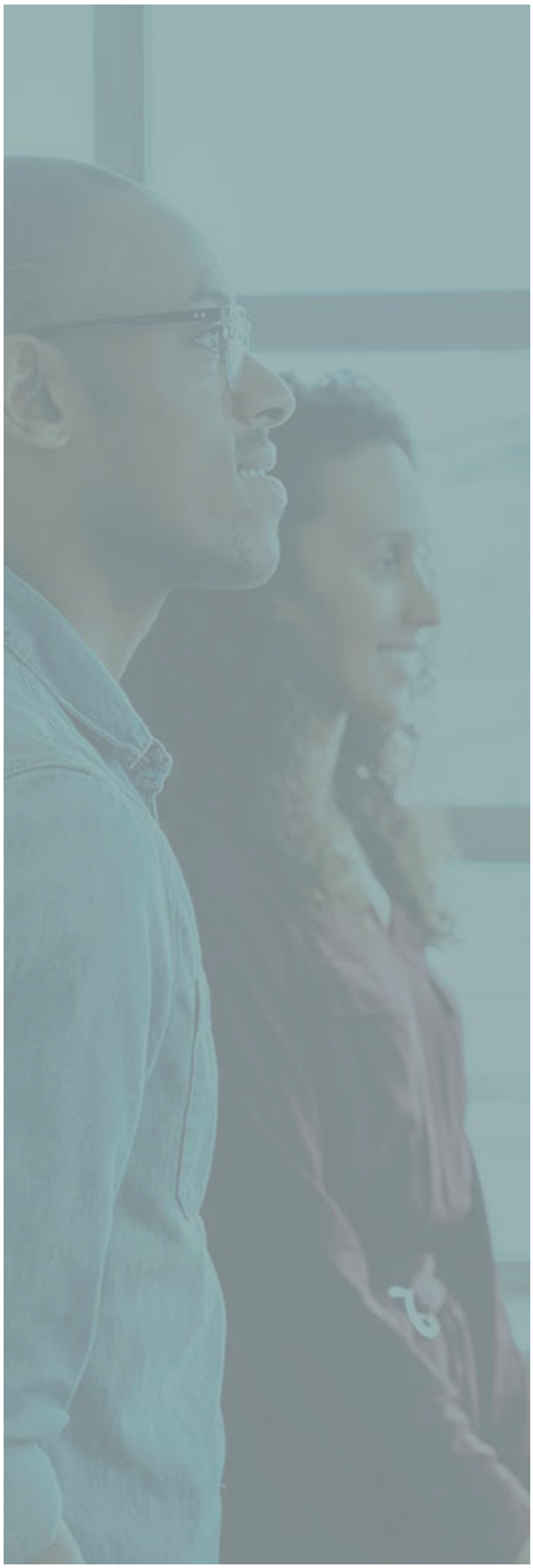
QUALITY IMPROVEMENT PROGRAM & WORK PLAN

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

Fiscal Year 2019-20

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO



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INTRODUCTION

In accordance with the California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440, the County of San Diego Behavioral Health Services (BHS) has a Quality Improvement (QI) Unit and an Annual Quality Improvement Work Plan (QIWP).

The goals of the BHS QI Unit are based on the healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: "Crossing the Quality Chasm." The targeted quality improvement aims for all health care services are to be safe, client centered, effective, timely, efficient, and equitable. These IOM aims are interwoven throughout the QI Unit and QIWP. In addition, both are guided by BHS' mission statement and guiding principles.

BHS Guiding Principles:

- To foster continuous improvement to maximize efficiency and effectiveness of services.
- To support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems.
- To maintain fiscal integrity.
- To ensure services are:
    - Outcome driven
    - Culturally competent
    - Recovery and client/family centered
    - Innovative and creative
    - Trauma-informed
- To assist County employees to reach their full potential.

County of San Diego Behavioral Health Services Mission Statement:

To help ensure safe, mentally healthy, addiction-free communities.

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

QUALITY IMPROVEMENT (QI) UNIT

QI Unit Purpose

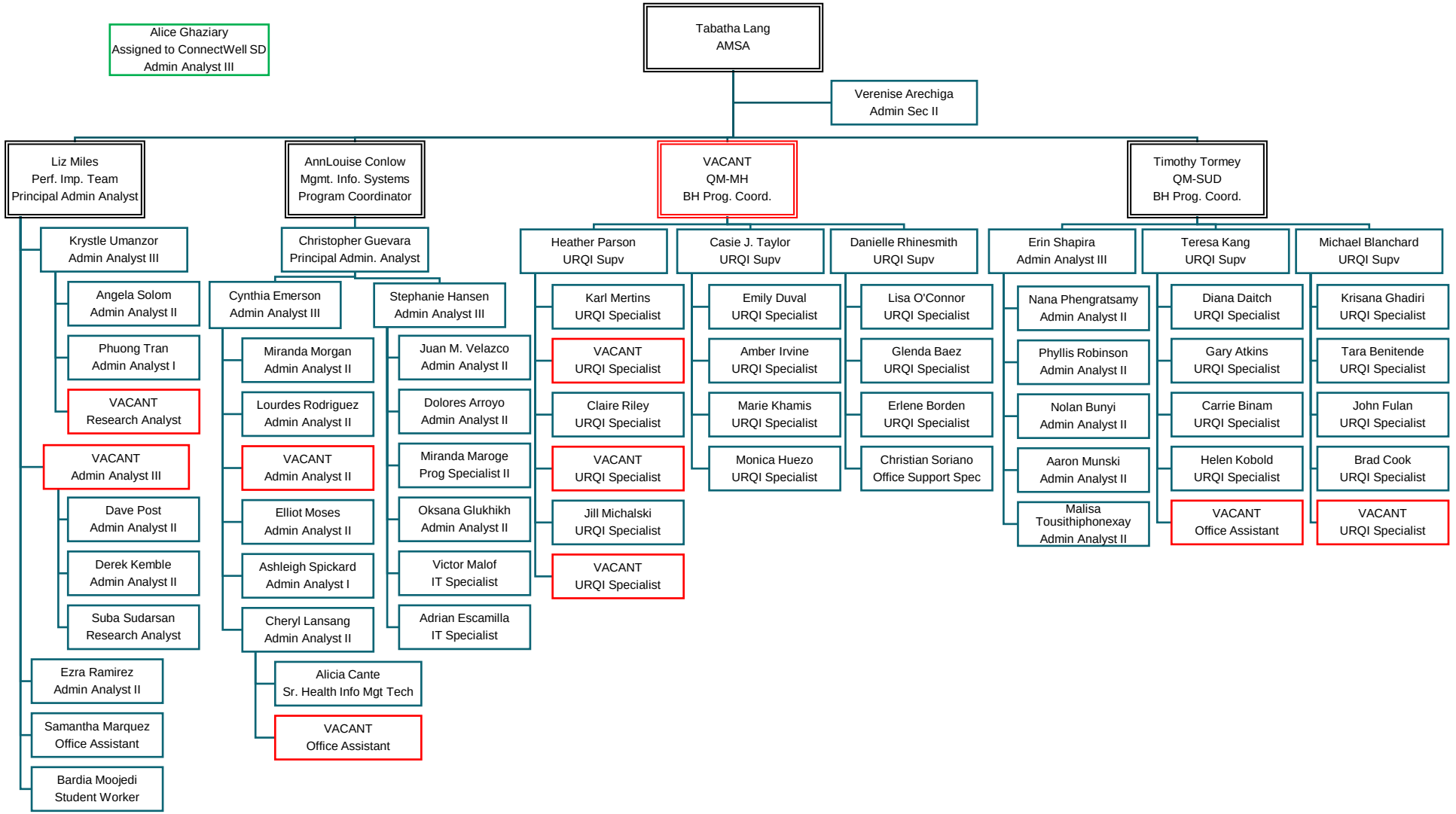
The purpose of the BHS QI Unit is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Unit delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use disorder services provided. The QI Unit encompasses the efforts of clients, family members, clinicians, mental health advocates, substance abuse treatment programs, quality improvement personnel, and other stakeholders.

The QI Unit and Quality Improvement Work Plan (QIWP) are based on the following values:

- Development of QI Unit and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Unit and QIWP objectives.
- QI Unit and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

QI Unit Organizational Chart



QI Unit Structure

The following are components of the QI Unit structure:

- **Executive Quality Improvement Team (EQIT)**
  The EQIT is responsible for implementing the QI Unit, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities. The EQIT consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Chief. The EQIT reviews Serious Incidents and Grievances routinely.
- **Quality Improvement Performance Improvement Team (QI PIT)**
  The QI Unit includes the BHS QI PIT, which monitors targeted aspects of care on an ongoing basis and produces reports monthly, quarterly, or annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So that opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are frequently brought to the EQIT and QRC for input.
- **Quality Management (QM) Team**
  The QM team is another component of the QI Unit and is comprised of Quality Improvement Specialists—licensed therapists and clinicians—who conduct a variety of reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs.
- **Management Information Services (MIS) Team**
  The MIS Unit provides support services to BHS programs through internal security management of user accounts, development of electronic forms, troubleshooting system issues, implementation of new functionality within the Cerner Community Behavioral Health (CCBH) Client Management System, user acceptance testing of releases for CCBH and the Web Infrastructure for Treatment Services (SanWITS), and the coordination of IT support for BHS Administration. Staff serve in a variety of advisory capacities including committees on interoperability and other system functionality. Staff also collaborate with other BHS departments, the County's outsourced IT Vendor, and Cerner, the software vendor for CCBH to design, test, and implement new functionality and hardware.
- **Quality Review Council (QRC)**
  The QI Unit includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and the QIWP. The QRC meets at least quarterly, and the members are clients or family members, as well as stakeholders, from the behavioral health communities across all regions. The QRC provides advice and guidance to BHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review, interpretation, and evaluation of quality

improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.

- **Quality Improvement Committees (QICs)**

  The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:

  - QRC Membership Committee
  - Peer-Family Employment

The QI Unit's recent accomplishments include, but are not limited to:

- Collaborating with Optum in developing the System of Care Application, a web application where providers can access and submit all information required by the Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Final Rule, also known as the Mega-Regs
- Developing the updated SUD Behavioral Health Advisory Board report to reflect new Drug Medi-Cal (DMC) System of Care outcomes
- Developing the master demographics report from Optum to help streamline reporting requirements by having demographics "ready to go"
- Developing the Accountability Report Package to provide direct feedback to programs and help highlight potential costs
- Implementing an improved discharge summary form for Mental Health Services
- Collaborating with other teams and stakeholders on the Whole Person Wellness pilot project
- Completing and submitting the 2019 Cultural Competence and 3-Year Strategic Plan to DHCS
- Updating the 2019 Mental Health Implementation Plan
- Developing a new Interactive Annual Systemwide Dashboard and Interactive Justice Population Dashboard
- Enhancing the Justice Population report methodology and sharing data with the County of San Diego Probation Department
- Developing a detailed capacity analysis on Inpatient Hospital/Long Term Care/Board & Care/Housing Prices with a focus on Admin Days

- Producing a detailed predictive analysis on the effects of the shuttering of Palomar Hospital's Psychiatric Inpatient Unit, based on recorded effects of Tri City Hospital's Psychiatric Inpatient Unit closing
- Stratification of PERT client characteristics by overall emergency utilization
- Homefinders program data matching to highlight the 100 clients and families with the highest need for a housing voucher
- Launching the Cal Medi-Connect Data match project

The following radial diagram depicts the committees and workgroups that make up the structure of the QI Program:

QI Process

BHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key systems, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built, measured consistently, interpreted, and articulated into the performance of the BHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of BHS. It is applied when examining the care and services delivered by the BHS network of providers, programs, facilities, and the Administrative Service Organization.

Goals of Quality Improvement

The goals of the quality improvement process are to:

1) Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards
2) Monitor these functions accurately
3) Draw meaningful conclusions from the data collected using valid and reliable methods
4) Implement useful changes to improve quality
5) Evaluate the effectiveness of changes

Client and Family Involvement in QI

Consistent with our goals of involving clients and family members in the quality improvement process, many of the QI activities are based on input from clients and family members.

Clients, family members, providers and stakeholders are involved in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Behavioral Health Advisory Board, community coalitions, planning councils, community engagement forums, client and family focus groups, client- and family-contracted liaisons, youth and Transition Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input from the County Behavioral Health website.

Quality Review Council Focus

QRC has identified the following potential focus topics for FY 2019-20:

- Client-centered services: client grievances, client interaction with the Support Specialists, customer service, and monitoring of requests for Appeals and State Fair Hearings.
- Safety: reducing serious incidents, medication monitoring standards, and suicide prevention.
- Effective services: continuity of care; housing efforts in board & care, independent living facilities, and recovery residences; reducing readmissions; consumer employment and workforce development; and continued collaboration with stakeholders and hospital partners.
- Efficient and accessible services: focus on expanding crisis stabilization services.
- Equitable services: client and family access to information in their preferred language, and continuity of care and connection to services.
- Timely services: timely access to crisis and non-crisis Access and Crisis Line options, access time for mental health and substance use disorder assessments, access time between assessment and initial treatment, and establishing a standard no-show rate.

Performance Improvement Projects

To be responsive and transformative, the QI Unit will continue its work on four Performance Improvement Projects (PIPs) focused on:

1) <u>Family Engagement (Mental Health Clinical)</u>

   While research has found that high caregiver engagement in a child's therapy results is associated with better client outcomes (Dowell & Oggles, 2010), data from the CYF System of Care indicates that family therapy is not being provided to clients as often as it is in other service systems. While there is no standard amount of family therapy that has been recommended by professional mental health organizations, practice guidelines from the American Academy of Child and Adolescent Psychiatry state that caregivers should be active participants in their child's treatment. Particularly, in the case of behavior disorders, the most promising interventions focus on the caregivers.

   This clinical PIP focuses on providing training on caregiver engagement and examines whether this intervention will increase the number of family therapy sessions, and the quality of caregiver participation in these sessions.

2) Discharge Summary Reasons: Client-Reported Reasons for Discontinuing Services (Mental Health Non-Clinical)

Initial efforts focused on identifying why some programs within the Outpatient (OP) level of care had unexpectedly high or low proportions for some discharge reasons. For example, only 7% of clients were discharged from the OP level of care for the reason "satisfactorily achieved goals." Upon further examination of the data extracted from the CIBH MIS, it became evident that some of the problems were likely due to the nature of the discharge question in the system. A detailed analysis of the data was conducted, and issues were found that are likely impacting the effectiveness of the information and the interpretation of the data. A summary of these issues includes:

- The current Discharge Summary Form (DSF), mixes the "where" and "why" questions to be addressed during discharge. Only one choice is allowed, so often the choice has to be made between two equally applicable choices (e.g., "SAG" and "TLLOC" for a Crisis Residential program).
- There are redundant choices in different part of the DSF that often are in conflict in the data.
- Even given a well-designed DSF, the information cannot be interpreted at the systemwide level. For example, OP and Crisis Residential would choose differently with regard to the use of certain answer choices to reflect the same disposition.

The non-clinical PIP encompasses both a redesign of the discharge form and an intervention designed to reduce the rate of clients who do not return.

Through consultation with other BHS stakeholders, it was revealed that other groups were simultaneously aware of and discussing possible solutions to the problem. The PIP then forged ahead into consolidating these efforts and organized stakeholder and interested party meetings. The first such meeting resulted in a draft plan of action consisting of design ideas for a new discharge form with improved content and layout.

Information was also gathered from clients during the Spring 2018 Client Satisfaction Survey. The questions were designed to gain insight to the client's perspective of the circumstances under which they are discharged from services. The analysis of these survey questions took place during FY 2018-19 Q1. Following these efforts, a plan was formulated to implement the new DSF in CCBH and test its effectiveness and impact on the clients. Results of the supplemental questions were evaluated against existing summary choices.

The PIP research team piloted specific interventions at the North Central Clinic to determine change due to the new contact process. The analysis of North Central

discharge data for the period during which the program was practicing the newly established re-contact protocol revealed a greatly decreased rate of discharge due to clients not returning.

As the PIP comes to a close, a meeting with the North Central Clinic and the contract coordinator was held to discuss the effectiveness of the entire process, with modifications and rollout to two additional clinics.

3) Relapse Prevention Evidence-Based Practice (DMC Clinical)

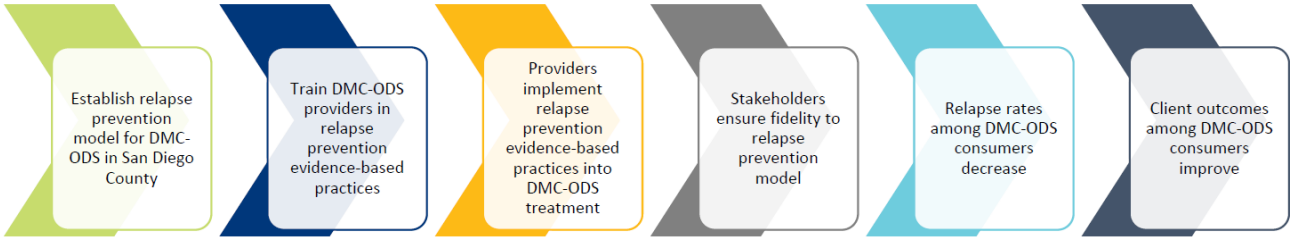
This clinical PIP focuses on evaluating fidelity to relapse prevention evidence-based practices (EBPs) and whether these improve client outcomes among clients of the DMC-ODS in San Diego County.

During the end of 2018, stakeholders observed utilization and fidelity to the relapse prevention EBP at DMC-ODS programs in the County. Stakeholders then trained treatment providers at DMC-ODS SUD programs in relapse prevention evidence-based practices in the beginning of 2019, then continued to observe utilization and fidelity.

It is expected that training the County's DMC-ODS providers in relapse prevention evidence-based practices will:

- Increase fidelity to the relapse prevention evidence-based practices;
- Decrease relapse rates among consumers of the DMC-ODS; and
- Improve outcomes among consumers (see Figure 1).

Figure 1. Relapse Prevention Evidence-Based Practice Logic Model



During the end of 2018 and beginning of 2019, DMC-ODS providers in San Diego County participated in a Relapse Prevention EBP concept training. Providers began using the Relapse Prevention concepts in their clinical practice after the training. Six programs (four outpatient and two residential programs) volunteered to pilot a Relapse Prevention evidence-based practice RoadMAP Toolkit curriculum. Providers at these programs were trained in the curriculum and began implementing the curriculum with

clients during quarter 4 of FY 2018-19. After four months of the pilot, the PIP workgroup evaluated results of the pilot and will make a recommendation on whether the curriculum should be offered to the entire DMC-ODS (or certain LOCs), or if a different curriculum should be explored.

4) Grievances and Appeals Awareness (DMC Non-Clinical)

This PIP seeks to improve the utilization of processes and identification of problems within DMC-ODS and other BHS programs by increasing client awareness of the grievances and appeals processes.

In October 2018, clients receiving SUD treatment services from DMC-ODS were surveyed on their familiarity and comfort level with the grievances and appeals processes, including their perception of existing materials on these processes. Following the survey, a team of subject matter experts from BHS, JFS, CCHEA, and HSRC will be assembled to develop new training materials which will be vetted with clients through interview and focus groups. Recommendations from the vetting process will then be considered before representatives from JFS and CCHEA begin training DMS-ODS SUD program treatment providers in providing new materials and explaining the grievances and appeals process to clients. From this intervention, clients will be surveyed on their familiarity and comfort with the processes, and then the number of grievances filed after the intervention will be compared with prior numbers.

It is expected that increasing awareness of the grievances and appeals processes among consumers of the DMC-ODS will increase the number of grievances that are filed, helping to identify programmatic and system-wide issues that can be addressed, ultimately improving the system as a whole and increasing satisfaction with the DMC-ODS in the future (see Figure 2).

Figure 2. Grievances and Appeals Processes Logic Model

In the Fall of 2018, the research team developed a webinar to train providers on how to explain the grievances and appeals process to clients, including making handouts

and brochures available, and posters visible. All SUD providers were requested to complete the webinar by early 2019 and to begin dissemination of materials to clients. At this time, client advocacy partners (JFS and CCHEA) also began visiting the SUD programs to explain the grievances and appeals processes to providers and clients via a series of in-services.

During Q3 of FY 2018-19, a PIP workgroup comprised of key stakeholders and client advocates was assembled. The workgroup provided input on the development of new methods to present the grievance and appeals processes to clients. These methods are being tested with a sample of clients who are also being surveyed on their experience to provide recommendations about how to improve the processes.

The client advocacy groups participated in a Wellness and Recovery summit in March 2019. The summit was attended by more than 300 clients, and representatives from the client advocacy groups participated in a panel discussion about advocacy, led a presentation about the services they provide, and staffed a resource booth at the event. At the beginning of the summit, attendees were asked via a survey about their familiarity with the grievances and appeals processes, comfort with the processes, and any reasons why they might not have filed a grievance or an appeal when they wanted to. Attendees were re-surveyed on these topics at the end of the summit. Survey responses were analyzed during Q4 of FY 2018-19.

During Q4 of FY 2018-19, the PIP workgroup launched a third intervention involving advocates from JFS and CCHEA holding office hours at select programs to provide clients with greater comfort and awareness of the grievances and appeals processes. To gather information about the usefulness of the office hour sessions, clients who visit the sessions were given a short feedback form to complete about their experience. This survey was developed during Q1 of FY 2019-20.

To gather post-intervention data, clients who receive services during the week of the TPS survey in October 2019 will be asked the same questions about their comfort and familiarity with the grievances and appeals processes that clients were asked in October 2018. These data will help determine if client familiarity and comfort with these processes improved in the system. Additionally, the number of grievances filed since dissemination of the new materials to clients will be compiled.

Targeted Aspects of Care Monitored by the QI Unit

Appropriateness of Services

- Assessment
- Level of Care
- Treatment Plans
- Discharge Planning
- Education Outcomes
- Employment Outcomes
- Utilization Management
- Crisis Stabilization Services

Access to Routine, Urgent and Emergency Services

- Crisis Stabilization Services
- Access Times for Assessments
- Access to Inpatient Hospital Beds
- Access to Crisis Residential Services
- Access to Residential Treatment Services
- Call Volume for the Access and Crisis Line (ACL)

Utilization of Services

- Retention Rate
- Completion Rate
- Readmission Rate
- Patterns of Utilization
- Average Length of Stay (ALOS) for Hospitals

Client Satisfaction

- Grievances
- Satisfaction Surveys
- Provider Transfer Requests Cultural Competence
- Trauma-Informed
- Staff Cultural Competence
- Analysis of Gaps in Services
- Provider Language Capacity
- Penetration Rate of Populations
- Training Provided and Evaluated for Feedback

Client Rights

- LPS Facility Reviews
- Patient Advocate Findings
- Quarterly Client Rights Reports
- Conservatorship Trend Reports

Effectiveness of Managed Care Practices

- Provider Satisfaction
- Provider Denials and Appeals
- Credentialing Committee Actions
- Client Appeals and State Fair Hearings

Coordination with Physical Health and Other Community Services

- MOAs with Healthy San Diego
- Integration with Physical Health Providers
- Outcomes Resulting from Improved Integration

Safety of Services

- Serious Incidents
- Medication Monitoring
- On-Site Review of Safety

QI WORK PLAN DEVELOPMENT

QIWP Goals

The QIWP Goals define targeted measures by which BHS can objectively evaluate the quality of services, both clinical and administrative, provided to clients and families. Some of the goals are process goals while others are measurable objectives. The target areas for improvement have been identified in the following ways:

1) Client and family feedback about areas that need improvement
2) Systemwide enhancement identified through data and analysis

Annual Evaluation of the QIWP

BHS shall evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for any process revisions and modifications.

Target Objectives for the QIWP

The targeted objectives of the QIWP are based on the IOM aims and address QRC recommendations. It ensures high-quality, trauma-informed systems and services are being engaged by clients and family members in San Diego County.

DEVELOPING THE QIWP

The purpose of the BHS QIWP is to establish the framework for evaluating how the QI Unit contributed to meaningful improvement in trauma-informed care and administrative services.

It defines the specific areas of quality of services, both clinical and administrative, that BHS will evaluate for FY 2019-20.

The QIWP defines the objectives, goals, indicators and/or measures, and data collection methods. It also includes plans for monitoring previously identified issues, sustaining improvement from previous years, and tracking of issues over time.

The QIWP will be monitored and revised throughout the year, as needed. It will be reviewed and approved by the QRC, and a formal evaluation will be completed annually.

MENTAL HEALTH SERVICES GOALS

Domains	#	Goals	Indicators	Data Collection Methods
Services are Client Centered	1	**Decrease the proportion of Quality of Care grievances compared to the previous fiscal year.**	Number of grievances related to quality of care.	Quarterly Grievances and Appeals report. Annual Medi-Cal Beneficiary Grievance and Appeal Report (ABGAR)
	2	**90% of adult clients will report that staff was sensitive to their cultural background in the State-required Consumer Perception Survey.**	Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey (YSS) responses to items focused on providers' responsiveness to client's cultural background	Annual client satisfaction survey, including threshold languages from MHSIP and YSS
Services are Safe	3	**Decrease the number of completed suicides in the Behavioral Health System of Care by 5% from FY 2018-19.**	Suicide rate in the System of Care	Suicide report based on data from the Medical Examiner's Office
	4	**Increase by 5% the number of first time PERT clients connected to BHS services within 30 days after PERT service.**	Number of first-time post-PERT discharge with a BHS service within 30 days.	Processing required for data from CCBH
Services are Effective	5	**Increase by 5% the number of individuals discharged from a psychiatric hospital that connect to treatment services within 7 and within 30 days after discharge.**	Connection to services within 7 and within 30 days after psychiatric inpatient discharge.	ASO report and dashboard on client services 7 and 30 days following psychiatric hospital discharge. Data from CCBH and ASO

Domains	#	Goals	Indicators	Data Collection Methods
Services are Effective	6	**Clinicians will report that Adult and Older Adult system of care clients are getting better, as evidenced by significant improvement from pre and post assessment in the overall mean of client outcome measures.**	Illness Management and Recovery (IMR) and Recovery Markers Questionnaire (RMQ) Scores	Quarterly mHOMS Outcomes Report
	7	**Establish a baseline for the proportion of clients that discharge to a lower level of care.**	Number of clients with a discharge reason/disposition of lower level of care	MIS-37 Discharge Summary Report
Services are Efficient and Accessible	8	**Provide specialty mental health services to 2% of county uninsured or Medi-Cal under 200% Federal Poverty Level (FPL) eligible population.**	Number of Specialty Mental Health Services clients in ratio to number San Diego County residents who are uninsured or Medi-Cal under 200% FPL. Percent of uninsured or Medi-Cal under 200% FPL.	Quarterly reports and Databook. CO-2 Medi-Cal Penetration Rate Report Triennial Disparities Report.
	9	**Ensure a minimum of 85% of interpreter services are provided by BHS contractors' bilingual staff to ensure treatment is immediately accessible to all clients regardless of language preference.**	Percentage of interpreter services performed by bilingual staff	Quarterly Interpreter Services Report
	10	**Increase the number of crisis stabilization beds in the North County region.**	Number of crisis stabilization unit beds	Confirmation by program staff

Domains	#	Goals	Indicators	Data Collection Methods
Services are Equitable	11	**100% of Mental Health programs will be co-occurring service capable.**	Attendance rates for the CADRE training series (program designed for implementation of the Comprehensive, Continuous Integrated System of Care (CCISC) model.	Tracking to be done by program coordinators and RIHS' documentation of CADRE attendance to ensure providers receive training for implementing a framework for working with co-occurring MH & SUD
	12	**100% of clients and families indicating in the State-required Consumer Perception Surveys that they had access to written info in their primary language and/or received services in the language they prefer.**	MHSIP and YSS responses to items focused on the availability of materials and services in the clients' preferred language.	Annual Consumer Perception Survey for MH, collected by UCSD
Services are Timely	13	**a) 95% of calls answered by the Access and Crisis Line (ACL) crisis queue are within 45 seconds.** **b) b. Average speed to answer all other (non-crisis) calls is within 60 seconds.**	Number of crisis and non-crisis ACL calls received. Response rates for crisis and non-crisis ACL calls.	Report on ACL access times and types of calls received. Quarterly ACL Performance Standards Report.
	14	**a) 100% of CYF programs meet the mental health assessment timeliness standard (10 days).** **b) 100% of A/OA programs meet the mental health assessment timeliness standard (10 days).** **c) 100% of CYF and A/OA programs meet the timeliness standard for mental health assessment requests deemed as urgent (48 hours).**	Percent of CYF and A/OA providers who provide face-to-face clinical contact within timeliness standards.	Data from the Access to Services Journal on routine and urgent mental health services requests.

SUBSTANCE USE DISORDER SERVICES GOALS

Domains	#	Goals	Indicators	Data Collection Methods
Services are Client Centered	1	**Decrease the proportion of Grievances/Appeals related to Quality of Care by 5%, compared to the previous fiscal year.**	Number of grievances related to quality of care.	Quarterly Grievances and Appeals report.
	2	**Increase by 5% the number of Youth clients who indicate they received services that were right for them on the SUD Treatment Perception Survey (TPS).**	Treatment Perceptions Survey results	Annual Consumer Perception Survey for SUD, collected by UCSD
Services are Safe	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.**	Number of serious incidents.	Quarterly Incident Report
Services are Effective	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 programs shall not be readmitted into the same or another withdrawal management program within 30 days.**	Discharge data from SanWITS WM Readmission Report	SanWITS

Domains	#	Goals	Indicators	Data Collection Methods
Services are Effective	5	**100% of SUD Teen Recovery Center contracts will have a minimum of two school-based sites that are operational.**	Number of school-based sites	Tracking will be done by the Children, Youth and Families system of care
	6	**BHS will have two active PIPs (Performance Improvement Projects) that contribute to meaningful improvement in clinical care as monitored by the EQRO.**	The ongoing work on two DMC-ODS focused PIPs (Relapse Prevention and Grievance and Appeals Awareness)	On-going data collection conducted by UCSD
Services are Efficient and Accessible	7	**Ensure average speed to answer calls is within 60 seconds.**	Response rates for crisis and non-crisis ACL calls.	Report on ACL access times and types of calls received. Quarterly ACL Performance Standards Report
	8	**A minimum of 30% of Substance Use Disorder clients with a referred discharge will connect with services within 10 days.**	Number of clients discharged with referral but not connected within10 days (BHAB dashboard) and their demographic distribution	SanWITS
	9	**Ensure Medication Assisted Treatment (MAT) services are available in San Diego's North County region.**	MAT encounters at North County SUD program	SanWITS Total Units of Service Report
Services are Equitable	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.).**	Treatment Perceptions Survey results	Annual Consumer Perception Survey for SUD, collected by UCSD

Domains	#	Goals	Indicators	Data Collection Methods
Services are Timely	11	**100% of Opioid Treatment programs (OTPs) shall meet the access timeliness standard of 3 business days for an initial dosing of medication.**	Access time data	SanWITS
	12	**Establish a baseline for the number of timely access NOABDs required.**	Number of timely access NOABDs sent	NOABD tracking in SanWITS