Behavioral Health & Recovery Services (BHRS)

SUD ODS Quality Improvement Work Plan & FY 20/21 Evaluation

FY 2021/22

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INTRODUCTION

Behavioral Health and Recovery Services is committed to empowering our diverse community with hope, recovery, and wellness by providing comprehensive holistic care. To this end, staff from the Quality Performance and Management (QPM) Division in coordination with Substance Use Disorder (SUD) Division prepared the following FY 21-22 DMC-ODS Work Plan and FY 20-21 Program Evaluation.

QUALITY MANAGEMENT PROGRAM DESCRIPTION

The QPM Division shall be accountable to the Behavioral Health and Recovery Services Director as described in Title 9 CCR, Section 1810.440(a) (1) and is responsible for monitoring DMC-ODS program performance and outcomes including, but not limited to: utilization management, utilization review, provider appeals, credentialling and monitoring, resolution of beneficiary grievances. Operation of the QPM Division shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4). QPM shall include active participation by practitioners and providers, as well as beneficiaries and family members in the planning, design and execution of QPM's activities, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C). There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d).

WORK PLAN INITIATIVES – FISCAL YEAR 2021-2022

The work plan seeks to address recommendations from last year's EQRO review as well as findings from the county's own internal quality review process. The intent of the work plan is to describe and guide DMC-ODS quality improvement activities for Fiscal Year 2021-2022. These strategic activities were developed by:

- Reviewing performance outcomes from FY 2020/21, as well as previous years when pertinent;
- Establishing measurable objectives for FY 2021-22;
- Identifying feasible strategies that SUD programs and administrators can implement to achieve these objectives during the year;[1]
- Describing data monitoring processes.[2]

The work plan is broken down into four sections:

1. Expanding Access
2. Increasing Timeliness of Service
3. Improving Quality of Care
4. Achieving Positive Outcomes

Each of the four sections includes several client-focused goals and objectives. The baseline data that were taken into consideration to formulate specific objectives and activities are shown for FY 2020/21, unless otherwise specified, in order to reflect meaningful trends over time.

[1] Unless otherwise specified in the tables below, the SUD Division is responsible for implementing workplan strategies
[2] Unless otherwise specified in the tables below, the QPM Division is responsible for monitoring performance data

DMC-ODS WORK PLAN (FY 21/22)

Initiative 1: Expand Access to Care
Program activities will be overseen by SUD Division Director. Data monitoring will be completed by QPM with support from the SUD Division Director and Staff Services Analyst unless otherwise specified below within Planned Activities column. (*). The QIC reviews the work plan goals and activities semi-annually.

Goal	Objective (FY 21/22)	Baseline data[3] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
1 Serve eligible Medi-Cal beneficiaries (overall penetration rate)	Significantly increase penetration rate to approach Medium County rate of 1.14% (*Source:* FY 19/20 BHC Approved Claims Report)	In FY 19/20, 971 beneficiaries were served. Our penetration rate was 0.85% (*Source:* FY 19/20 BHC Approved Claims Report[4])	SUD has planned ongoing outreach activities to inform community members and partners on how to access available services. For example, Recovery Month drive-through event;, Red Ribbon Week presentations to schools; Meet and Greets with school personnel; presentations to schools; Suicide Awareness event booth; food giveaway event; outreach with hospitals, maternity homes, Planned Parenthood, and primary care clinics to promote perinatal services.
2 Provide access for underserved populations (Hispanic/Latinx)	Significantly increase Hispanic/Latinx penetration rate to approach Medium County rate of 0.64%. (*Source:* FY 19/20 BHC Approved Claims Report)	In FY 19/20, 432 Hispanics/Latinx were served. We achieved a 0.56% penetration rate. (*Source:* FY 19/20 BHC Approved Claims Report)	Continue to air Spanish radio ads. Increase outreach to the Hispanic/Latinx population with a greater presence at existing community events (e.g., prevention, swap meets). Early in year, provided training to all SUD staff in providing SUD services within Latinx communities.

[3] See FY 20-21 Evaluation below for more details related to baseline data
[4] Most recent penetration rate data are derived from BHC from a FY 19/20 report. BHC has estimated penetration rates for FY 20/21 from the previous year's Medi-Cal eligibles, but for the sake of consistency, we are reporting only FY 19/20 penetration rates.

Goal		Objective (FY 21/22)	Baseline data[3] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
3	Provide access to youth (ages 0-17)	Surpass the Medium County penetration rate of 0.16%. *(Source:* FY 19/20 BHC Approved Claims Report)	In FY 19/20, 62 youth (age 12-17) were served. We achieved a 0.16% penetration rate. *(Source:* FY 19/20 BHC Approved Claims Report)	The RAFT program manager will reach out to school principals. SUD counselors will maintain relationships with school counselors and send out quarterly newsletters about SUD programming. An open house will be held for the new RAFT facility. Counselors will continue to provide quarterly presentations to parents at SAFE meetings. RAFT will continue to place radio ads. In response to demand, SUD will seek to provide screenings in several high schools. **Data monitoring through coordination with BHRS leadership, TA assistance provided by the EQRO reviewer and SUD Division, PIP monthly committee groups and QIC monitoring*
4	Expand staffing capacity to meet the demand (clinical oversight)	Increase to one full-time dedicated LPHA to provide clinical oversight and consultation	By July 2021, 0.5 FTE LPHAs were available for clinical oversight.	Confirmation was received that the LPHA position was not approved. Efforts to obtain approval for 1 FTE LPHA at midyear budget will continue. Continue recruiting/hiring efforts as well as ongoing work with personnel, particularly to address shortage of qualified staff.
5	Expand staffing capacity to meet demand (case management)	Fill one additional position (for a total of 3 approved positions) and gain approval for 4th case manager	As of July 2021, 2 FTE case manager positions are currently filled.	Recruit one additional case management position and advocate for an additional position.

Goal		Objective (FY 21/22)	Baseline data[3] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
6	Expand programmatic capacity to meet demand (sober living beds)	Continue to provide and fill 30-40 sober living beds	County increased the number of sober living beds provided from zero to 30.	Clarify the procedure for sending beneficiaries to SLE homes and for ensuring beds are filled to capacity when there is demand.
7	Expand programmatic capacity to meet demand (high-intensity residential treatments)	Analyze 3.5 utilization to establish baseline	This program had not yet started.	Monitor contract and provide support to residential provider, CSMA, in order to launch program. *Measure and monitor 3.5 utilization on a monthly basis beginning with the launch of the program
8	Expand programmatic capacity to meet demand (withdrawal management)	Launch 3.2 WM by the end of the FY; Serve 20 in the first year	No WM services were provided.	Provide ongoing education among beneficiaries and providers about MAT to reduce stigma. Develop MOU with a contract provider and launch services in early 2022.
9	Increase service delivery to meet demand (recovery support services)	Provide at least 2000 total units of recovery support services to 50 beneficiaries (i.e., 40 units/client)	Programs provided a total of 760 units of recovery service to 33 clients in FY 20/21 (23 units/client).	SUD Division will continue to train and educate on Recovery Services Policy. Provide training at next Division Meeting on Dec 10, 2021

Goal		Objective (FY 21/22)	Baseline data[3] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
10	Increase service delivery to meet demand (Intensive Outpatient Treatment)	Restart IOT services. Increase penetration rate to Medium County rate of 0.10% and $1,252/ beneficiary (*Source:* FY 19/20 BHC Approved Claims Report)	Twenty-five individuals were billed an average of $194/person. The penetration rate was 0.02% (*Source:* FY 19/20 BHC Approved Claims Report)	Provide training to expand identification of beneficiaries who meet ASAM criteria for IOT services, prescribe sufficient dosage to such beneficiaries, and document accordingly. Incentivize beneficiaries to participate with recovery residence placements. Increase groups to 1.5 hours.
11	Expand access to services through technology, e.g., telehealth	Research and develop capacity to provide and track telehealth options as needed	The use of technological tools to access services was minimal, and the precise amount unknown.	Develop protocols, procedures, or policies for using telehealth. Provide additional staff training, especially on holding video-based groups. Purchase new equipment if needed and if funds are available.
12	Provide seamless access to services for unserved beneficiaries	Maintain a 95% answered call rate with less than 1 minute of wait time	The answered call rate was 96%. The longest wait time was 1 minute, with an average time to answer of 12 seconds.	Continue to monitor ACD call volume data reports and review during monthly test call meetings. Use data to improve seamless access to service.
13	Beneficiaries attend appointments	Significantly reduce no-show rates	The no-show rate for outpatient services was 32.2%.	Transition responsibility for reminder calls from office assistant to clients' primary counselor

Initiative 2: Increase Timeliness of Services
Program activities will be overseen by SUD Division Director. Data monitoring will be completed by QPM in conjunction with the SUD Division Director and Staff Services Analyst unless otherwise specified below within Planned Activities column (*). QIC will review timeliness reports bi-annually.

Goal		Objective (FY 21/22)	Baseline data (FY 20/21 or as noted)	Planned Activities (FY 21/22)
1	Ensure timely offer to first *non-urgent* face-to-face appointments	Maintain 90% of beneficiaries being offered an assessment appointment within 10 working days of request for service	The rates of beneficiaries who were offered a face-to-face assessment within 10 days was 95% for County-operated programs and 98% for Contractor-operated programs.	Returned to face-to-face assessments following initial year of COVID restrictions. * Use Access log to monitor individual programs
2	Ensure beneficiaries attend first *non-urgent* face-to-face (routine) appointment	60% of beneficiaries will attend first non-urgent appointment	56% of beneficiaries attended a first appointment	Counselors make reminder calls and introduce themselves 3-5 days prior to appointments. Discuss what to expect and inquire about childcare or other considerations as needed.
3	Ensure timely offer to first *urgent* face-to-face appointments	A significantly higher proportion of beneficiaries will be identified as requiring urgent care. 80% of beneficiaries with an urgent condition will be offered an assessment appointment within 48 hours of request for service.	Less than 2% of beneficiaries were identified as having an urgent condition. Of these, 60% were offered a face-to-face appointment within 48 hours.	Revise Access screening script to include new definition of SUD urgent conditions. Train staff.
4	Ensure timely access to NTP dosing	Maintain 95% standard for NTP dosing within 3 days	We achieved a 98.7% standard of NTP dosing within 3 days.	The SUD Program Analyst will monitor contractor data and meet with managers to identify strategies if average wait times for first dosage is longer than one day. **NTP dosing wait times to be monitored quarterly*

Goal	Objective (FY 21/22)	Baseline data (FY 20/21 or as noted)	Planned Activities (FY 21/22)
5 Beneficiaries will have timely access to residential treatment	90% of beneficiaries offered an assessment @ residential placement within 10 working days of request for service Track length of time between assessment and residential placement offer (waiting list)	Hobie House: The average length of time from assessment to residential placement for was 1.3 days. Tranquility Village: The average length of time from assessment to residential placement was 1.0 days.	Provide technical assistance to residential programs to ensure accurate timeliness and waiting list data.

Initiative 3: Improve Quality of Care
Program activities will be overseen by SUD Division Director. Data monitoring will be completed by QPM with support from the SUD Division Director and Staff Services Analyst unless otherwise specified in Planned Activities column with an asterisk (*). The QIC reviews the work plan goals and activities semi-annually.

Goal	Objective (FY 21/22)	Baseline data[5] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
1 Beneficiaries receive culturally competent, relevant and equitable service	Establish SMART goals within the Cultural Competency plan to specifically measure equity, inclusionary practices and diversity within the SUD Division's system of care	The SUD manager co-chairs Cultural Humility, Social Justice and Health Equity Committee. The SUD is a standing item on the agenda. SUD representatives solicit community feedback and educate other committee members. The Cultural Competency Plan continues to include a wider array of MH initiatives and objectives.	Embed SMART goals related to reducing disparities and increasing inclusionary practices within the DMC-ODS network of care into the Cultural Competency Plan. Measure outcomes based on SMART goals SUD staff members will continue to attend and co-chair monthly Cultural Humility, Social Justice and Health Equity Committee meetings. Members will continue to solicit input on ensuring that programming is welcoming and inclusive, and they will continue to educate and share resources with other committee representatives. * A SUD staff member of the QIC committee will attend Cultural Humility, Social Justice and Health Equity Committee on a quarterly basis to monitor progress towards meeting objective.

Commented [JS1]: Trechann: please check if there are SUD-related SMART goals in in CCP. If not, leave as is. If so, revise Objective (second column) to say "Measure" SMART goals described in the Cultural Competency Plan related to equity, inclusionary practices and diversity within the SUD System of Care. And, revise first paragraph in Planned Activities to say: On a semi-annual basis evaluate SUD system of care using SMART goals embedded in Cultural Competency Plan.

[5] See FY 20-21 Evaluation below for more details related to baseline data

Goal		Objective (FY 21/22)	Baseline data[5] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
2	Beneficiaries receive treatment at a level of care consistent with ASAM treatment criteria	Return to at least 80% matching rate between ASAM-criteria assessment of level of care needs and placement decisions. Reduce percentage of incongruent placements because of unspecified reasons or unavailable placements	There was a 76% matching rate between LOC determination and placement decision in FY 20/21. For unmatched admissions, 20% were due to care not being available and 58% were due to unspecified reasons for incongruence.	Provide staff training to reduce entry of unspecified reasons for incongruence.
3	Beneficiaries in residential receive a continuity of care in accordance with the long-term nature of chronic illness and recovery	40% of residential discharges will transition to a lower level of care, representing a 25% increase over FY 20/21	In FY 19/20, 23% of the 186 residential discharges transitioned to lower level of care, compared to 32% of 246 residential discharges in FY 20/21.	BHRS will facilitate coordinated case consultation with BHRS and CSMA SUD counselors focusing on improving transition planning. See PIP report for additional details. **Data monitored monthly in PIP meetings and quarterly at QIC Committee*
4	Beneficiaries receive care in accordance with evidence-based practices	Implement Adverse Childhood Experiences screening and train all staff in Motivational Interviewing and ASAM criteria-based assessment and treatment planning	Staff received ACES training and in-house training in ASAM-based assessment and treatment planning, but we had a difficult time contracting with an external trainer.	We will integrate ACES screening into the assessment process and continue to seek external Motivational Interviewing and ASAM trainers.

Goal	Objective (FY 21/22)	Baseline data[5] (FY 20/21 or as noted)	Planned Activities (FY 21/22)
5 Beneficiaries are satisfied with services	Achieve 85% overall satisfaction for adults and youth Increase cultural sensitivity for adults and youth	Surveys indicated 95% overall satisfaction: 96% overall satisfaction specifically for adults, and 78% overall satisfaction specifically for youth	Continue to administer statewide TPS survey. Analyze results and develop reports at least semi-annually to share with stakeholders for performance accountability and QI. Discuss findings related to cultural sensitivity in the Cultural Humility, Social Justice and Health Equity Committee

Initiative 4: Achieve Positive Outcomes

Program activities will be overseen by SUD Division Director. Data monitoring will be completed by QPM in conjunction with the SUD Division Director and Staff Services Analyst on a semi-annual basis, unless otherwise specified below within Planned Activities column (*).Data committee will review automated discharge status reports on a monthly basis, and QIC will review on a quarterly basis. SUD Division will review outcome data with residential contractors on a quarterly basis.

Goal		Objective (FY 21/22)	Baseline data (FY 20/21 or as noted)	Planned Activities (FY 21/22)
1	Beneficiaries successfully complete treatment episodes	55% of residential and outpatient beneficiaries will discharge successfully	53% of residential and 51% of outpatient episodes discharged successfully (discharge statuses 1-4).	The SUD division is increasing case management services as part of its clinical PIP initiative. Effective case management will help motivate and inspire beneficiaries to complete each stage of treatment and transition to more appropriate level of care.
2	Beneficiaries receive discharge interview upon program completion (i.e., lower Cal-OMS administrative discharge rate)	Maintain 80% standard discharges for residential episodes Achieve 50% standard discharge for outpatient programs	81% of residential episodes and 23% of outpatient episodes received a standard discharge. (Methodological note: denominator included those that had no recorded discharge status i.e., "0")	Continue to collaborate with AS Analyst to schedule and train providers in strategies to lower the CalOMS administrative discharge rate by improving client engagement, in addition to encouraging exit interviews between beneficiaries and their counselors if the client decides to leave before treatment completion.
3	Beneficiaries successfully reintegrate into the community following residential treatment	Less than 8% of beneficiaries will readmit within 30 days	We noted 8.9% 30-day readmission rate to residential treatment.	See Clinical PIP for improvements in residential discharge planning and relapse prevention.

EVALUATION OF FISCAL YEAR 2020/21 WORK PLAN

The Quality Improvement Work Plan Evaluation was jointly performed by QPM and SUD Division Director with support from Automation Services and an evaluation consultant. The evaluation measures and interprets performance outcomes for each of the QI objectives and corresponding planned activities that were included in the FY20/21 Work Plan. Data sources are embedded in the tables and occasionally in footnotes at the bottom of each page.

EVALUATION OF PREVIOUS WORK PLAN (FY 20/21)

Initiative 1: Expand Access to Care

<table>
<tr><th colspan="2">Goal</th><th>Objective
(FY 20/21)</th><th>Activities Performed
(FY 20/21)</th><th>Outcomes & Evaluation
(FY 20/21)</th></tr>
<tr><td>1</td><td colspan="4">Provide services to Medi-Cal beneficiaries (overall penetration rate)
No objectives were specified for FY 20/21. See workplan for FY 21/22 objectives</td></tr>
<tr><td>2</td><td>Provide access for underserved populations (Hispanic/ Latinx)</td><td>Increase penetration rates for Hispanic/Latinx beneficiaries to 0.64% (Medium County penetration rate. Source: FY 19/20 BHC Claims Data)

Increase the number of Hispanic beneficiaries served to 450</td><td>Revised the brochure about services within department and Healthy House translated materials to Spanish and Hmong.

Aired radio ads in Spanish, including on Spanish radio.</td><td>Hispanic/Latinx Claims Data
<table><tr><th></th><th># served</th><th>Penetration</th><th>Med County Penetration</th><th>Claims/ beneficiary</th><th>Med County Claims</th></tr><tr><td>FY 18-19</td><td>250</td><td>0.41%</td><td>0.55%</td><td>$2,263</td><td>$3,543</td></tr><tr><td>FY 19-20</td><td>432</td><td>0.56%</td><td>0.64%</td><td>$3,094</td><td>$3,753</td></tr></table>
Analysis: Number of beneficiaries served, and penetration rates increased in FY19/20 but remain below medium county rates. Claims per beneficiaries increased but are still below average medium county claims from the previous year. (Data sources: BHC Claims Report. FY 18/19 & FY 19/20.)

Anasazi records identify 418 Hispanic/Latinos served in FY 20/21</td></tr>
</table>

<table>
<tr><th colspan="2">Goal</th><th>Objective
(FY 20/21)</th><th>Activities Performed
(FY 20/21)</th><th>Outcomes & Evaluation
(FY 20/21)</th></tr>
<tr><td>3</td><td>Provide access to youth (ages 0-17)</td><td>Provide youth outpatient services to 93 beneficiaries (~0.24% penetration rate)</td><td>We launched a non-clinical PIP to increase referral and penetration rates, including outreach to partner organizations to educate about the availability and access to services.
Activities included Meet and Greets with School Counselors; Quarterly newsletters to schools; Presentations to parents and youth probation at SAFE meetings; and radio advertisements.</td><td>
<table>
<tr><th colspan="6">Youth 12-17</th></tr>
<tr><th></th><th># served</th><th>Penetration</th><th>Med County Penetration</th><th>Claims/ beneficiary</th><th>Med County Claims</th></tr>
<tr><td>FY 18-19</td><td>34</td><td>0.18%</td><td>0.20%</td><td>$1,349</td><td>$1,716</td></tr>
<tr><td>FY 19-20</td><td>62</td><td>0.16%</td><td>0.16%</td><td>$1,767</td><td>$1,496</td></tr>
</table>

Analysis: The number of youth served in Merced County increased, but the penetration rate declined from 0.18% to 0.16% because of a large increase in those eligible (12-17). Merced penetration rate equals that of medium county. In FY 19/20 Merced's claims per beneficiary is higher than medium county averages. (Data sources: BHC Claims Report. FY 18/19 & FY 19/20.)

Anasazi records identify 61 Youth (0-17) served in FY 20/21</td></tr>
<tr><td>4</td><td>Expand staffing capacity to meet the demand (clinical oversight)</td><td>One full-time dedicated LPHA to provide clinical oversight and consultation</td><td>The SUD program planned to submit a request for approval of one FTE LPHA dedicated to DMC-ODS and obtain authorization to recruit and fill the position; however, we have not yet been able to fill the vacant position as others have taken precedence for hiring qualifying candidates.</td><td>A shortage of qualified staff leaves DMC-ODS without a dedicated FTE LPHA. There is still less than 0.5 FTE clinical oversight (combined as parts of other positions).</td></tr>
</table>

Goal		Objective (FY 20/21)	Activities Performed (FY 20/21)	Outcomes & Evaluation (FY 20/21)
5	Expand staffing capacity to meet demand (case management)	Hire 2 additional full-time case managers for a total of 4 FTEs to provide centralized case management and care coordination	One additional AOD counselor position was approved, for a total of three FTEs. We are still recruiting to fill the third position.	As of July 1, 2021, there are currently 2 FTE case manager positions filled, which is 2 short of the 4 FTE objective.
6	Expand programmatic capacity to meet demand (sober living beds)	Provide 30 sober living beds	We finalized the Sober Living Contract and applied for additional SABG funding to expand support with the current provider (CSMA; supplementation for high rent for homes).	Merced County increased the number of sober living beds provided from zero to 30.
7	Expand programmatic capacity to meet demand (high-intensity residential treatments)	No objective was specified for FY 20/21	We completed the DMC certification process for residential treatment 3.5 through CSMA and launched programming at the end of June f 2021.	The program had not yet started.
8	Expand programmatic capacity to meet demand (withdrawal management)	No objective was specified for FY 20/21	Prior to COVID, CMSA was hoping to launch WM and get certified by Jan 2021. Program was certified but it lost its medical staff.	Services were not yet available. We are currently relying on the ER for detox.

<table>
<tr>
<td>9</td>
<td>Increase service delivery to meet demand (recovery support services)</td>
<td>Provide 400 units of recovery support services to 30 beneficiaries</td>
<td>Updated a draft Recovery Services Policy (awaiting approval). Informal training for staff</td>
<td>
Recovery Support
<table>
<tr><th></th><th># served</th><th>Penetration</th><th>Med County Penetration</th><th>Claims/ beneficiary</th><th>Med County Claims</th></tr>
<tr><td>FY 18-19</td><td>7</td><td>0.01%</td><td>0.02%</td><td>$2,921</td><td>$708</td></tr>
<tr><td>FY 19-20</td><td>19</td><td>0.02%</td><td>0.03%</td><td>$559</td><td>$855</td></tr>
</table>
Analysis: In FY 19/20, 19 beneficiaries (0.02% of eligibles) received an average of $559 in recovery support services, which was less than Medium County penetration rate of 0.03% and average claims of $855. (Source: BHC Claims Data)

In FY 20/21 33 beneficiaries received an average of 760 units of service, averaging 23 units per beneficiary. (Source: Anasazi billing records)
</td>
</tr>
<tr>
<td>10</td>
<td>Increase service delivery to meet demand (Intensive Outpatient Treatment)</td>
<td>No objective was specified for FY 20/21</td>
<td>In FY 20/21, SUD programs had to cut hours and couldn't provide IOT due to COVID. We had difficulty getting beneficiaries to participate on-site for the minimum time expected.</td>
<td>
Intensive Outpatient
<table>
<tr><th></th><th># served</th><th>Penetration</th><th>Med County Penetration</th><th>Claims/ beneficiary</th><th>Med County Claims</th></tr>
<tr><td>FY 18-19</td><td>32</td><td>0.03%</td><td>0.11%</td><td>$761</td><td>$3,368</td></tr>
<tr><td>FY 19-20</td><td>25</td><td>0.02%</td><td>0.10%</td><td>$194</td><td>$1,252</td></tr>
</table>
Analysis: In FY 19/20 25 individuals had an average of $194 approved claims. The penetration rate for intensive outpatient services was 0.02%. The Medium County penetration rate was 0.10% and average approved claims was $1,252 per year. (Source: BHC Approved Claims Report)
</td>
</tr>
<tr>
<td>11</td>
<td>Expand access to services through technology, e.g., telehealth</td>
<td>No objective was specified for FY 20/21</td>
<td>We ordered some equipment and applied for grants to expand telehealth.</td>
<td>According to managers, staff are a little scared to use telehealth. We have a step-by-step procedure, but we have observed it wasn't used a lot. We had two virtual groups; they were successful</td>
</tr>
<tr>
<td>12</td>
<td>Provide seamless access to services</td>
<td>Establish expectations for: (1) staffing levels;</td>
<td>BHRS established an Automatic Call Distribution</td>
<td>The following were monthly averages:
Total Calls: 459</td>
</tr>
</table>

	for unserved beneficiaries	(2) response wait time; (3) percent of dropped calls; (4) percent of voice mail responses	(ACD) system for our ACCESS team. The ACD went live on 4/1/2021.	Answered Calls: 440 (96%) Abandoned Calls: 19 (4%) Longest Wait Time: 00:01:00 Average Time to Answer: 00:00:12 Average Talk Time: 00:10:36 Total Talk Time: 05:54:25 (Source: ACD report FY 20-21)
13	Beneficiaries attend appointments (i.e., low no-show rates) No objective was specified for FY 20/21. See Work Plan for FY 21/22 objectives			

Initiative 2: Increase Timeliness of Services

Goal	Objective (FY 20/21)	Activities Performed (FY 20/21)	Outcomes & Evaluation (FY 20/21)
1 Ensure timely offer to first *non-urgent* face-to-face appointments	90% of beneficiaries will be offered an assessment appointment within 10 working days of request for service	Monitored data	County programs: 95% (826/865) of beneficiaries with non-urgent conditions received a first offered appointment within 10 working days. [Children: 96%; Adult 95%; Older Adult 96%]. (Source: WorkPlan 2.1-2.3 2020-2021 SUD- EQRO Timeliness file) Contractor programs: 98.2% of beneficiaries with non-urgent conditions received a first offered appointment within 10 working days (Source: Kingsview Dashboard)
2 Ensure beneficiaries attend first *non-urgent* face-to-face (routine) appointment	No objective was specified for FY 20/21	Monitored data	County programs: 56% (485/865) of beneficiaries engaged in first appointment. Of those who attended, 87% (423/485) met the 10 working days standard. (Source: WorkPlan 2.1-2.3 2020-2021 SUD- EQRO Timeliness file)

Goal	Objective (FY 20/21)	Activities Performed (FY 20/21)	Outcomes & Evaluation (FY 20/21)
3 Ensure timely offer to first *urgent* face-to-face appointments	A significantly higher proportion of beneficiaries will be identified as requiring urgent care. (In previous year, only 7 beneficiaries were identified as requiring urgent care.) 80% of beneficiaries with an urgent condition will be offered an assessment appointment within 48 hours of request for service	In Jan '21, Division Director re-trained Access Team and CSU day shift employees on conducting screenings, identifying urgent conditions, and providing referrals. Access staff were expected to coordinate with SUD program to add additional slots for urgent conditions, but staff did not fully understand this expectation. There were significant call-outs and vacancies in Access program. Substitute staff did not receive sufficient training in identifying urgent conditions.	County programs: Less than 2% of beneficiaries were identified as having urgent conditions (15/865); 60% (9/15) of these beneficiaries with an urgent condition were offered an appointment within 48 hours. (Source: WorkPlan 2.1-2.3 2020-2021 SUD- EQRO Timeliness file)
4 Ensure timely access to NTP dosing	Maintain 95% standard for NTP dosing within 3 days	Monitored data	The average length of time from initial request to 1st appointment was 1.13 days, with 98.7% meeting a 3-day standard. (Source: Aegis spreadsheet and Kingsview Dashboard)

Goal	Objective (FY 20/21)	Activities Performed (FY 20/21)	Outcomes & Evaluation (FY 20/21)
5 Beneficiaries will have timely access to residential treatment	Use Anasazi service data rather than CalOMS data to measure wait time from initial ASAM assessment to residential placement	Aegis and CSMA started reporting their timeliness data; Kingsview assisted with the data analysis and report.	Hobie House: The average length of time from assessment to residential placement for was 1.3 days. Tranquility Village: The average length of time from assessment to residential placement was 1.0 days. In order for residential programs to track wait for first offered intake assessment and length of waiting list, the programs will need to record several additional fields for all first contacts: (1) date of first offered intake assessment (2) if contact met residential ASAM criteria; 3) date of first offered bed day. It is recommended that the programs track urgent conditions as well.

Initiative 3: Improve Quality of Care

Goal	Objective (FY 20/21)	Activities Performed (FY 20/21)	Outcomes & Evaluation (FY 20/21)
1 Beneficiaries receive culturally competent, relevant and equitable service	The BHRS Cultural Competence (CC) Committee and the CC plan will address both SUD and MH-related concerns.	The Cultural Competence Committee renamed itself as the *Cultural Humility, Social Justice and Health Equity Committee*. The Committee is now co-chaired by a member of the SUD Division, and an SUD Program Manager regularly attends monthly meetings. In January, the committee added a standing agenda item for issues pertaining to SUDs and the SUD Division.	The evaluator reviewed monthly *Cultural Humility, Social Justice and Health Equity Committee* meeting minutes starting January 2021 and noted the following SUD-related activities: In April, a SUD representative solicited input from committee members about ways SUD programs could exercise greater humility. They verbally committed to sharing more information about AA/NA groups. During the meeting, the Dual Dx program received "rave reviews." The program was described by participants as providing a strong sense of connectedness and belonging. Representatives reported on a community collaboration to extend services to Westside. In the May meeting, SUD staff solicited feedback on making the lobby and interview rooms more inviting to people of various cultures and walks of life. SUD staff educated other participants about the diversity of experience, subcultures, and stigmas experienced by people with SUDs, and described the dual charges of serving individuals but also educating community and local providers.

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			The 2020 *Cultural Competency Plan* mentions SUD disorders but continues to include a wider array of MH initiatives and MH-focused objectives.
2 Beneficiaries receive treatment at a level of care consistent with ASAM criteria	Maintain 80% matching rate between LOCI Assessments and actual placement decisions.	We continued to monitor LOC congruence data.	The matching rate declined from 81% in FY 19/20 to 76% in FY 20/21. Of the unmatched placements, 1% were legal issues; 3% clinical judgement; 19% patient preference; 20% related to unavailability of level of care. The remaining 58% of instances recorded unspecified reasons. Given the fact that the DMC-ODS network is continuing to expand services, it is not surprising that 20% of assessments indicated a level of care that was unavailable. However, the high degree of unspecified incongruencies is concerning because it makes it difficult to judge the degree of access to appropriate levels of care.
3 Beneficiaries receive a continuity of care in accordance with the long-term nature of chronic illness and recovery	50% of beneficiaries who complete residential treatment will begin outpatient services within 30 days of residential discharge.	County SUD counselors provided case management to 46% of beneficiaries in residential programs. This was significantly higher than the 7% who received case management the previous year in spite of the fact that the case management program was understaffed.	In FY 20/21 out of 244 residential discharges, 73 (30%), transitioned to a lower level of outpatient care within 30 days. This was significantly higher than the 23% (42/186) from the previous year.

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4 Beneficiaries receive care in accordance with evidence-based practices	100% of SUD staff will be trained in trauma-informed care and Adverse Childhood Experiences screening	Merced was the recipient of a grant to train staff in Adverse Childhood Experiences (ACES). The SUD Division identified a curriculum and trainer and trained staff in completing screenings.	All staff completed ACES training but haven't implemented screenings yet.
5 Beneficiaries are satisfied with services	At least 85% of beneficiaries will report overall satisfaction with program experience	We collected Treatment Perception Surveys and analyzed the data.	Adults: We collected 82 surveys (54% from outpatient; 40% from residential; 6% from narcotic. 96% paper-based; 4% electronic; 2% Spanish and 1% Hmong). Results indicated 96% overall satisfaction (up from 89% in the previous year). In addition to high overall satisfaction ratings, 96% felt welcomed. Lowest rate (86%) was attributed to cultural sensitivity. Youth: We collected 9 surveys (100% outpatient, English, and paper-based). Results showed 78% overall satisfaction (down from 93% in the prior year). The highest rating (100%) was reported for being treated with respect. The lowest satisfaction (50%) was attributed to cultural sensitivity.

Initiative 4: Achieve Positive Outcomes

Goal	Objective (FY 20/21)	Activities Performed (FY 20/21)	Outcomes & Evaluation (FY 20/21)
1 Beneficiaries successfully complete treatment episodes	At least 63% of residential and 53% of outpatient episodes will successfully complete treatment (Cal-OMS discharge statuses 1-4)	The SUD division increased case management services as part of its clinical PIP initiative. Case management intends to help motivate and inspire beneficiaries to complete each stage of treatment and transition to more appropriate level of care.	The percentage of outpatient discharges that were successful (discharge status 1-4) increased slightly between FY 19/20 and FY 20/21, from 50% (398/791) to 51% (466/916). The percentage of residential discharges that were successful declined from 61% (120/197) to 53% (133/249) during the same period in spite of an increase in the number of clients who received case management[6]
2 Beneficiaries receive discharge interview upon program completion (i.e., lower Cal-OMS administrative discharge rate)	At least 63% of residential and 40% of outpatient episodes will be identified as standard (i.e., non-administrative) completions (Cal-OMS discharge statuses not including 4 & 6)	See above	In FY 20/21 81% (210/259) of residential episodes, and 23% (374/1612) of outpatient episodes received a standard discharge.[7]

[6] Methodological note: denominator excluded those that had no recorded discharge status, i.e., "0"
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3 Beneficiaries successfully reintegrate into the community following residential treatment	No objective was specified for FY 20/21	No specific activities were performed with respect to this goal.	New objective included in the FY 21/22 Work Plan