits & post training spot- checks); Auditing & Monitoring	DHS-BHD will monitor and evaluate the appropriateness and quality of services through periodic service audits and chart reviews. DHS- BHD will incorporate compliance feedback from state and federal audits.
Medication Monitoring	Medication Monitoring Peer Review Tracking Log; JV220 tracking log	Medical Director; FYT Psychiatry staff & Psychotropic Oversight Committee; Quality Improvement	DHS-BHD will continue to monitor the effectiveness and quality of medications, including medication practices. DHS-BHD will consolidate SB1291 medication monitoring metrics in the implementation of SmartCare E.H.R.
Penetration Rates	Approved claims data from SmartCare E.H.R. and EQRO	Quality Improvement	DHS-BHD will continue to monitor penetration rates and discuss improvement strategies within the QIC. This includes: 1) Increase overall penetration rates. 2) Increase Latino/Hispanic/Latinx penetration rates.
Performance Monitoring	CANS/ANSA Outcomes, Consumer Perception Survey, CalOMS data	Quality Improvement; System of Care Section Managers, Clinical Specialists, QAPI	DHS-BHD will conduct CANS/ANSA outcome data analysis across the MHP system. DHS-BHD will conduct an annual consumer perception survey per state requirements. DHS-BHD will use CalOMS data for outcome analysis across the DMC-ODS.

Provider Appeals	Provider Appeals Log	Quality Assurance	DHS-BHD will continue to monitor provider appeals.
Sentinel Events	Incident Report Database	Section Managers, Medical Director, Quality Improvement	DHS-BHD will continue to regularly monitor sentinel events and continue to meet monthly to analyze sentinel events for quality improvement purposes.

SECTION II. QUALITY IMPROVEMENT ACTIVITIES

Quality Improvement works closely with System of Care section leaders, program managers, and other quality improvement stakeholders across the system to assess performance, monitor QI efforts for previously identified performance issues, and target areas of improvement within Sonoma County's behavioral health service delivery system. The following table outlines the Quality Improvement Objectives for this year based on review and analysis of BHP system performance and stakeholder feedback.

Objective 1.	**CAPACITY:** Behavioral Health Plan network will meet the needs of the community
Objective 2.	**QUALITY:** Clients experience measurable improvement in functioning, emotional wellness, and recovery
Objective 3.	**EQUITY:** Clients will receive to culturally responsive behavioral health care
Objective 4.	**COORDINATION OF CARE:** Clients will have continuity of care cross settings
Objective 5.	**WORKFORCE:** Workforce is sufficient, trained, and empowered to provide quality care
Objective 6.	**SUD TREATMENT:** Substance use disorder (SUD) services are provided to all clients in need with follow-up to maintain recovery

<table>
<tr><th>Objective 1.</th><th>CAPACITY: Behavioral Health Plan network will meet the needs of the community</th></tr>
<tr><td>Performance Measures</td><td>

How much did we do?

a. # of clients enrolled to behavioral health programs

How well did we do it?

b. 80% of new clients will be offered an appointment within 10 business days for non-urgent, non-psychiatric requests **(PIP)**

c. Average wait times to enroll in programs is less than 14 days (10 business days)

Is anyone better off?

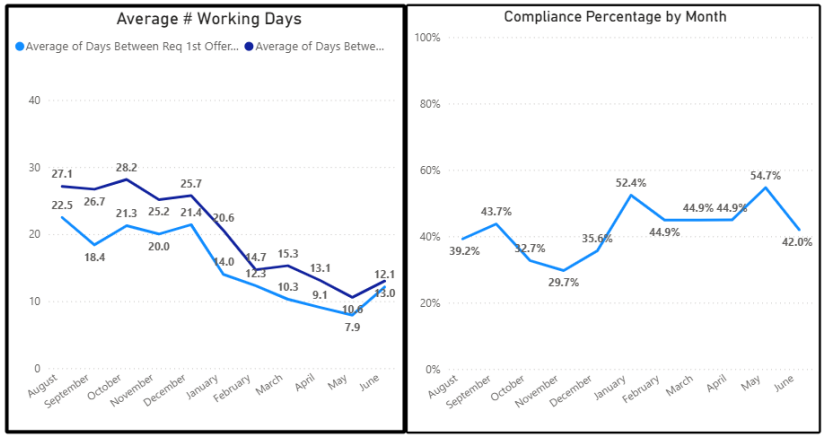
d. % of clients at the appropriate level care determined by their assessment scores

</td></tr>
<tr><td>Baseline</td><td>

a. Clients enrolled to behavioral health programs

Section	FY 23-24	FY 24-25
Access	1032	1150
Adult	4062	4771
Youth	1032	1064
SUD	1696	2185
Total	6393	9781

b. New clients offered an appointment within 10 business days for non-urgent, non-psychiatric requests



c. Average days from request to enrollment

Section	FY 23-24	FY 24-25
Adult	47.2	40.3

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	<table><tr><td>Youth</td><td>16.3</td><td>19.2</td></tr><tr><td>SUD</td><td>7.9</td><td>6.5</td></tr><tr><td>Total</td><td>25.6</td><td>22.4</td></tr></table> d. % of clients at the appropriate level care determined by their assessment scores – Rate to be determined.
Action Steps	• Monitor timely access, enrollment, and wait time metrics monthly by section to identify capacity constraints and trends. • Conduct reviews intake processes to identify bottlenecks affecting timely access. • Compare program demand, staffing levels, and service availability to assess alignment with community needs. • Implement focused improvement projects in programs with the longest wait times or lowest access performance. • Review level-of-care placement patterns to assess alignment between assessment scores and program enrollment.
Responsible Partners	• BH Division Director • Section Managers • QI Manager • QAPI Section Manager

Objective 2.	**QUALITY: Clients experience measurable improvement in functioning, emotional wellness, and recovery**
Performance Measures	**How much did we do?** a. % of clients with assessments up-to-date (every 6 months for CANS & 12 months for ANSA) **How well did we do it?** b. Meet or exceed State-wide average for Perception of Outcomes and Functioning domain scores on Consumer and Treatment Perception Surveys (CPS & TPS) c. % of clients receiving frequency of therapy for their level of care **Is anyone better off?** d. Reduce average # of actionable CANS / ASNA scores per client e. Reduce average per client utilization of emergency, acute, and crisis services
Baseline	**Adult Programs**

How much did we do?

% of client with assessments up-to-date

Fiscal Year	Active Clients at End of FY	% Assessment Up-to-date
2023-24	1587	65.8%
2024-25	1693	74.9%
Total	**1693**	**74.9%**

How well did we do it?

% of clients receiving frequency of therapy services recommended for their level of care

Fiscal Year	Clients	Therapy Services	Therapy Services PMPM	% Clients with Therapy
2023-24	1769	3676	0.16	6.8%
2024-25	1943	6455	0.24	8.6%
Total	**2235**	**10131**	**0.21**	**9.9%**

Is anyone better off?

Reduce per client utilization of emergency, acute, and crisis services

Fiscal Year	Clients	Acute Admits	Acute Admit per Client
2023-24	2040	1108	0.58
2024-25	2126	893	0.40
Total	**2531**	**2001**	**0.48**

Is anyone better off?

Reduce # of actionable core items on CANS / ANSA assessments

Fiscal Year	Evaluated Clients	Avg. actionable Core	Actionable core change	% with actionable core decrease	Core change since initial
2023-24	59	18.0	0.7	24.6%	0.6
2024-25	825	19.0	0.2	35.8%	0.4
Total	**864**	**18.7**	**0.2**	**35.2%**	**0.4**

Youth & Family Programs

How much did we do?

% of client with assessments up-to-date

Fiscal Year	Active Clients at End of FY	% Assessment Up-to-date
2023-24	459	77.4%
2024-25	521	79.3%
Total	**521**	**79.3%**

How well did we do it?

% of clients receiving frequency of therapy services recommended for their level of care

Fiscal Year	Clients	Therapy Services	Therapy Services PMPM	% Clients with Therapy
2023-24	947	10797	1.24	34.8%
2024-25	804	11210	1.50	37.7%
Total	**1253**	**22007**	**1.36**	**39.7%**

Is anyone better off?

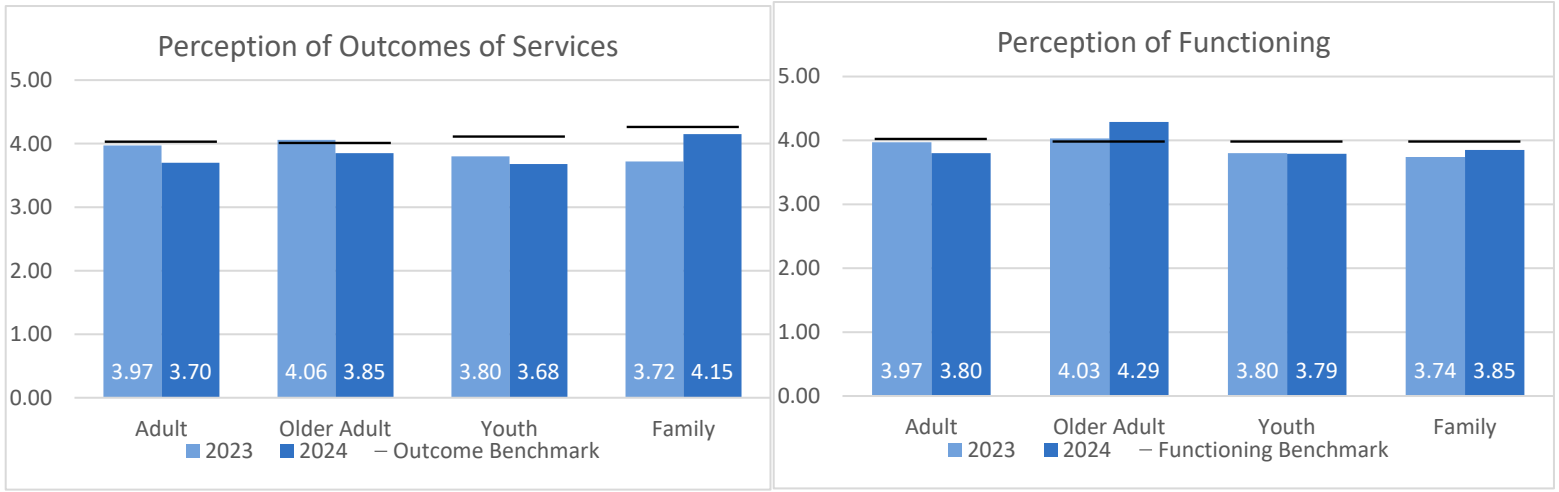
Reduce per client utilization of emergency, acute, and crisis services

Fiscal Year	Clients	Acute Admits	Acute Admit per Client
2023-24	963	175	0.24
2024-25	831	179	0.29
Total	**1289**	**354**	**0.26**

Is anyone better off?

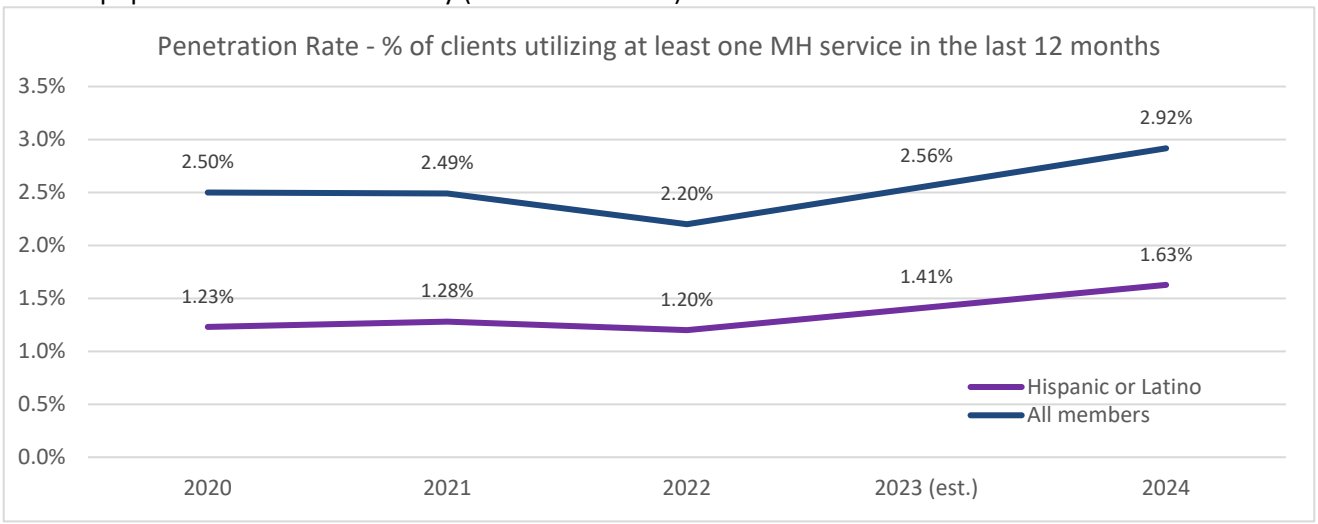
Reduce # of actionable core items on CANS / ANSA assessments

Fiscal Year	Evaluated Clients	Avg. actionable Core	Actionable core change	% with actionable core decrease	Core change since initial
2023-24	390	11.7	-0.7	45.1%	-1.1
2024-25	502	13.3	-0.9	56.3%	-1.2
Total	**683**	**11.7**	**-1.1**	**54.0%**	**-1.5**

	b. Meet or exceed State-wide average for Perception of Outcomes and Functioning domain scores on Consumer and Treatment Perception Surveys (CPS & TPS) 
Action Steps	• Track trends in actionable ANSA/CANS scores to evaluate changes in client acuity over time. • Monitor assessment completion rates and follow up with programs that fall below targets. • Review outcome and perception survey results with programs to identify strengths and improvement opportunities. • Review utilization of emergency and acute services to identify opportunities for preventive intervention.
Responsible Partners	• Program Managers • Section Managers • QI Manager

Objective 3.	EQUITY: Clients will receive to culturally responsive behavioral health care
Performance Measures	**How much did we do?** a. % of Hispanic / Latino clients utilizing at least one service in the last 12 months compared to the total Medi-Cal eligible population of Sonoma County (Penetration Rate) b. % of Spanish language capacity compared to language preference of enrolled client population **How well did we do it?** c. % of services provided in their preferred language without a translator **Is anyone better off?** d. % of clients agreeing that staff were sensitive to their cultural needs on CPS & TPS

Baseline	a. % of Hispanic / Latino clients utilizing at least one service in the last 12 months compared to the total Medi-Cal eligible population of Sonoma County (Penetration Rate)

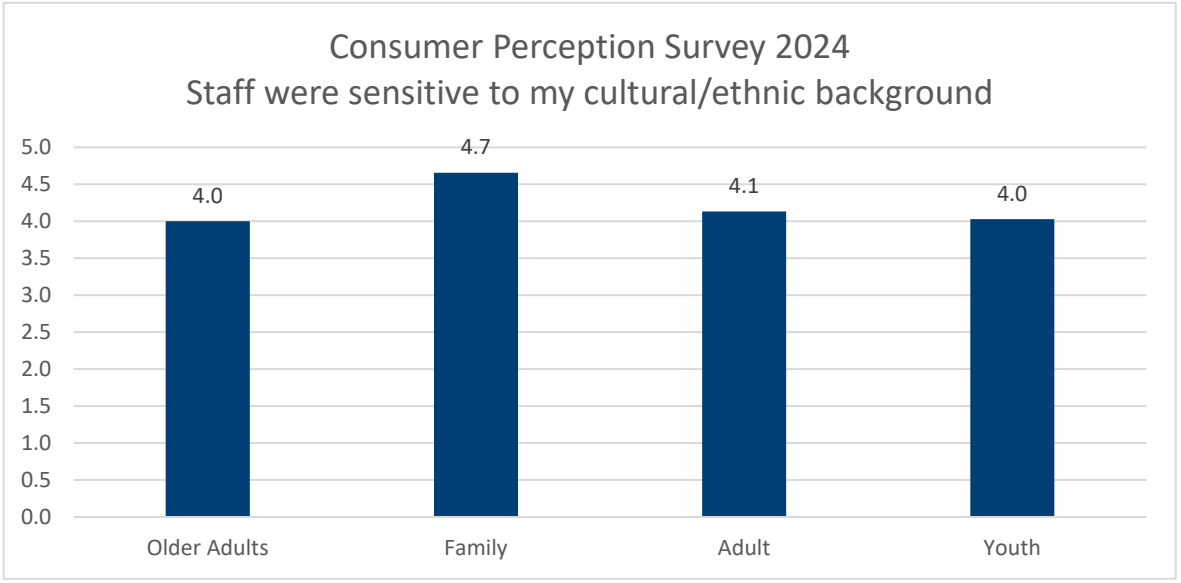


b. % of Spanish language capacity compared to language preference of enrolled client population

	Spanish Speaking	Total	% Spanish Speaking
Adult Clients	56	1493	4%
Adult Staff FTE	18	111	16%
YFS Clients	50	461	11%
YFS Staff FTE	37	123	30%

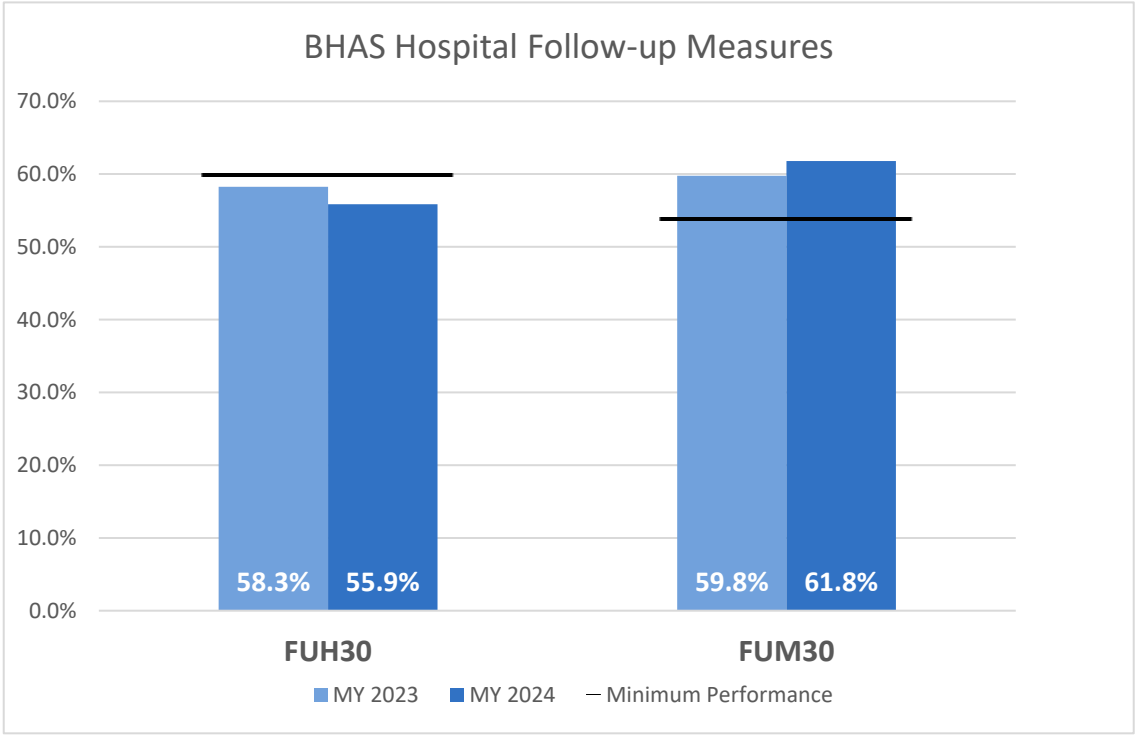
c. % of services provided in their preferred language without an interpreter.

Fiscal Year	2023-24		2024-25	
System Detail	% Services in Preferred Language without Interpreter	Billable Services with Interpretation Need	% Services in Preferred Language without Interpreter	Billable Services with Interpretation Need
MH - ASOC	97.0%	219	81.0%	166
MH - CSOC	49.1%	809	61.9%	1021
Access	36.6%	94	1.6%	197
Total	**54.8%**	**1122**	**54.3%**	**1384**

	d. % of clients agreeing that staff were sensitive to their cultural needs on CPS & TPS 
Action Steps	• Monitor service utilization and access patterns by race, ethnicity, and language to identify potential disparities. • Monitor staff language capacity and cultural competencies in comparison to client population needs. • Analyze client experience survey results for potential disparities or opportunities for improvement. • Support program initiatives to address outcome disparities.
Responsible Partners	• BH Division Director • Section Managers • Cultural Responsiveness, Inclusion & Training Coordinator • QI Manager

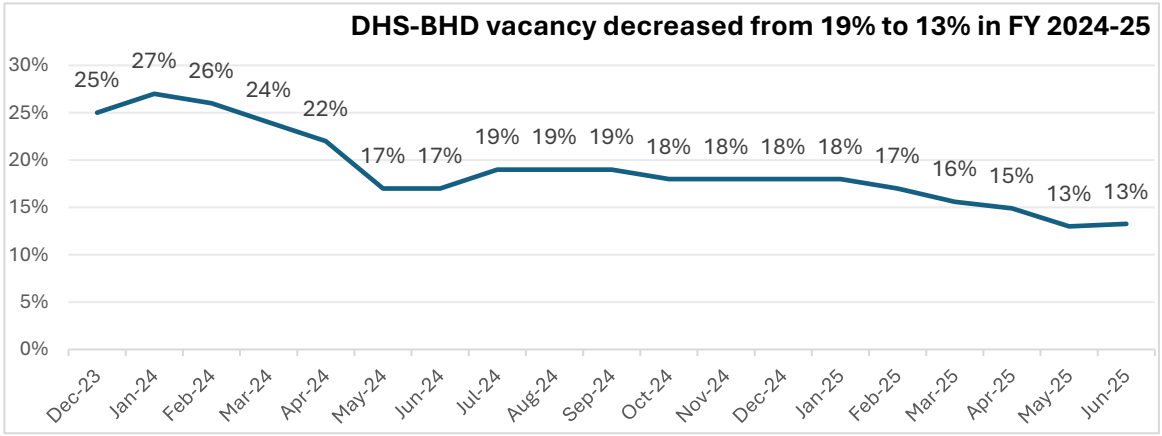
Objective 4.	**COORDINATION OF CARE: Clients will have continuity of care cross settings**
Performance Measures	**How much did we do?** a. # of acute discharges with a model care discharge plan **How well did we do it?** b. % follow-up after emergency room visit for mental health within 30 days (BHAS FUM) **(PIP)** c. % follow-up after inpatient stay or hospitalization for mental health within 30 days (BHAS FUH) **Is anyone better off?**

<table>
<tr><td></td><td>d. Reduce % of clients readmitted to acute or crisis facilities within 30 days</td></tr>
<tr><td>Baseline</td><td>a. # of acute discharges with a model care discharge plan – Rate to be determined.

b. % follow-up after emergency room visit for mental health within 30 days (BHAS FUM) (PIP)
c. % follow-up after inpatient stay or hospitalization for mental health within 30 days (BHAS FUH)
 

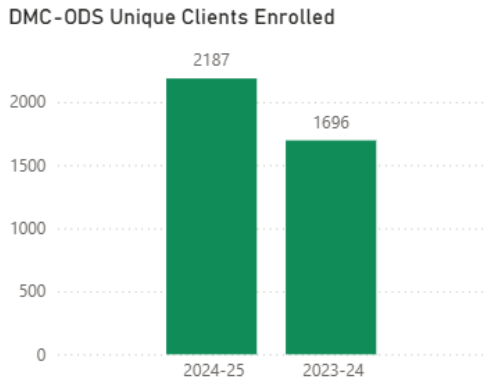
d. Reduce % of clients readmitted to acute or crisis facilities within 30 days
<table>
<tr><th>Fiscal Year</th><th>Acute Discharge Total</th><th>Acute Readmission Within 7 Days</th><th>Acute Readmission Within 30 Days</th><th>% Acute Readmission in 7 Days</th><th>% Acute Readmission in 30 Days</th></tr>
<tr><td>2023-24</td><td>1114</td><td>58</td><td>171</td><td>5.2%</td><td>15.4%</td></tr>
<tr><td>2024-25</td><td>1343</td><td>78</td><td>229</td><td>5.8%</td><td>17.1%</td></tr>
<tr><td>Total</td><td>2457</td><td>136</td><td>400</td><td>5.5%</td><td>16.3%</td></tr>
</table></td></tr>
<tr><td>Action Steps</td><td>• Review readmission patterns to identify high-risk populations and opportunities for improvement.
• Implement use of health information exchange (HIE) to improve tracking and follow-up of hospitalizations.</td></tr>
</table>

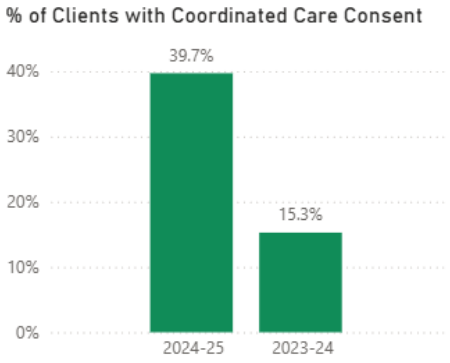
	• Develop strategies to improve communication between clients, family, and acute, outpatient, and community providers.
Responsible Partners	• Acute & Forensic Section Manager • CSU Manager • QI Manager

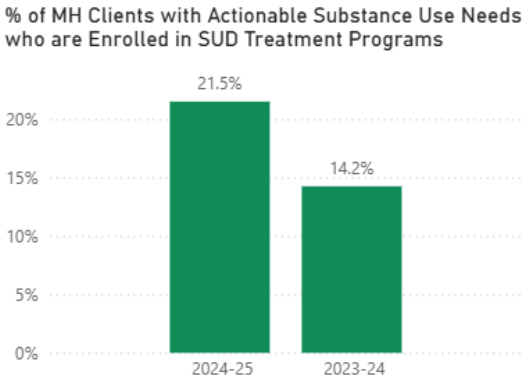
Objective 5.	WORKFORCE: Workforce is sufficient, trained, and empowered to provide quality care
Performance Measures	**How much did we do?** a. Reduce the DHS-BHD vacancy rate to 9%. b. # of peer support services provided across behavioral health programs **(PIP)** **How well did we do it?** c. Train staff to implement evidence-based practice to fidelity standards **Is anyone better off?** d. DHS-BHD staff retention rate
Baseline	a. Reduce the DHS-BHD vacancy rate to 9%.  b. # of peer support services provided across behavioral health programs **(PIP)** Fiscal Year MH - ASOC 2024-25 9

	d. DHS-BHD staff retention rate – Rate to be determined.
Action Steps	• Monitor vacancy rates and hiring metrics to maintain workforce. • Develop implementation plan for evidence-based practice implementation. • Review staffing models and productivity expectations to ensure alignment with service demand. • Track peer support service delivery trends to identify expansion opportunities. • Conduct workforce feedback and engagement assessments in line with departmental initiatives.
Responsible Partners	• Section Managers • Cultural Responsiveness, Inclusion & Training Coordinator • QA Manager • QI Manager

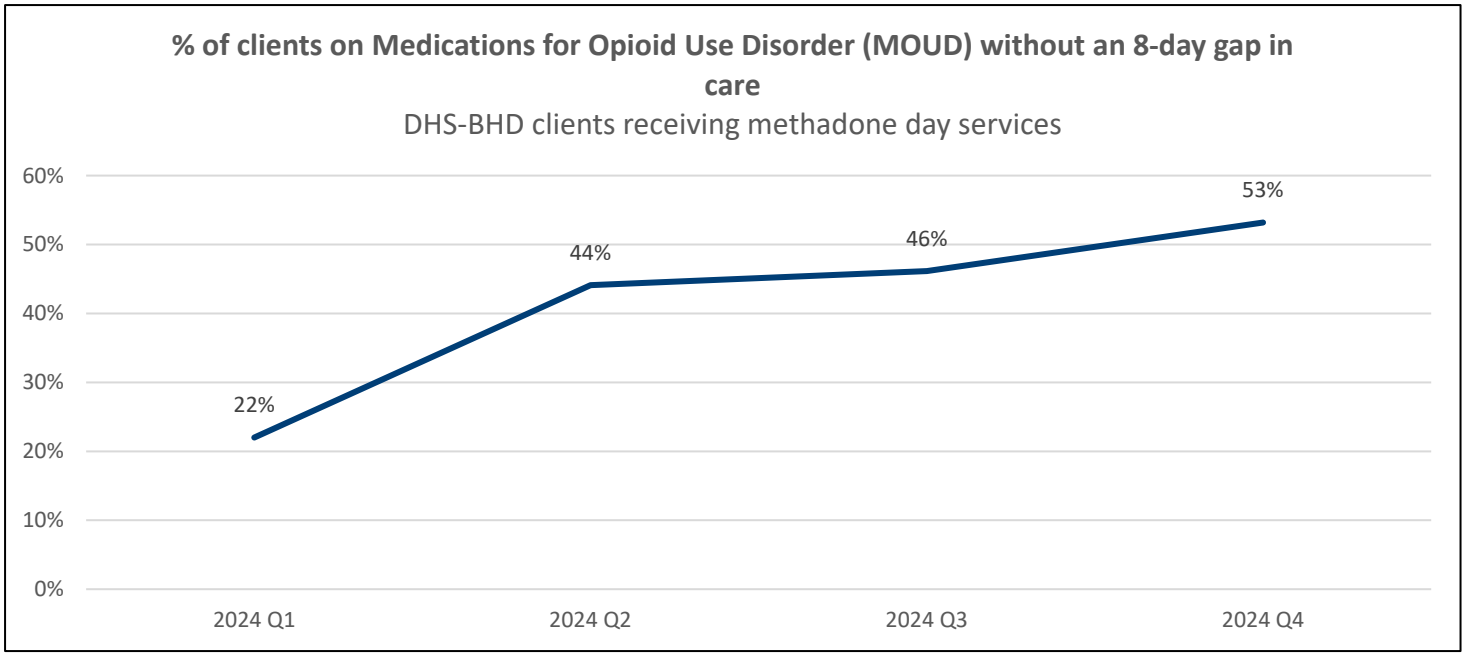
Objective 6.	**SUD TREATMENT: Substance use disorder (SUD) services are provided to all clients in need with follow-up to maintain recovery**
Performance Measures	**How much did we do?** a. # of clients enrolled in DMC-ODS programs **How well did we do it?** b. % of clients with a coordinated care consent c. % of MH clients with actionable substance use needs who are enrolled in SUD treatment programs **Is anyone better off?** d. % of clients on Medications for Opioid Use Disorder (MOUD) without a gap in care (BHAS POD) **(PIP)** e. % of discharged clients with no new arrests during last 30 days of treatment (CalOMS) f. % of employable clients discharged as employed/training/job search (CalOMS)
Baseline	a. # of clients enrolled in DMC-ODS programs b. % of clients with a coordinated care consent c. % of MH clients with actionable substance use needs who are enrolled in SUD treatment programs





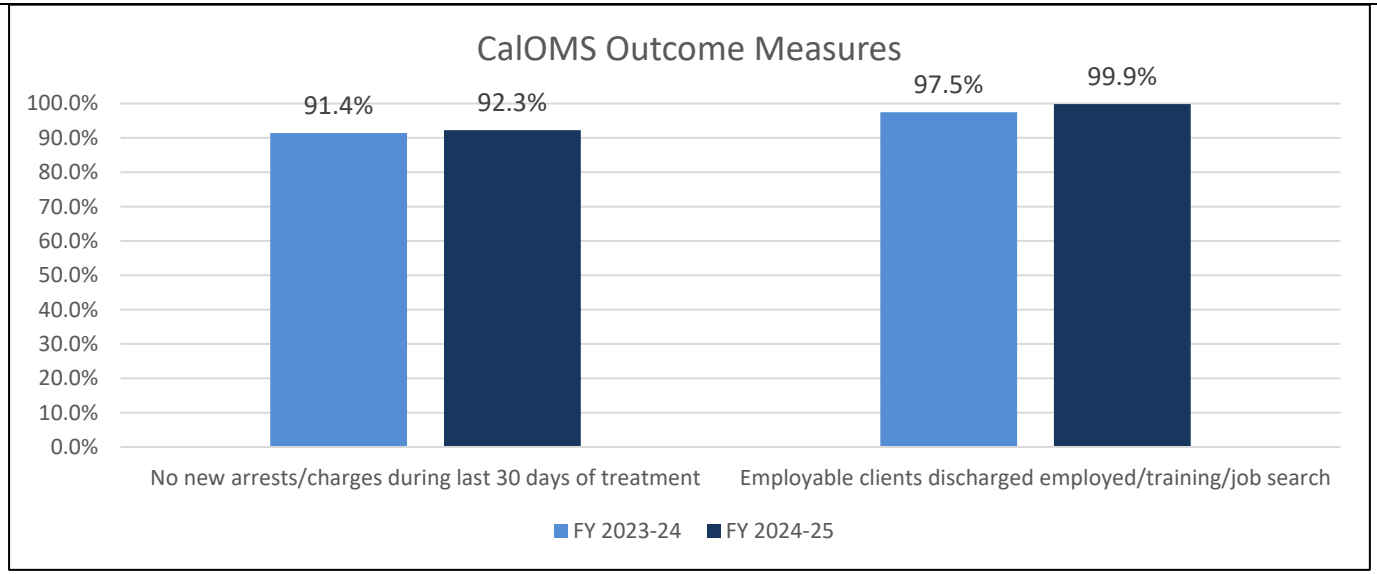


d. % of clients on Medications for Opioid Use Disorder (MOUD) without a gap in care (BHAS POD) **(PIP)**



e. % of discharged clients with no new arrests during last 30 days of treatment (CalOMS)

f. % of employable clients discharged as employed/training/job search (CalOMS)

	
Action Steps	• Onboard newly contracted CBOs to expand SUD program capacity. • Monitor SUD program wait time, access, and enrollment metrics to identify trends and opportunities for improvement. • Review data and identify opportunities for improvement in coordination of care between MH and SUD programs. • Track coordinated care consent rates and follow up with programs below benchmarks. • Monitor and improve CalOMS data processes to improve data quality. • Monitor MOUD continuity measures to identify gaps in medication-assisted treatment. • Analyze discharge outcomes and recidivism indicators to inform care transition improvements.
Responsible Partners	• SUD Section Manager • QA Manager • QI Manager