



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



# **QUALITY IMPROVEMENT**

## **Substance Use Disorder Services Work Plan Evaluation**

*Fiscal Year 2019-2020*

## 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. The plan describes quality improvement activities including plans for sustaining improvement, monitoring of previously identified issues, and tracking of target areas over time. 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.

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Quality Improvement Work Plan (QIWP) Evaluation  
Developed by the County of San Diego Health and Human Services Agency,  
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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](mailto:BHSQIPIT.HHSA@sdcounty.ca.gov).



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## WORK PLAN GOALS

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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 HHS and Behavioral Health Services' vision, mission, and strategy/guiding principles.

### County of San Diego, Health and Human Services Agency

**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 the 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

Decrease the proportion of Grievances/Appeals related to *Quality of Care* by 5%, compared to the previous fiscal year (FY).

### METHODS

- Compared the annual number of *Quality of Care* grievances between FY 2018-19 and FY 2019-20 using the Quarterly Grievances and Appeals report.
- Tracked the number of appeals received related to *Quality of Care*.

### DATA / RESULTS

#### Grievances and Appeals Report

Out of the total 184 grievances received, 129 of those were related to *Quality of Care*. **This is a 4% decrease compared to *Quality of Care* grievances received in FY 2018-19**, which was 99 out of 134.

During FY 2019-20, *Quality of Care* was the largest proportion of all grievances received at 70%. *Quality of Care* includes the following subcategories and totals for FY 2019-20:

- **Staff Behavior Concerns** – 52 (40%)
- **Treatment Issues/Concerns** – 19 (15%)
- **Medication** – 12 (9%)
- **Cultural Appropriateness** – 2 (2%)
- **Other Quality of Care Issues** – 44 (34%)

There were four appeals received for *Quality of Care*, all of which were in the Treatment Issues/Concerns subcategory and were resolved in a timely manner.

## Services are Client Centered

### GOAL 2

Increase by 5% the number of Youth clients who indicate they received services that were right for them on the substance use disorder (SUD) Treatment Perception Survey (TPS) compared to the previous fiscal year.

### METHODS

- The annual Youth Treatment Perceptions Survey (TPS) was completed by any client 18 years old or younger served by a SUD program in the Children, Youth and Families (CYF) System of Care contracted by SDCBHS during the October 2019 survey period.
- Responses to the following question were evaluated: "I received services that were right for me."

### DATA / RESULTS

- Of the 130 youth clients who responded to the survey question, "I received services that were right for me," 77% either Agree or Strongly Agree with this statement. **This is a positive increase of 2% from the previous survey period conducted in October 2018.** While the goal of a 5% increase was not met, the trend is moving in an upward direction.

Satisfaction by Item Response: Systemwide (Youth)		
Survey question based on services received within the last year	N	% Strongly Agree/Agree
I received services that were right for me.	130	77%

- In a clinical view, 88% of youth clients who had an American Society of Addiction Medicine (ASAM) assessment in FY2019-20, had an actual ASAM level that matched their recommended ASAM level.
- The proportion of actual ASAM levels matching the recommended ASAM levels is higher compared to youth responses of their perception that they received services that were right for them.

## Services are Safe

### GOAL 3

Establish a baseline for SUD serious incidents, identifying trends specifically in suicide attempts; serious allegations of or confirmed inappropriate staff behavior; and apparent overdose of alcohol/drugs.

#### METHODS

- Monitored serious incidents by reviewing the Quarterly Incident Report.
- Utilized the SUD Serious Incident Report to align with the Department of Health Care Services (DHCS) requirements.
- Tracked the number of Serious Incidents by System of Care, separated by adult and youth, and looked at trends specifically in suicide attempts, serious allegations of or confirmed inappropriate staff behavior, and apparent overdose of alcohol or drugs.

#### RESULTS

**In FY 2019-20, there were 64 total serious incidents reported for Substance Use Disorder Services system of care, all of which were from the adult population.**

The established baseline for the aforementioned categories of SUD serious incidents reported is shown in the chart below, and is as follows:

- ***Suicide attempts*** – 4
- ***Serious allegations of or confirmed inappropriate staff behavior*** – 7
- ***Apparent overdose of alcohol/drugs*** – 13

#### DATA

Serious Incident Report FY 2019-20  
Substance Use Disorder Services - Adult

Serious Incident	July-19	Aug-19	Sept-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	June-20	Total
Incident in the Media	1	-	-	-	-	-	1	-	-	-	1	-	3
Death by Suicide	1	-	-	-	-	-	-	-	-	-	-	-	1
Death Under Questionable Circumstances	1	-	1	1	3	1	1	-	1	-	-	1	10
Suicide Attempt	-	-	2	1	-	-	-	-	-	-	1	-	4
Tarasoff (Report received by Program)	-	-	-	1	-	-	2	-	-	-	-	-	3
Serious Allegations of or Confirmed Inappropriate Staff Behavior	1	-	-	-	1	3	-	2	-	-	-	-	7
Serious Physical Injury	1	-	-	-	-	-	-	-	-	-	-	-	1
Apparent Overdose of Alcohol/Drugs	2	-	1	1	4	-	2	-	-	1	2	-	13
Other	1	5	2	3	1	3	1	2	1	-	2	1	22
<b>Total</b>	<b>8</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>9</b>	<b>7</b>	<b>7</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>6</b>	<b>2</b>	<b>64</b>

## Services are Effective

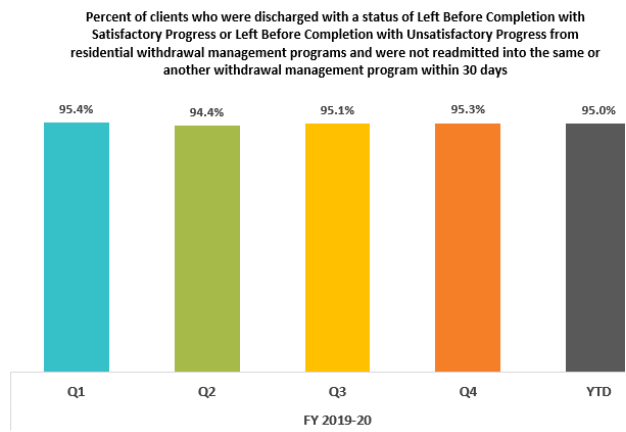
### GOAL 4

90% of clients who were discharged with a status of Left Before Completion with Satisfactory Progress or Left Before Completion with Unsatisfactory Progress from residential withdrawal management (WM) programs shall not be readmitted into the same or another withdrawal management program within 30 days\*.

### METHODS

Reviewed admission and discharge data for WM programs from SanWITS extract.

### DATA / RESULTS



During FY 2019-20, there were 1,953 clients who were discharged from Residential WM programs with a status of *Left Before Completion with Satisfactory Progress* or *Left Before Completion with Unsatisfactory Progress*. Out of 1,953 clients, **95.0% (1,856) were not readmitted to a WM program within 30 days from discharge**. Non-readmission rate shows a steady trend above 90%.

\*After QI Work Plan goals were published, WM discharge statuses were further explained that if the client has gone through WM as planned and is referred to the next level of care, then "*Left Before Completed with Satisfactory Progress*" should be used as the discharge status.

FY 19-20	"Left Before Completion with Satisfactory Progress/ Standard" WM Discharges	Not Readmitted to WM within 30 days	Percent
Q1	327	322	98.5%
Q2	336	324	96.4%
Q3	217	211	97.2%
Q4	181	176	97.2%
<b>Total</b>	<b>1,061</b>	<b>1,033</b>	<b>97.4%</b>

The table above reflects the non-readmission rate for WM discharges with "*Left Before Completion with Satisfactory Progress/Standard*" status only. **For FY 2019-20, non-readmission rate shows a steady trend at above 96%.**



## Services are Effective

### GOAL 5

100% of SUD Teen Recovery Center contracts will have a minimum of two school-based sites that are operational.

### METHODS

- Each designated region's main sites will be assigned at least two school-based sites that provide treatment.
- School sites available for treatment will be documented.

### RESULTS

- There are a total of seven main site regions, most of which have two or more designated school-based sites that provide treatment services.
- **Two of the main site regions currently only have one assigned school-based site.** This is due to recent delays, including the COVID-19 pandemic. Meetings with school districts and plans to add another school-based treatment site have been temporarily put on hold.
- Children, Youth and Families System of Care is actively working to add more school-based sites.

Main Site	School Sites
TRC North Coastal	Rancho Buena Vista HS
TRC North Inland	Valley HS Fallbrook HS Ramona HS Poway Unified
TRC North Central	James Madison HS Patrick Henry HS
TRC Central	San Diego HS Hoover HS Alba HS
TRC Central SE	Morse HS Lincoln HS
TRC East	Chaparral HS
TRC South	Otay HS Montgomery HS

## Services are Effective

### GOAL 6

BHS will have two active PIPs (Performance Improvement Projects) that contribute to meaningful improvement in clinical care as monitored by the EQRO.

#### METHODS

Data collection conducted by UCSD:

**Relapse Prevention Clinical PIP** - development and implementation of a Relapse Prevention Evidence-Based Practice model to decrease rates of early discharges without satisfactory progress from treatment programs by 5%.

- Monitored the rate of early discharges in the system and in clients exposed to intervention.
- Monitored the rate of connections within 30 days of treatment completion with a referral to a lower level of care.

**Grievances and Appeals Non-Clinical PIP** - improving accessibility of materials and educating clients to increase awareness and comfort with the grievance and appeals processes among clients in the DMC-ODS by 5%, and to increase utilization of these processes by 5%.

- Evaluated responses on the Treatment Perceptions Survey (TPS) supplemental survey.
- Monitored the number of grievances filed and reported to DHCS.

#### RESULTS

Relapse Prevention Clinical PIP	
Indicator	Result
<i>Reduction in early discharges by 5%</i>	Met and exceeded, with a reduction of 16%
<i>Increase in Connections by 5%</i>	Met and exceeded, with an increase of 14%
Grievances and Appeals Non-Clinical PIP	
Indicator - TPS Results	Result
<i>Reduction of 5% in clients that report that they strongly disagree/disagree that they understand how to file a grievance</i>	Partially Met, with a reduction of 4%
<i>Reduction of 5% in clients that report that they strongly disagree/disagree that they understand how to file an appeal</i>	Partially Met, with a reduction of 3%
<i>Reduction of 5% in clients that report that they did not know or were not informed by their provider of the grievance and appeals process</i>	Met and exceeded, with a reduction of 6%
Indicator - Utilization	Result
Increase of 5% in utilization of the grievance and appeals process	Met with a 103% increase in utilization in the same quarter as baseline

# Services are Efficient and Accessible

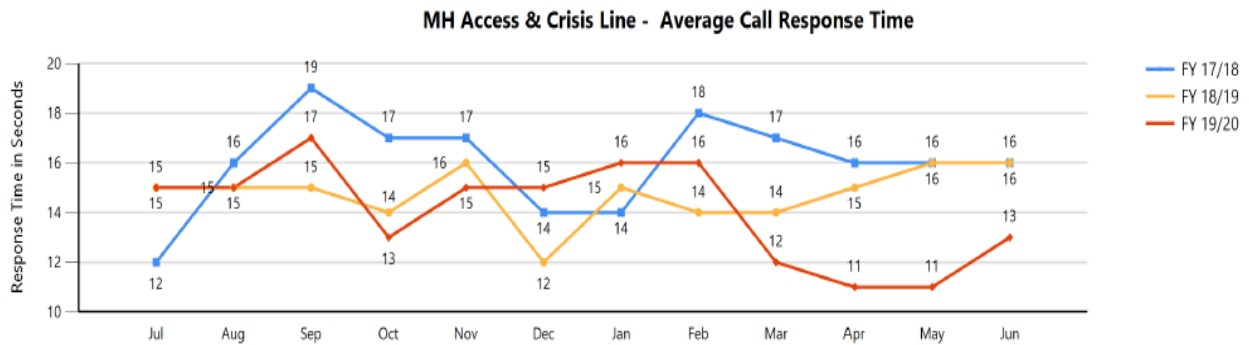
## GOAL 7

Ensure average speed to answer calls is within 60 seconds (ACL).

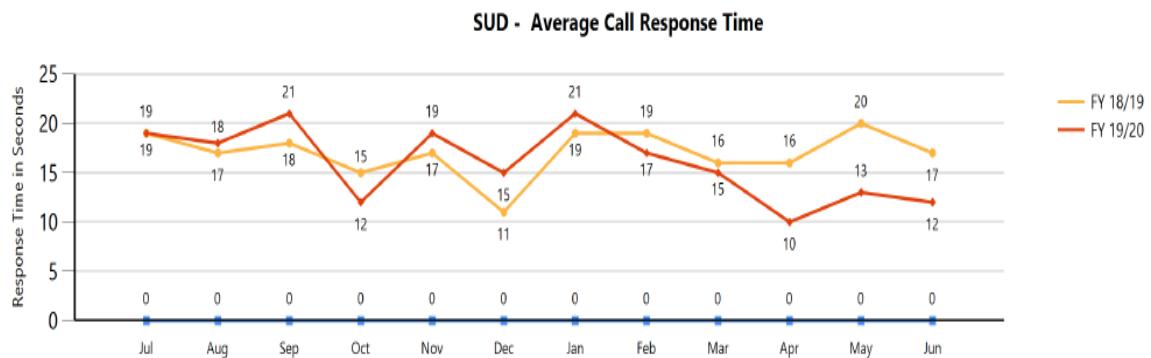
### METHODS

- Utilized ACL-1 Call Statistics Report to analyze Access and Crisis Line (ACL) access times and types of calls received.
- Applied the same methodology used for the report to establish the average speed for crisis and non-crisis ACL calls received during FY 2019-20.

### DATA / RESULTS



- Access and Crisis Line (ACL) crisis calls in queue are answered within 45 seconds. Crisis queue calls may have co-occurring mental health and substance use related matters.



- **SUD monthly average call response time for FY 2019-20 ranged from 10 to 21 seconds.**
- FY 2019-20 had an average response time of 16 seconds, which is a 6% increase from the average response time in FY 2018-19.

## Services are Efficient and Accessible

### GOAL 8

A minimum of 30% of Substance Use Disorder clients with a referred discharge will connect with services within 10 days.

### METHODS

- Reviewed admission and discharge data from SanWITS extract.
- Analyzed the number of SUD clients who were discharged with a status of *Completed Treatment with Referral*.
- Analyzed the number of SUD clients who were discharged with the same status and admitted to a SUD program within 10 calendar days, during FY 2019-20.

### DATA

FY 2019-20	Total Discharges	Connected Within 10 Days	Percent
Q1	1,023	321	31%
Q2	1,149	296	26%
Q3	1,364	344	25%
Q4	1,176	370	31%
Total	4,712	1,331	28%

### RESULTS

In FY 2019-20, there were 4,712 clients who were discharged from SUD programs with a status of *Completed Treatment with Referral*. **Out of 4,712 clients, 28% (1,331) were connected to another SUD program within 10 days from discharge.** This falls slightly below the goal set at 30% for FY 2019-20.



## Services are Efficient and Accessible

### GOAL 9

Ensure Medication Assisted Treatment (MAT) services are available in San Diego's North County region.

### METHODS

- Utilized data collected on yearly Total Units of Service (TUOS) Report for FY 2019-20. TUOS report reflects the number of SUD units of service provided.
- Analyzed number of MAT encounters and units for North County SUD programs, stratified by quarter. These numbers reflect MAT services in Opioid Treatment programs (OTPs).

### DATA

North County Region MAT Services	Q1	Q2	Q3	Q4	FY 2019-20 Total MAT Services	Unique Clients
North Coastal	1,306	1,877	1,790	1,369	6,342	119
North Inland	1,181	1,334	1,781	2,283	6,579	226
<b>Total</b>	<b>2,487</b>	<b>3,211</b>	<b>3,571</b>	<b>3,652</b>	<b>12,921</b>	<b>328</b>

### RESULTS

North County MAT services ranged from 2,487 to 3,652 services quarterly, with a FY 2019-20 total of 12,921 services provided. **North County Region saw a total of 328 unique clients served in FY 2019-20, with an average of 3,230 quarterly services provided.**

## Services are Equitable

### GOAL 10

A minimum of 85% of adult TPS satisfaction survey respondents will agree that staff were sensitive to his/her cultural background (race/ethnicity, religion, language, etc.).

### METHODS

- The annual adult Treatment Perceptions Survey (TPS) was completed by any adult served by a SUD program in the Adult/Older Adult (AOA) System of Care contracted by SDCBHS during the October 2019 survey period.
- Responses to the following question were evaluated: “Staff were sensitive to my cultural background.”

### DATA

Adult Satisfaction by Item*			
Questions based on services received within the last year:	N	% Strongly Disagree/Disagree	% Strongly Agree/Agree
7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	2,361	2%	88%

### RESULTS

Of the 2,361 individuals who responded to the question *Staff were sensitive to my cultural background*, during the survey period, **88% reported strongly agree/agree that staff were sensitive to their cultural background including race/ethnicity, religion, and language.** This level of satisfaction has met and exceeded the FY 2019-20 goal.

## Services are Timely

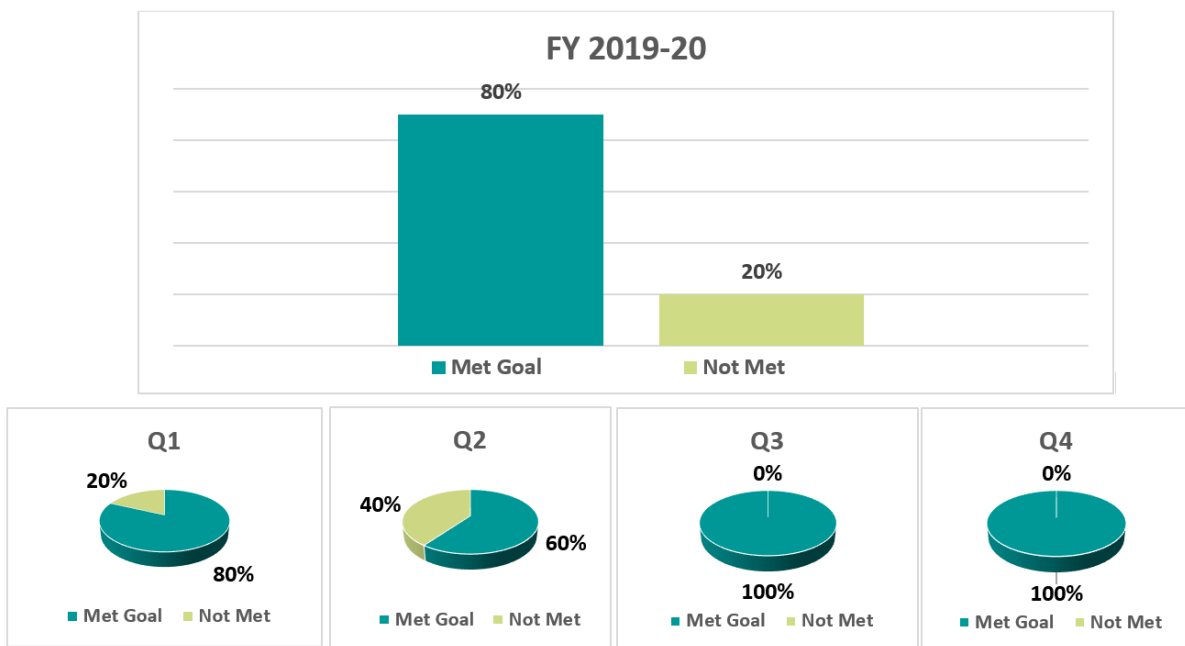
### GOAL 11

100% of Opioid Treatment programs (OTPs) shall meet the access timeliness standard of 3 business days for an initial dosing of medication.

### METHODS

- Utilized data collected on Average Access Time quarterly report for FY 2019-20.
- Analyzed number of Opioid Treatment programs for FY 2019-20 with a 3 business day standard from initial request to initial dosing of medication.

### DATA



### RESULTS

**In FY 2019-20, 80% of the Opioid Treatment Programs (OTPs) met the access time standard of 3 business days.** The quarterly trend of OTPs meeting the timeliness standard varied. In Q1, 80% of OTPs met the goal, in Q2 60% of OTPs met the goal, while in Q3 and Q4 100% of OTPs met the goal.

## Services are Timely

### GOAL 12

Establish a baseline for the number of timely access Notice of Adverse Benefit Determinations (NOABDs) required.

### METHODS

- Timely Access NOABDs are issued when there is a failure to provide timely access to services.
- Utilized data collected from QSR NOABD tracking for FY 2019-20.
- Measured total number of timely access NOABDs sent.

### DATA

Timely Access NOABDs	Q1	Q2	Q3	Q4	FY 2019-20
# of timely access NOABDs	0	0	7	4	11
% of NOABDs	0.0%	0.0%	0.6%	0.5%	0.3%

### RESULTS

For FY 2019-20, there were a total of 11 timely access NOABDS, with 7 in Q3 and 4 in Q4. Timely Access NOABDs accounted for only 0.6% of total NOABDs for Q3, 0.5% for Q4 and 0.3% of total NOABDs for FY 2019-20. SUD programs are relatively new to data entry requirements for NOABDs and will be further examined to establish a baseline.