



COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT

Substance Use Disorder Services Work Plan Evaluation

Fiscal Year 2018-2019

INTRODUCTION

As required by the California Department of Health Care Services (DHCS), the County of San Diego Behavioral Health Services (SDCBHS) produces an annual Quality Improvement Work Plan (QIWP) that establishes the quality improvement goals for the current fiscal year. One QIWP is produced for Mental Health Services (MHS), and a separate QIWP is also produced for Substance Use Disorder Services (SUD). The plan describes quality improvement activities including plans for sustaining improvement, monitoring of previously identified issues, and tracking of target areas over time. The QIWP demonstrates how the planned quality improvement activities have contributed and will contribute to meaningful improvement in clinical care and services provided. This process helps ensure the system is safe, effective, accessible, equitable, and focuses on the inclusion of the individuals and family members served. The system is also reflective of business principles in which services are delivered in a cost-effective, outcome-driven, and trauma informed fashion.

At the end of each fiscal year, the goals stated in the QIWP are evaluated to determine the overall effectiveness of the behavioral health system and the quality improvement program. This evaluation informs SDCBHS of potential areas for improvement, as well as areas to develop or enhance based on collaborative goals, and ultimately ensure that services provided are inclusive and delivered appropriately to the individuals being served.

FISCAL YEAR 2018-2019

Quality Improvement Work Plan (QIWP) Evaluation
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Summary data and a brief synopsis are provided for each QIWP goal.

If more information is desired, please email your request to BHSQIPIT.HHSA@sdcounty.ca.gov.

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Work Plan Goals

The QIWP goals define targeted measures by which SDCBHS can objectively evaluate the quality of services, both clinical and administrative, provided to the individuals and family members receiving services. The goals are separated into six target areas: Services Are Client Centered; Services are Safe; Services Are Effective; Services Are Efficient and Accessible; Services Are Equitable; and Services Are Timely. The target areas are in line with the priorities outlined by the DHCS. Some of the goals are process goals while others are measurable objectives. The prime objective incorporated in the QIWP goals is to continuously improve both clinical and administrative service delivery through a systematic process of monitoring critical performance indicators and implementing specific strategies to improve the process, access, safety, and outcomes of all services provided. All goals are in line with the Health and Human Services Agency and Behavioral Health Services' vision, mission, and strategy/guiding principles.

County of San Diego, Health and Human Services Agency (HHSA)

Vision: Healthy, Safe, and Thriving San Diego Communities.

Mission: To make people's lives healthier, safer, and self-sufficient by delivering essential services.

Strategy:

1. **Building a Better System** focuses on how the County delivers services and how it can further strengthen partnerships to support health. An example is putting physical and mental health together so that they are easier to access.
2. **Supporting Healthy Choices** provides information and educates residents, so they are aware of how choices they make affect their health. The plan highlights chronic diseases because these are largely preventable, and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within.** As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk". Simply said, change starts with the County.

Behavioral Health Services (BHS)

Vision: Safe, mentally healthy, addiction-free communities.

Mission: In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery and client/family centered, and innovative and creative.
3. Foster continuous improvement to maximize efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees to reach their full potential.

Services Are Client Centered

GOAL 1

Establish a baseline for the number of Grievances and Appeals received.



METHODS

1. Created the grievances and appeals tracking log to align with the Department of Health Care Services (DHCS) requirements.
2. Tracked the number of grievances related to accessibility of services, quality of care, program requirements, staff interactions and interpersonal relationship issues.
3. Tracked the number of appeals received and resolved.

DATA

State Fiscal Year	Q1	Q2	Q3	Q4	YTD Total
Total # of Member Grievances Received	36	24	27	47	134
Total # of Appeals Received	1	0	0	1	2
Total # of Grievance Resolutions	0	45	27	54	126
Total # of Appeal Resolutions	1	0	0	1	2
# of Appeals Resolved in Favor of Plan	1	0	0	1	2
# of Appeals Resolved in Favor of Beneficiary	0	0	0	0	0
# of Grievances regarding:	Q1	Q2	Q3	Q4	YTD Total
Access to Care	0	0	2	1	3
Quality of Care	34	20	12	33	99
Program Requirements	0	0	0	0	0
Failure to Respect Enrollee's Rights	1	4	5	7	17
Interpersonal Relationship Issues	0	0	0	0	0
Other:	1	0	8	6	15
Transition of Care Requests	Q1	Q2	Q3	Q4	YTD Total
Total # Transition of Care Requests Received	0	0	0	0	0
# Transition of Care Requests Approved	0	0	0	0	0
# Transition of Care Requests Denied	0	0	0	0	0

Services Are Client Centered

RESULTS

Grievances and Appeals Report

- The total number of SUD grievances received during FY 2018-19 was 134.
- Out of 134 received, 99 of those were grievances related to **Quality of Care** which includes treatment issues or concerns, staff behavior concerns, and medication issues.
- **Quality of Care** was the largest proportion of all grievances at 74%.
- The average number of grievances received per quarter was 34. Quarter 4 (Q4) was the highest quarter with 47 grievances received.
- The total number of grievance resolutions at the time of report was 126, which is a 94% resolution rate. Some grievances are in process and resolutions are currently pending.
- Grievances associated with **Failure to Respect Enrollee's Rights** and **Other** were on the low end with a total of 17 and 15 respectively, while **Access to Care** was minimal at 3.
- There were no grievances received for **Program Requirements** or **Interpersonal Relationship Issues**.
- Additionally, there were no **Transition of Care** requests reported during this fiscal year.
- For appeals, there were two appeals received during FY 2018-19. This resulted in two appeal resolutions, in favor of the Plan.

NEXT STEPS

- Continue to track grievances and appeals, examining the trends between *Quality of Care*, *Failure to Respect Enrollee's Rights*, and the *Other* categories.
- Discuss quarterly findings at Quality Review Council meetings to review and identify trends in services and provider interactions.
- Ensure clients are aware of the grievance and appeals process and encourage feedback from them.
- A Performance Improvement Plan (PIP) was established to help increase awareness of the Grievance and Appeal process for clients.



Services Are Client Centered

GOAL 2

100% of clients shall indicate in the Substance Use Disorder (SUD) Services Client Survey that they chose their treatment goals with their provider's help.

METHODS



1. Administered the Treatment Perceptions Survey (TPS) in October 2018.
2. Evaluated responses to the following question: "I chose the treatment goals with my provider's help" for adult clients and "My counselor and I worked on treatment goals together" for youth clients.
3. Continued to educate providers regarding the importance of client involvement in treatment planning.

DATA

Satisfaction by Item Response: Systemwide

Questions based on services received within the last year	N	% Strongly Agree/Agree
Adult		
I chose the treatment goals with my provider's help.	1,538	86%
Youth		
My counselor and I worked on treatment goals together.	150	82%

Services Are Client Centered

RESULTS

2018 Treatment Perception Surveys (TPS)

Adults

- 86% of adult clients who participated in the survey indicated they either Agree or Strongly Agree that they chose their treatment goals with the provider's help.
- Results for this indicator was based on 1,538 overall survey participants.

Youth

- 82% of youth clients who participated in the survey indicated they either Agree or Strongly Agree that they worked on treatment goals together with their counselor.
- Results for this indicator was based on 150 overall survey participants.

Evaluate. Disseminate. Include.



NEXT STEPS

- Continue to evaluate clients' perception of program inclusiveness, based on client feedback as well as program level results.
- Disseminate the TPS program level results to Program Monitors and ensure programs are including clients' contributions in their treatment goals.

Services Are Safe

GOAL 3

Establish a baseline for the number of Substance Use Disorder (SUD) Serious Incidents reported.

METHODS

1. Utilized the Substance Use Disorder (SUD) Serious Incident Report to align with the Department of Health Care Services (DHCS) requirements.
2. Tracked the number of Serious Incidents by System of Care and separated by Adult and Youth.

Serious Incident Report: FY 2018-19 Behavioral Health Services - Quality Improvement Serious Incidents by System of Care <i>Substance Use Disorder Services</i>		
	Adult	Youth
July 2018	6	0
August 2018	4	0
September 2018	2	0
October 2018	4	0
November 2018	5	0
December 2018	0	0
January 2019	11	0
February 2019	4	0
March 2019	10	0
April 2019	3	1
May 2019	7	0
June 2019	8	0
Total	64	1

DATA

Serious Incident Report FY 2018-19
Substance Use Disorder Services - Adult

	July-18	Aug-18	Sept-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June-19	Total
Incident in the Media	-	-	-	-	-	-	-	-	-	-	1	-	1
Death by Suicide	1	1	-	-	1	-	1	1	-	-	-	1	6
Death Under Questionable Circumstances	-	-	-	3	-	-	1	-	4	1	1	2	12
Suicide Attempt	-	-	2	1	2	-	-	-	-	-	1	-	6
Tarasoff (Report received by Program)	-	-	-	-	1	-	-	-	-	-	-	-	1
Serious Allegations of or Confirmed Inappropriate Staff Behavior	1	1	-	-	-	-	-	1	2	1	3	1	10
Serious Physical Injury	-	-	-	-	-	-	2	-	-	-	-	-	2
Apparent Overdose of Alcohol/Drugs	2	1	-	-	-	-	2	2	3	-	-	2	12
Other	2	1	-	-	1	-	5	-	1	1	1	2	14
Total	6	4	2	4	5	0	11	4	10	3	7	8	64

Serious Incident Report FY 2018-19
Substance Use Disorder Services - Youth

	July-18	Aug-18	Sept-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June-19	Total
Incident in the Media	-	-	-	-	-	-	-	-	-	1	-	-	1
Total	0	0	0	0	0	0	0	0	0	1	0	0	1

Services Are Safe

RESULTS

- In FY 2018-19, there were 65 total Serious Incidents reported.
- 64 Serious Incidents reported were from adults, while only one involved a youth.

Adults

- The highest reported Serious Incident for adults was “Other” at 14 incidents. This category includes serious incidents such as using a fake prescription to obtain medication, detoxification that leads to seizures and requires medical attention, and falsifying a drug test and then making threats at the program.
- In addition to the “Other” type of incidents, there were three categories that had the most Serious Incidents reported within adult programs:
 - 1) Death Under Questionable Circumstances
 - 2) Apparent Overdose of Alcohol/Drugs
 - 3) Serious Allegations of or Confirmed Inappropriate Staff Behavior

Youth

- There was only one Serious Incident reported for youth.
- Type of incident reported was an “Incident in Media.”

NEXT STEPS

- Continue to track Serious Incidents reported and examine any trends present.
- Discuss quarterly findings at QRC meetings to review and identify trends or cycles in incidents.
- Ensure programs are aware of the Serious Incident reporting process.



Services Are Safe

GOAL 4

Monitor the coordination of care of clients who were connected to services within 10 days and 30 days to minimize avoidable hospitalizations.

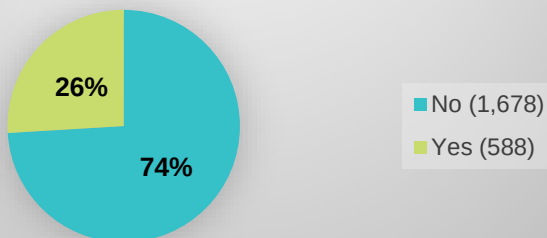


METHODS

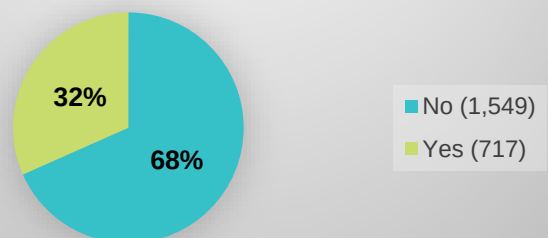
1. Monitored transitions from residential programs to outpatient programs to track continuity of care to ensure consistent treatment.
2. Identified clients discharged from residential programs with a referral to an outpatient program to track connections within 10 days or 30 days of the discharge.
3. Identified and analyzed the trend of transitions between the levels of care.

DATA

FY 2018-19 Referred Client Transitions from Residential Programs to Outpatient Programs (within 0 to 10 days)

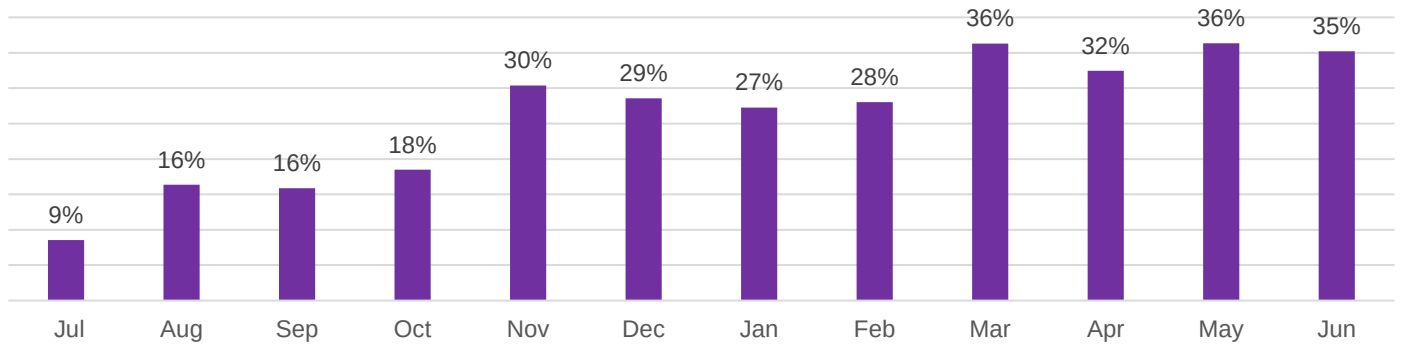


FY 2018-19 Referred Client Transitions from Residential Programs to Outpatient Programs (within 0 to 30 days)

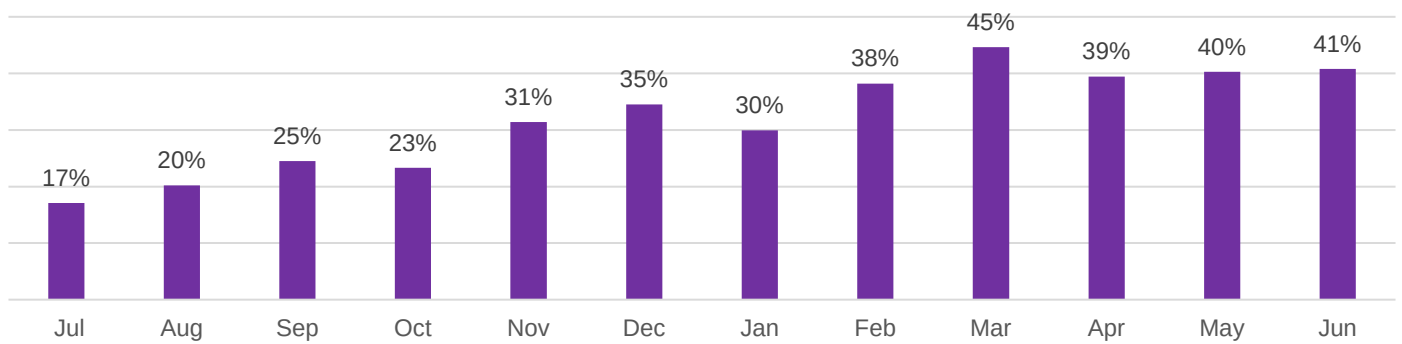


Services Are Safe

FY 2018-19 Residential Discharges connected to Outpatient Programs within 10 days



FY 2018-19 Residential Discharges connected to Outpatient Programs within 30 days



RESULTS

- Of all the residential discharges, 26% were connected to outpatient services within 10 days and 32% were connected within 30 days.
- Connection rate for 10 days and 30 days show a gradual upwards trend.

NEXT STEPS

- Analyze the transition trend in the upcoming fiscal year.
- Analyze the role of demography in client transition by LOC.
- Conduct analysis to determine if connections to continued treatment services impact hospitalization rates of clients.



Services Are Effective

GOAL 5

Establish a baseline for the readmission rate for Withdrawal Management services.

METHODS

1. Reviewed admission and discharge data for Withdrawal Management (WM) services.
2. Identified the denominator as the number of WM clients who were discharged from WM programs during FY 2018-19.
3. Identified the numerator as the number of WM clients who were discharged from WM programs in FY 2018-19 and were readmitted to a WM program within 30 days from discharge.



DATA

WM Programs	Q1	Q2	Q3	Q4	FY 2018-19
Total Discharges	527	724	740	722	2,713
Readmission Within 30 Days	21	47	48	25	141
Readmission Rate	4.0%	6.5%	6.5%	3.5%	5.2%

Services Are Effective

RESULTS

- There were 2,713 clients who were discharged from Withdraw Management (WM) programs in FY 2018-19.
- Out of 2,713 clients, 141 were readmitted to a WM program within 30 days from discharge.

Baseline for readmission rate for WM services is 5.2%.

Track. Review. Communicate.

NEXT STEPS

- Continue to track the readmission rate for Withdrawal Management services in the upcoming FY 2019-20, comparing results to the baseline.
- Look for trends that show a decrease in the readmission rate and an increase in referrals after withdrawal management services have been provided.
- Communicate with programs to enhance the continuity of care coordination.



Services Are Effective

GOAL 6

At a minimum, 70% of clients shall either be employed, in a structured employment preparation program, in a formal educational setting, or enrolled in an eligibility program, as measured at the end of the treatment phase.



METHODS

1. Utilized data collected on the Quarterly Status Report for FY 2018-19. Data was submitted by providers to their Program Monitors on a quarterly basis.
2. Identified the denominator as the number of discharged clients who were in treatment at least 31 days and discharged from a treatment program in FY 2018-19.
3. Identified the numerator as the number of discharged clients who were in treatment at least 31 days and were employed, in structured employment preparation program, in a formal educational setting, or enrolled in an eligibility/benefits program providing cash income (SSI, SSD, VA, CalWORKS, etc.) upon discharge.

DATA

FY 2018-19 as of Jun 30, 2019	Discharge Outcomes		
Modality	Denominator: Discharged clients who remained in treatment for 31+ days	Employment & Education (Self Sufficiency)	
		Numerator	Goal
			70%
DMC-ODS Outpatient Treatment (Adult) Total	1,144	1,027	89.0%
DMC-ODS Residential Treatment & WM (Adult) Total	98	77	78.0%
DMC-ODS Residential Treatment (Adult) Total	1,407	1,054	74.0%
DMC-ODS Outpatient Treatment (Youth) Total	538	391	72.0%
DMC-ODS Outpatient Treatment (Perinatal) Total	311	210	67.0%
DMC-ODS Residential Treatment & WM (Perinatal) Total	469	276	58.0%
DMC-ODS Residential Treatment (Youth) Total	68	50	73.0%
Total	4,035	3,085	76.0%

Services Are Effective

RESULTS

- There were 4,035 clients who were in Substance Use Disorder (SUD) treatment for 31 days or more and were discharged in FY 2018-19.
- Out of 4,035 clients, 76% or 3,085 were either employed, in a structured employment preparation program, in a formal educational setting, or enrolled in an eligibility/benefits program at the end of the treatment phase.
- Adult outpatient treatment programs have the highest percentage (89%) of clients who were either employed, in a structured employment preparation program, in a formal educational setting, or enrolled in an eligibility program at discharge.

Communicate. Inquire. Track.



NEXT STEPS

- Communicate findings to programs and support continued self-sufficiency efforts.
- Continue to track this outcome in SanWITS with more consistency once Electronic Health Record is implemented in 2020.

Services Are Client Centered

GOAL 7

San Diego County Behavioral Health Services (SDCBHS) will conduct two Performance Improvement Plans (PIPs) to be completed by April 2020.

METHODS

Non-clinical PIP:

1. A non-clinical PIP was established to increase client knowledge of the grievance and appeal process.
2. The PIP was developed based on the annual state-wide Treatment Perception Survey (TPS) supplemented with additional data on a client's familiarity and comfort with filing a Grievance or Appeal.
3. Several meetings were held to discuss ideas and get feedback from the External Quality Review Organization (EQRO) representative, client advocate, internal and external Drug Medi-Cal (DMC) PIP workgroups as well as stakeholders.
4. Three interventions were developed and implemented throughout the fiscal year for the non-clinical PIP.
5. Post intervention assessments were performed by measuring the availability and visibility of materials at the providers' sites and clients' familiarity and comfort with the Grievance and Appeal process.

Clinical PIP:

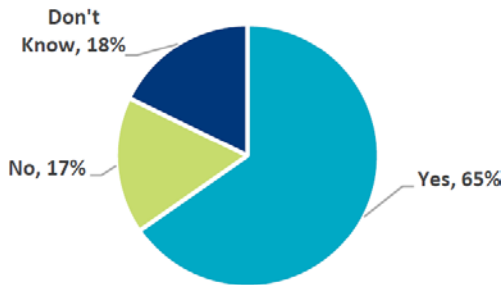
1. A clinical PIP was established to identify a Relapse Prevention Evidence Based Practice model to be implemented across the DMC-ODS service providers in San Diego County.
2. The PIP was initiated based on analysis of discharge reports from FY 2017-18.
3. Several meetings were held between SUD Providers, EQRO representatives and internal and external DMC PIP workgroups.
4. Six programs volunteered to pilot the Relapse Prevention Evidence Based Practice Road Map toolkit curriculum which was demonstrated to research groups as well as providers.
5. For the clinical PIP, a multistep intervention was developed and implemented throughout the fiscal year.
6. Post intervention assessments were performed to determine the impact of the Relapse Prevention Evidence Based Practice Road Map toolkit on treatment completion rates as well as to check how the model was received by the clients.



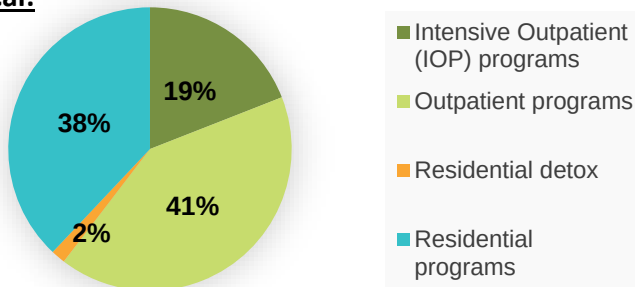
Services Are Client Centered

Non-Clinical:

My provider informed me of the grievance and appeal process. (n=1,686)



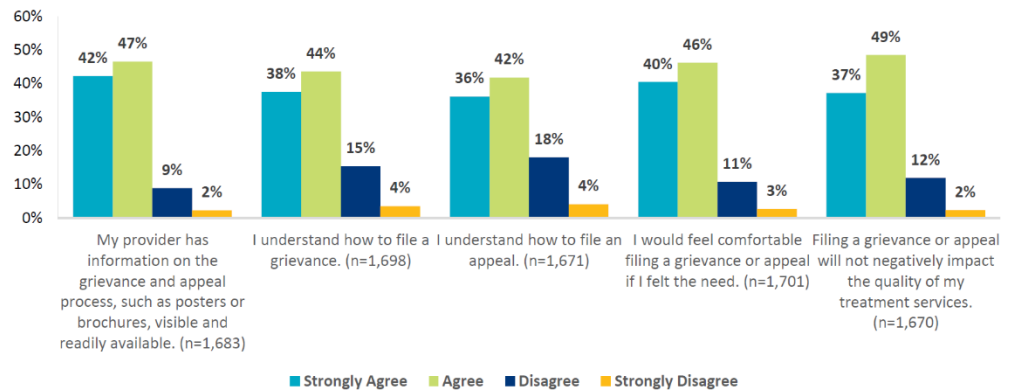
Clinical:



Percent discharged with status "left before completion with unsatisfactory progress" from different Level of Care (LOC) programs in FY 2017-18.

DATA

All Respondents (N=1,719)



There were 3,417 treatment episodes (25%) with a discharge status of "left before completion with unsatisfactory progress."

RESULTS

Non-Clinical Data

The baseline data shows that:

- 19% of clients disagreed or strongly disagreed that they understood how to file a grievance.
- 22% disagreed or strongly disagreed that they understood how to file an appeal.
- 35% reported that their provider did not inform them, or they did not know if their provider had informed them, of the grievance and appeals process.

These findings suggested that there was an opportunity to increase awareness of the grievance and appeals processes within the SUD SOC, which led to multiple interventions through a non-clinical PIP.

Clinical Data

The baseline data shows that:

- A total of 3,417 clients were discharged with the status of "left before completion with unsatisfactory progress."
- Among the 3,417 discharges, 41% were from Outpatient programs, 38% from Residential programs, 19% from Intensive Outpatient (IOP) programs and the remaining 2% were from Residential Detox programs (as shown in the pie chart above).

These findings suggested an opportunity to develop a clinical PIP to address the needs in the system.

NEXT STEPS

- Work with PIP workgroup to continue to involve peers/family members in the interventions.
- To measure effectiveness and usefulness, clients receiving services at programs with providers who complete the Relapse Prevention EBP training should be surveyed weekly about their knowledge and usage of key components of the Relapse Prevention EBP.

Services Are Client Centered

GOAL 8

100% of Outpatient services shall be within 15 miles from client's residence.

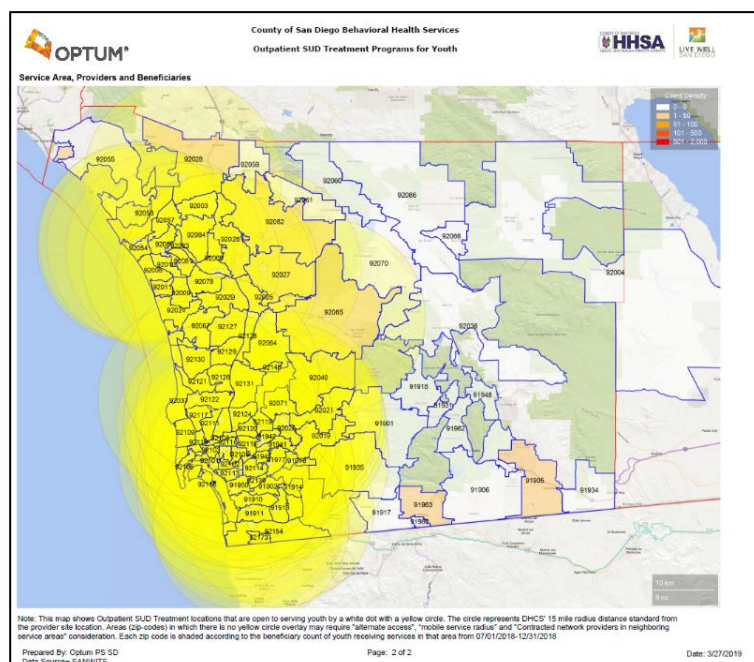
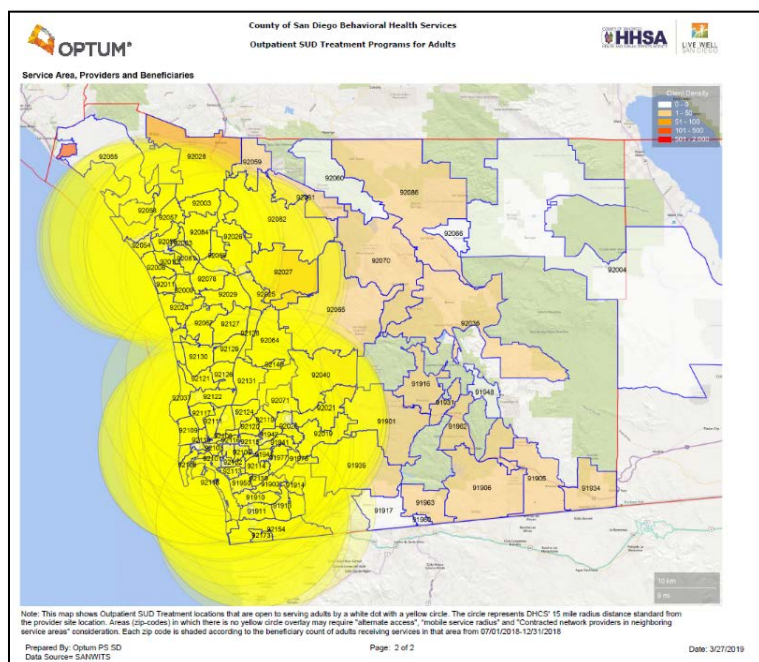
METHODS

1. Used geographic access maps, access charts, and summaries.

DATA

Geographical service area for adults.

Geographical service area for youth.



The Geographic Access Maps are available on Section 6.1 of the Technical Resource Library at https://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html#7

- Accessibility charts have been analyzed to ensure network adequacy for driving distance/time.
- Given that nearly two thirds of San Diego County is undeveloped, surrounded by protected forest/desert, and has a considerably low population, the County requested and received Alternate Access standards from the Department of Health Care Services (DHCS) for eight adult and two youth service areas to meet distance/time standards in the rural areas.

Services Are Client Centered

Adult Outpatient Rural Service Areas*

Zip Code	Service Area
91906	Campo
91963	Potrero
91935	Jamul
91916	Descanso
92036	Julian
92065	Ramona
92061	Pauma Valley
92028	Fallbrook

* Received Alternate Access standards for these service areas.

Youth Outpatient Rural Service Areas*

Zip Code	Service Area
91905	Boulevard
91963	Potrero

* Received Alternate Access standards for these service areas.

RESULTS

- Confirmed that the Alternate Access standards for rural areas was approved by DHCS.
- DHCS found San Diego to be in compliance for network adequacy, this includes the Alternate Access standards request (AAS).

NEXT STEPS

- Continue to track and ensure that urban service areas meet accessibility standards.
- Continue Telehealth services when appropriate.
- Continue to provide Roaming Outpatient Access Mobile (ROAM) services, which have been effective since July 1, 2018 and received well, utilizing contracted providers in the North Inland and East rural areas of San Diego County.



Services Are Efficient and Accessible

GOAL 9

Establish a Withdrawal Management dedicated facility in the North Region.



METHODS

1. Began efforts to expand Withdrawal Management (WM) services to a dedicated facility in North Region.
2. Established a new contract with a facility in the North Region specifically to include Withdrawal Management services.

DATA

- Withdrawal Management services combine detoxification and pre-treatment/referral services to individuals as they withdraw from alcohol and other drugs.
- Programs are short-term, non-medical models and are structured, supervised, safe, and sober environments which allows SUD-dependent individuals to withdraw from substance use and receive referrals to available treatment and recovery services.
- The northern region of San Diego County was identified by the Board of Supervisors as an area that needs to have more services available for its residents in crisis, since one of the larger crisis facilities recently downsized. The goal also supports the need to improve continuum of care for individuals with substance use problems.
- The County's Board of Supervisors are taking steps to improve the region's behavioral health system of care by addressing the need for increased access to behavioral health services in North County, including crisis stabilization and withdrawal management/addiction services.

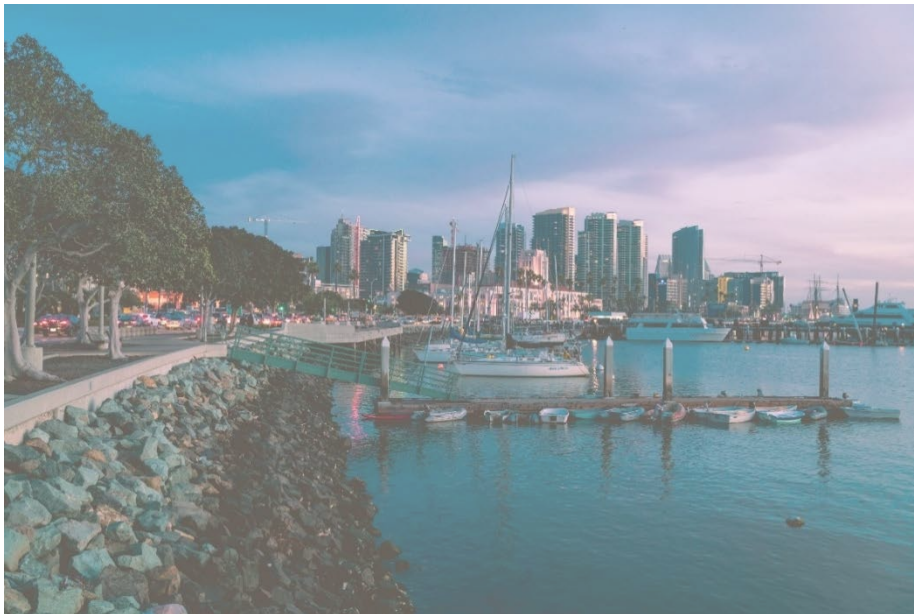
Services Are Efficient and Accessible

RESULTS

- A new contract with Interfaith Community Services established a Withdrawal Management program in North County effective January 2019, with an extended startup phase.
- The services will be offered on-site with other treatment level programs to provide a continuum of services.
- Once operational, the newly integrated Withdrawal Management structure will offer an additional service for adults in the North Region.

NEXT STEPS

- Identify a date for implementation of services at the newly contracted program.
- Begin tracking utilization of Withdrawal Management services once implemented.



Services Are Efficient and Accessible

GOAL 10

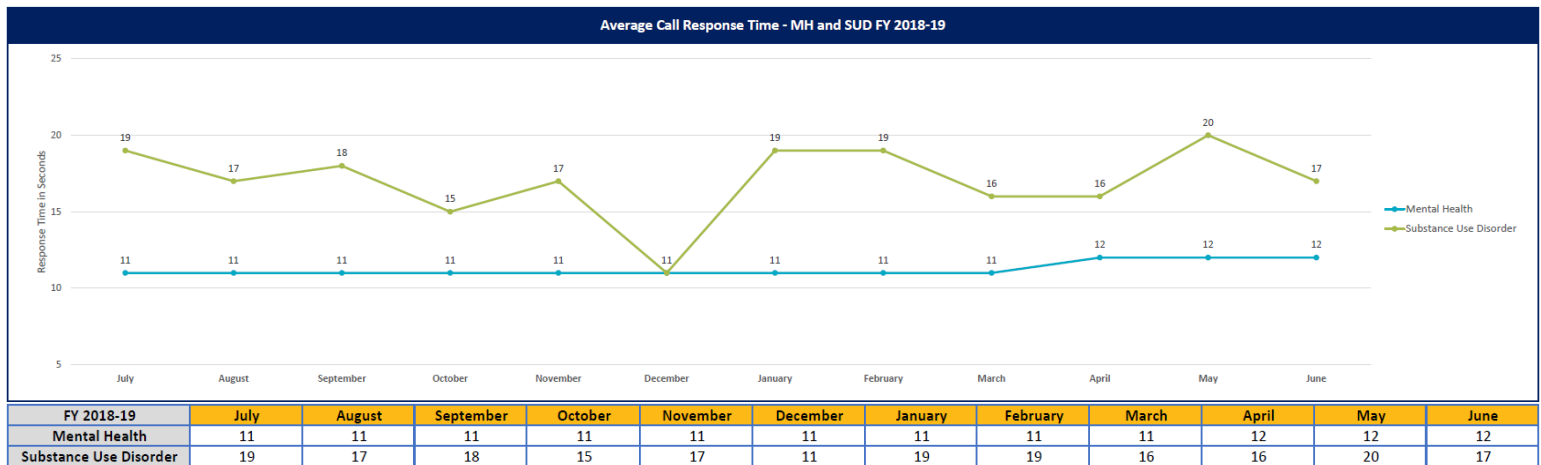
- Ensure 95% of calls answered by the Access and Crisis Line (ACL) crisis queue are within 45 seconds.
- Ensure average speed to answer all other (non-crisis) calls is within 60 seconds in the client's preferred language.

METHODS

- Worked with Optum to monitor Access and Crisis Line data for FY 2018-19.
- Used Optum's Access Crisis Line data.
- Analyzed Average Call Response Time graphs and tables from ACL-1 June 2019 report for Mental Health and Substance Use Disorder calls.
- Calculated the percentage of ACL crisis queue line calls that were answered within 45 seconds and tracked results from month to month.
- Calculated the average response times for non-crisis access lines and tracked results from month to month.

DATA

The average response time for SUD related calls (crisis and non-crisis) is 17 seconds for FY 2018-19.



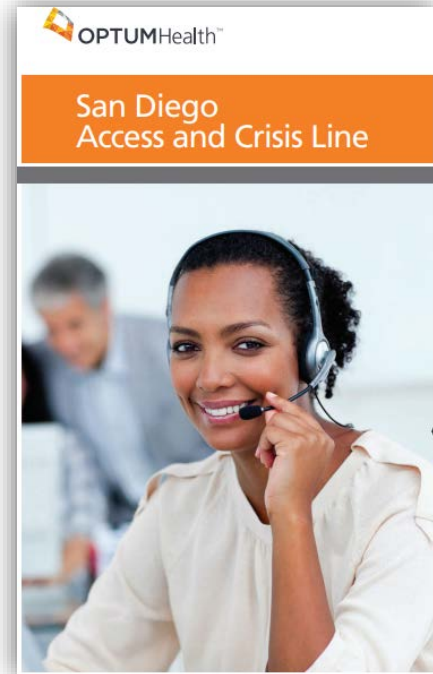
Services Are Efficient and Accessible

RESULTS

- 100% of calls answered by the Access and Crisis Line (ACL) crisis queue are within 45 seconds. Crisis queue calls may have co-occurring mental health and substance use related matters.
- The average response time for behavioral health crisis calls is 11 seconds.
- The average speed to answer all calls is within 17 seconds.
- The County of San Diego BHS began tracking the Access and Crisis Line for SUD related calls at the beginning of FY 2018-19.

NEXT STEPS

- There is a need to establish a baseline for preferred language and separate crisis and non-crisis calls.
- Current response time data for Access and Crisis Line (ACL) calls is not stratified by preferred language and does not separate crisis and non-crisis calls. The Performance Improvement Team (PIT) is working with Optum to add these data points to the ACL reports.
- The Performance Improvement team will continue to review the trends of SUD average call response times.



Track. Discuss. Collaborate. Review.



Services Are Equitable

GOAL 11

100% of clients shall indicate in the Substance Use Disorder (SUD) Services Client Survey that they were given information about their rights.



METHODS

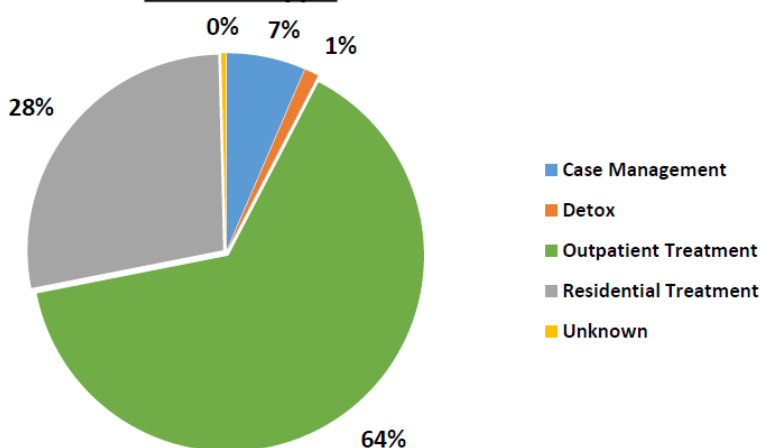
1. Administered the Substance Use Disorder (SUD) Survey to clients receiving SUD services during the survey period in 2018 in order to gauge client interactions and services received.
2. Evaluated responses to the following question: "I was given information about my rights."
3. Assembled a multi-functional Performance Improvement Plan (PIP) team, to help increase awareness of the client's right to file a grievance or appeal.
4. Clients were surveyed about their familiarity and comfort with filing a grievance or appeal.

DATA

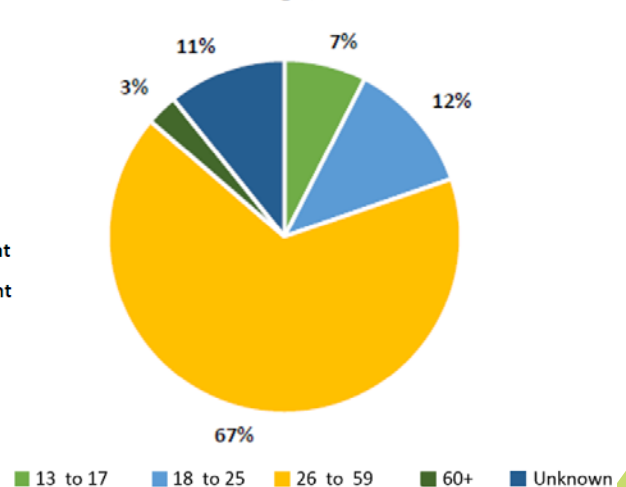
Survey Question	Average Score	Count of Survey Responses				
		1 = Strongly Agree	2 = Agree	3 = Neutral	4 = Disagree	5 = Strongly Disagree
15 - I was given information about my rights	1.69	(53%) 1,048	(33%) 640	(10%) 197	(3%) 56	(1%) 18

DEMOGRAPHICS ON RESPONDENTS

Service Type

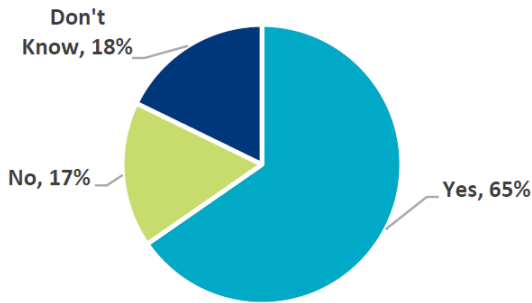


Age



Services Are Equitable

My provider informed me of the grievance and appeal process. (n=1,686)



RESULTS

San Diego County received 1,993 surveys during the survey period. Out of the total surveys received, 1,959 responded to the question: "I was given information about my rights." Overall, 86% of participants responded they Agreed (N = 640) or Strongly Agreed (N = 1,048) to the question. The surveys were completed by both youth and adults.

67% of clients who submitted a survey were between 26 to 59 years old and made up the largest percentage of respondents. The smallest portion (3%) of respondents were aged 60 or over, while youth aged 13 to 17 made up 7% of the overall responses.

The service type with the largest percentage of respondents was Outpatient Treatment and made up 64% of the total survey results. The second largest service type was Residential at 28%, while the lowest was Detox/Withdrawal Management at 1%. Results do not include N/A or missing answers.



My provider informed me of the grievance and appeal process.

Treatment Setting	Yes n (%)	No n (%)	Don't Know n (%)	Combined No and Don't Know n (%)
Detox/WM (standalone) (n=19)	10 (53%)	8 (42%)	1 (5%)	9 (47%)
OP/IOP (n=939)	618 (66%)	126 (13%)	195 (21%)	321 (34%)
OTP/NTP (n=103)	73 (71%)	21 (20%)	9 (9%)	30 (29%)
Residential (n=625)	401 (64%)	129 (21%)	95 (15%)	224 (36%)
Total (n=1,686)	1,102 (65%)	284 (17%)	300 (18%)	584 (35%)

My provider informed me of the grievance and appeal process.

Age Group	Yes n (%)	No n (%)	Don't Know n (%)	Combined No and Don't Know n (%)
Adult (n=1,548)	1,019 (66%)	272 (18%)	257 (17%)	529 (34%)
Youth (n=138)	83 (60%)	12 (9%)	43 (31%)	55 (40%)
Total (n=1,686)	1,102 (65%)	284 (17%)	300 (18%)	584 (35%)

Grievance and Appeal Survey

The Grievance and Appeal survey is useful for indicating if clients are aware of the grievance and appeal process, which is part of their overall rights. 65% of participants responded "Yes" to the following statement: "My provider informed me of the grievance and appeal process." The remaining 35% of respondents reported that their provider did not inform them or did not know if their provider had informed them of the grievance and appeals process.

Within the treatment setting, OP/IOP had the largest number of participants (N = 618) agree that they were provided information on the grievance and appeal process. Residential had the second highest number of participants agree, with 401 responding "Yes" to the question. The total across all participants surveyed who agreed that their provider informed them of the grievance and appeal process was 1,102.

The number of adults who agreed with the statement, "My provider informed me of the grievance and appeal process" was 1,019, which is 60% of the surveyed population. Youth made up approximately 5%, with 83 participants agreeing with the statement.

Next Steps

- Continue to evaluate feedback based on clients' responses to whether their program is providing the required and necessary information on client rights.
- Communicate with Programs to help ensure they are providing clients with required and important information regarding beneficiary rights.
- Continue with the current Performance Improvement Plan (PIP) through April 2020 to increase awareness of the Grievance and Appeal process, as a beneficiary right.
- Track and review the number of grievances and appeals received and utilization of the Grievance and Appeal process to determine if client familiarity with the process improves.

Services Are Equitable

GOAL 12

100% of programs will have a Cultural Competency Plan to ensure the program is equitably serving their community.

DATA

- Out of 33 SUD Legal Entities, 32 submitted their Cultural Competence Plans to Behavioral Health Services (BHS) this FY 2018-19 (97%).
- BHS has developed a Cultural Competency checklist (Fig 1) with input from the Cultural Competence Resource Team (CCRT). This assessment tool is for programs to evaluate their current Cultural Competence Plan and to integrate the plan components into the System of Care.
- The Cultural Competence Plan Development checklist includes CLAS Standards which offer a strong framework to provide culturally and linguistically appropriate services.
- BHS Quality Improvement presented the Cultural Competence Plan Development Checklist at the annual Quality Management Forum, which all providers were required to attend.
- 99.6% of the respondents to the Cultural Competence Assessment Survey (for both SUD and Mental Health), indicated that their organizations' Cultural Competence Plan identified and supported the CLAS Standards. The percentage for SUD only respondents is consistent at 98.7%.

METHODS

1. Each legal entity is required to submit their Cultural Competence Plan.
2. A Cultural Competence Plan Development checklist (Fig 1) was provided as a guide for programs to enhance their Cultural Competence Plan for providing trauma-informed and culturally competent systems and services.
3. Collaborated with Program Monitors and requested all SUD legal entities to provide their Cultural Competence Plans.
4. Each County-contracted and County-operated Program Manager was sent the Cultural Competence Assessment Survey (Fig 2) in February 2019.

Cultural Competence Plan Development Checklist						
SDCBHS recommends the use of this tool						
CULTURAL COMPETENCE PLAN COMPONENTS:	COMPONENT IMPLEMENTATION					In response to what data or information was the change/innovation/improvement made?
	In Progress:	Approx. Impl. Date:	Met:	Resources Used:	Date Met:	
Current Status of Program						
Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.	☐		☐			
Identify how program administration prioritizes cultural competence in the delivery of services.	☐		☐			
Agency training, supervision, and coaching incorporate trauma-informed systems and service components.	☐		☐			
Goals accomplished regarding reducing health care disparities.	☐		☐			
Identify barriers to quality improvement.	☐		☐			
Service Assessment Update and Data Analysis						
Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.	☐		☐			
Comparison of staff to diversity in community.	☐		☐			
A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.	☐		☐			
Use of interpreter services.	☐		☐			
Service utilization by ethnicity, race, language usage, and cultural groups.	☐		☐			
Client outcomes are meaningful to client's social ecological needs.	☐		☐			
Objectives						
Goals for improvements.	☐		☐			
Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.	☐		☐			
a) Trauma-informed principles and concepts integrated	☐		☐			
b) Faith-based services	☐		☐			

Fig 1: The Cultural Competence Plan Development checklist with CLAS Standards.

Section 1 Questions (continued)	Not at All	Barely	Somewhat	Fairly Well	Very Well	Yes	No
2. Does your organization's Cultural Competence Plan identify and support the CLAS Standards?	N/A	N/A	N/A	N/A	N/A	99.6%	0.4%
	N/A	N/A	N/A	N/A	N/A	100.0%	0.0%
	N/A	N/A	N/A	N/A	N/A	98.7%	1.3%

Fig 2: Section 1 of the 2019 CLCPA: Systemwide Report

Legend: Combined MHS SUD

Services Are Equitable

RESULTS

BHS is committed to enhancing Cultural Competence across all systems and services of care and encourages all programs to continually enhance their levels of cultural competence.

Each legal entity is required to have a Cultural Competence plan, which is reviewed by BHS to evaluate each program's current cultural competence and, if needed, assist with integrating the plan components into their organization's system of care.

BHS has identified and developed two assessment tools. One is for assessing organizational assessment: The Cultural and Linguistic Competence Policy Assessment (CLCPA) and the other is for Individual/Staff Assessment: Promoting Cultural Diversity Self-Assessment Checklist (PCDSA).

In addition to requiring legal entities providing a Cultural Competence plan, BHS annually updates and submits their Cultural Competence Plan to the Department of Health Care Services (DHCS). The three-year strategic plan is very thorough and includes the following 8 criteria:

- Commitment to Cultural Competence
- Updated Assessment of Service Needs
- Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
- Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
- Culturally Competent Training Activities
- County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
- Language Capacity
- Adaptation of Services



NEXT STEPS

- Collaborate with CCRT to review all legal entities' Cultural Competence Plans and provide feedback on each plan.
- Work with programs to discuss findings and advise how to advance cultural competence within their programs and provided services.
- Programs which have successfully adopted the Cultural Competence Plan can be an advocate for new programs.
- Follow-up with the program who has not confirmed or provided their most recent plan.

Services Are Timely

GOAL 13

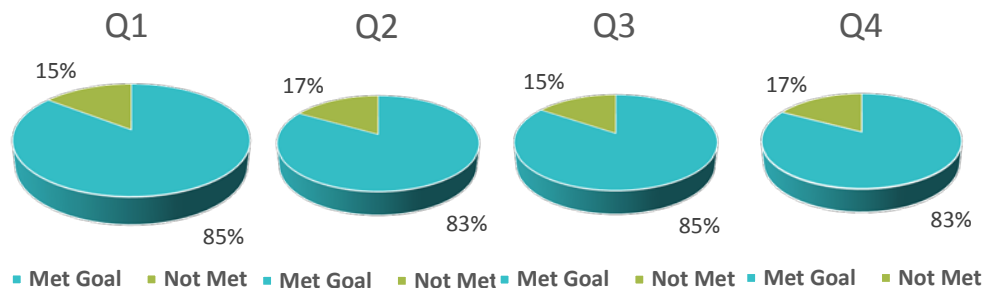
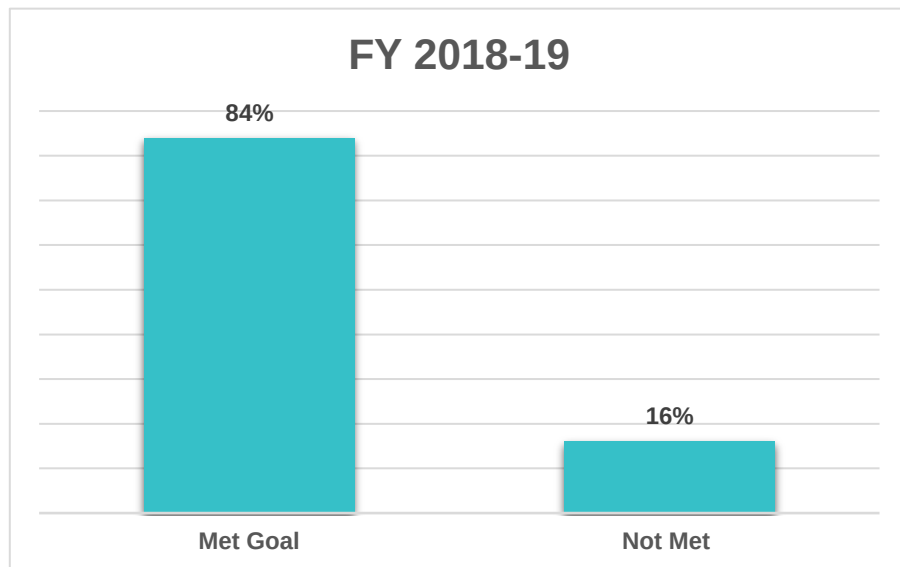
100% of Outpatient programs shall meet the access timeliness standard of 10 business days for the initial contact to a face to face appointment.

METHODS

1. Developed an Access Time report (monthly) to evaluate access times for clients across levels of care.
2. Analyzed the report to determine the percentage of outpatient programs which met the access timeliness standard of 10 business days.



DATA



Services Are Timely

RESULTS

- In FY 2018-19, 84% of outpatient programs met the timeliness standard of 10 business days.
- The rates demonstrate little change from quarter to quarter.

NEXT STEPS

- Discuss quarterly findings at QRC, BHAB meetings, and other council groups to review and identify trends in outpatient standard timeliness fulfillment.
- Examine the trends across different demographic groups to identify barriers to access.
- Discuss and collaborate with providers about the findings to improve access to services.

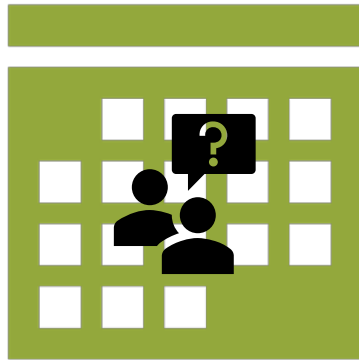
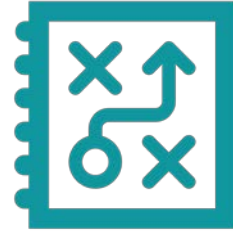
Discuss. Examine. Collaborate.



Services Are Timely

GOAL 14

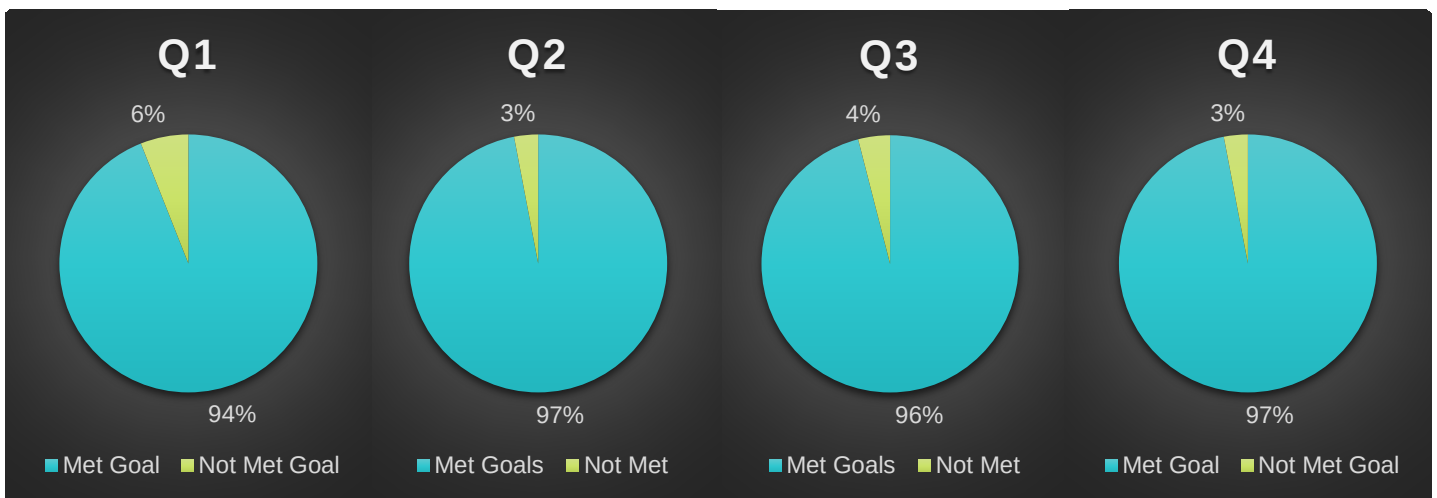
100% of Opioid Treatment Programs (OTPs) shall meet the access timeliness standard of 3 business days for a face to face appointment.



METHODS

1. Developed Access Time report (quarterly) for evaluating access time among clients across levels of care.
2. Analyzed the report to find out the percentages of Opioid Treatment Programs (OTP) that met the access timeliness standard of 3 business days.

DATA



Services Are Timely

RESULTS

- In FY 2018-19, more than 90% of the Opioid Treatment Programs met the access time standard of 3 business days in each quarter.
- The trend of OTPs meeting the timeliness standards from Quarter 1 (Q1) to Quarter 4 (Q4) is showing an increase of timeliness over time.



Discuss. Examine. Collaborate. Improve.



NEXT STEPS

- Discuss quarterly findings with programs to support continuous improvement efforts related to access times.
- Examine the trends across different demographic groups to determine any discrepancies.