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FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 26-28, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Drug Medi-Cal Organized Delivery System (DMC-ODS) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "San Diego" shall be used to identify the San Diego County DMC-ODS program, unless otherwise indicated.

DMC-ODS INFORMATION

DMC-ODS Reviewed — San Diego

Review Type — Virtual

Date of Review — April 26-28, 2022

DMC-ODS Size — Large

DMC-ODS Region — Southern

DMC-ODS Location — San Diego, CA

DMC-ODS Beneficiaries Served in Fiscal Year (FY) 2020-21 — 11,331

DMC-ODS Threshold Language(s) — English, Spanish, Arabic, Vietnamese, Tagalog, Farsi.

SUMMARY OF FINDINGS

Of the six recommendations for improvement that resulted from the FY 2020-21 EQR, the DMC-ODS addressed or partially addressed six recommendations.

California External Quality Review Organization (CalEQRO) evaluated the DMC-ODS on the following four Key Components that impact beneficiary outcomes; among the 23 components evaluated, the DMC-ODS met or partially met the following, by domain:

- Access to Care: 100 percent met (three of three components)
- Timeliness of Care: 50 percent met (three of six components), and 50 percent partially met (three of six)
- Quality of Care: 100 percent met (eight of eight components)
- Information Systems (IS): 83.3 percent met (five of six components), and 16.6 percent partially met (one of six)

The DMC-ODS submitted both of the two required Performance Improvement Projects (PIPs). The clinical PIP, Connections After Discharge with Referral, has had multiple remeasurements, was active and now considered completed with a moderate confidence validation rating. The non-clinical PIP, Connections to Substance Use

Disorder (SUD) Services After Psychiatric Emergency Response Team (PERT) Contact, has had multiple remeasurements, is active and now to be completed with a low confidence validation rating.

CalEQRO conducted two consumer family member focus groups, comprised of a total of 12 participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The DMC-ODS demonstrated significant strengths in the following areas: 1) Harm Reduction principles are being adopted address the harms caused by substance use broadening the system's potential reach within the community; 2) a history of successful coordination with allied agencies like mental health (MH) include integrated treatment at co-occurring enhanced programs; 3) Medication Assisted Treatment (MAT) treatment benefits from a well-developed level of coordination for substance use treatment in many hospitals, emergency departments and Federally Qualified Health Centers (FQHC); 4) active utilization of the Treatment Perception Survey (TPS) data results is present to guide program and system adjustments; 5) San Diego has invested in analytic staff, both internal and contracted, combining this strength with investments in data software, to produce data dashboards that are gaining widespread use throughout the DMC-ODS.

The DMC-ODS was found to have notable opportunities for improvement in the following areas: 1) with the ongoing surge in overdoses and fatalities, San Diego should continue its work to increase MAT within local jails in coordination with the Sheriff's department; 2) additional steps should be taken to address the ongoing provider workforce issues currently limiting staff assignments and individualized care; 3) assure that policy requires and resources are available to assure consistent tracking and reporting of time to service, service utilization and performance within the DMC-ODS; 4) work with system providers to allow for residential access during weekends, review limits on transportation for perinatal clients needed for reunification visits and update outdated program materials; 5) the electronic health record (EHR) is in the middle of several enhancement efforts and in planning implementation, San Diego will benefit from continued active engagement of their contract providers.

FY 2021-22 CalEQRO recommendations for improvement include: 1) San Diego should take steps to address protocol issues and introduce workflow solutions to assure a complete and an accurate data collection process for urgent service requests; 2) address performance issues pertaining to no-show rates of initial appointments, as well as timely follow-up following residential discharge; 3) youth service levels need continued focus and prioritization to assure expansion; 4) expand the number of goals in the Quality Improvement (QI) Workplan that are outcome and client oriented, making sure they have stated objectives that are measurable and include specific action plans designed to help achieve objectives; 5) 5) San Diego should build internal IT expertise

and management capacity, including identifying key leadership positions to ensure clinical IT system improvements remain a priority and timely progress toward goals pertaining to California Advancing and Innovating Medi-Cal (CalAIM) initiative are made.

INTRODUCTION

BACKGROUND

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 31 county DMC-ODS, comprised of 37 counties, to provide substance use treatment services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each DMC-ODS. DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO, to review and evaluate the care provided to the Medi-Cal beneficiaries.

Additionally, DHCS requires the CalEQRO to evaluate counties on the following: delivery of SUD treatment services in a culturally competent manner, coordination of care with other healthcare providers, and beneficiary satisfaction. CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205.

This report presents the FY 2021-22 findings of the EQR for San Diego DMC-ODS by Behavioral Health Concepts, Inc., conducted as a virtual review on April 26-28, 2022.

METHODOLOGY

CalEQRO's review emphasizes the county's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public behavioral health system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by substance use disorder systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review county-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from multiple source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, DMC-ODS approved claims, the TPS, California Outcomes Measurement System (CalOMS), and the American Society of Addiction Medicine (ASAM) level of care (LOC) data. CalEQRO reviews are retrospective; therefore, data evaluated are from FY 2020-21, unless otherwise indicated. As part of the pre-review process, each county is provided a description of the source of data and a summary report of their PMs, including Medi-Cal approved claims data. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the county's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of two elements pertaining to NA: Alternative Access Standards (AAS) requests and use of out-of-network (OON) providers.
- Summary of county-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, including sixteen PMs.
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the county's quality and operational processes.
- Consumer perception of the county's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of county strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of county beneficiaries. Further suppression was applied, as

needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE DMC-ODS ENVIRONMENT AND WITHIN THE COUNTY

In this section, the status of last year's (FY 2020-21) EQRO review recommendations are presented, as well as changes within the county's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The DMC-ODS noted the ongoing impact such as loss of staff, disruption of services, adjustments necessary to adopt telehealth and continued challenges with a remote or virtual service delivery model. CalEQRO worked with the county to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

San Diego is currently experiencing a behavioral health workforce crisis, impacting all aspects of the DMC-ODS. This crisis has been further exacerbated by the COVID-19 pandemic. The ongoing shortage of qualified, culturally diverse staff has impacted all parts of the larger behavioral health department and reflects the larger workforce shortages seen throughout the country, state, and region. The shortage has been severely impacting the larger San Diego County Behavioral Health Services (SDCBHS) department as well as DMC-ODS programs, both county-run and those contracted by service providers. San Diego notes that exacerbating these workforce issues is an increasing need for SUD treatment services throughout the region, which is continuing to grow with no signs of slowing.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

To address the unprecedented crisis in harms associated with substance use and the alarming trends in drug overdose deaths, the local Board of Supervisors (BOS) formally adopted a "harm reduction" strategy. This includes taking multiple actions to advance existing efforts to more aggressively address this issue and the stigma associated with substance use. These actions have included the reversal of the "Resolution to Oppose Needle Exchange Programs" and creation of a syringe replacement program and directing the creation of a comprehensive County Substance Use Harm Reduction Strategy. The BOS actions have also led to the expansion of nasal naloxone distribution in the community (including all DMC-ODS services and programs), meetings with the San Diego and the Sheriff's Department to plan MAT implementation; expanding the Safe Haven

transitional housing program designed around strategies to reduce the negative consequences of drug use; and the opening of the Community Harm Reduction Team shelter that connects eligible clients with shelter, behavioral health and SUD services, and case management (CM) services which facilitates naloxone distribution, fentanyl testing, and sterile syringe access.

- San Diego is engaging in a strategic client outreach initiative that seeks to connect with clients and keep them engaged in SUD programs. From July to December 2021, of the 58 unduplicated individuals engaged in services 72 or 75 percent are still engaged. Similar levels of engagement were seen in engaging clients into the Harm Reduction Shelter.

  A request for proposal (RFP) was released for a Specialized Cognitive Residential Substance Use Program. The project is an ASAM Level 3.3 program that will provide 24-hour residential substance use treatment, withdrawal management, recovery and ancillary services to adults aged 18 years and above. In addition to services for clients with substance use conditions, capacity for co-occurring mental health (MH) conditions is part of the program design. It is planned that the selected contract provider shall include services for clients who have functional limitations that are primarily cognitive.

- San Diego is engaged in a series of strategies and activities to overcome difficulty in recruiting, hiring, and retaining qualified individuals. These include implementing a systemwide personnel analysis, executive leadership participation in a countywide workforce steering committee, and evaluating strategies to support providers experiencing staffing shortage.

- SDCHS will realign departmental infrastructure, resources, and staffing to optimize the configuration of key activities and functions. These shifts will directly involve county and administrative staff for San Diego's DMC-ODS. Administrative units within SDCBHS will be shifted and enhanced to align under Operations, Service and Clinical Design, Population Health, Healthcare Oversight, and Strategy and Finance. Initial steps towards implementing these changes will impact Children, Youth and Families System of Care, Adult and Older Adult System of Care, juvenile forensics, and SUD services. To ensure seamless navigation throughout the systems of care, there will be a transition away from distinct systems of care with oversight defined by age cohorts and instead transition into a structure defined by service category. Within the service categories, there will be specialization by age cohorts. Similarly, SUD services under the DMC-ODS will be integrated with MH services within each service line to ensure seamless service delivery across the behavioral health continuum of care.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY

2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the county performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2020-21

Recommendation 1: San Diego has established baseline data for a Non-Clinical Performance Improvement Project (PIP) and plans to begin interventions the end of March 2021. San Diego needs to assure this timeline is met and continues work on their PIPs and if needed requests additional TA.

(This recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- San Diego reports their timeframe of implementing the PIP's primary intervention was staggered due to both resources and impacts of the pandemic. Involving their PERT team, the PIP was initiated in the central region of the county and then was expanded to the east region in April 2021. Subsequently it involved a PERT clinician in the north region by October 2021.
- It should be noted that plans to expand the PIP to other regions and PERT teams in the county, but low enrollment and complications related to the COVID-19 pandemic prevented further expansion during the PIP period as of April 2022.
- San Diego notes that while the acute population aimed to benefit from this PIP remain a system priority, it is unclear if current initiatives will remain a PIP project going forward.

Recommendation 2: San Diego needs to put in place a monitoring system to assure that all patients receive education and information about medication assisted treatment options available to them during assessment and treatment planning sessions. Also, that all levels of care make MAT options available for those with opioid or alcohol use disorders as supplements to treatment if clinically indicated.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In August 2021, San Diego began to include prompts to review MAT education and information documentation in both the Medical Record Review templates as well as in program forms, which documented the date MAT materials and education was provided. These prompting tools also include a requirement for staff to initial to attest that the activities took place. Compliance results are to be tracked in a spreadsheet.
- San Diego has plans to develop a PowerBI report to identify programs that require additional TA in using or documenting MAT education as required.
- Furthermore, a measure for the number of clients who received MAT services was added to the Quarterly Status Reports (for contract monitoring) of Teen Recovery Centers (TRC). Measures for referral to MAT services and completed MAT assessments will be added to the Statement of Work for SUD Perinatal Outpatient programs in FY 2022-23.
- San Diego is also implementing a MAT referral mechanism in SanWITS to allow tracking/monitoring with associated data.

Recommendation 3: San Diego should continue to work with the criminal justice system to be able to continue medications for inmates incarcerated when they enter the system with current MAT prescriptions.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In June 2021, the local BOS initiated a county-wide Substance Use Harm Reduction Strategy which amongst other initiatives, seeks to promote cross-sector collaboration to increase MAT access and/or continued MAT services for people that are recently incarcerated.
- Subsequent to this Board action, the Health and Human Services Agency (HHSA) and the Sheriff's Department initiated a memorandum of understanding (MOU) that ensures MAT continuity for detained clients and establishes a robust and continuous quality improvement program for ongoing evaluation.
- Since the establishment of the MOU, the clinical, medical, and administrative teams from HHSA and the Sheriff's Department have jointly toured detention facilities with MAT programs to gather best practices and learn established local protocols. Currently, teams are working collaboratively towards a phased implementation of MAT at all Sheriff's detention settings starting with the Las

Colinas Detention and Reentry Facility, where access to MAT and methadone are available via an opioid treatment program (OTP).

Recommendation 4: San Diego needs to update the Cultural Competence Plan (CCP) to include more specific SUD goals/objectives and evaluate them each year.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- San Diego's 2021 CCP and Three-Year Strategic Plan was submitted to DHCS in June 2021.
- Specific SUD content and goals are part of the current strategic plan cycle as well as those which are applicable to both MH and SUD. The SUD specific goals include efforts to enhance collaboration with the Indian Health Council including for the DMC-ODS to increase services in rural areas; enhance services through a perinatal equity initiative focused on the African-American community, providing education resources and support for soon to be fathers; establish a new framework for healthcare in the jails specifically minimizing the outsourcing of healthcare and increasing the number of county staff or providers in roles of nurses, MH professionals, and drug treatment providers; and to increase the representation from DMC-ODS treatment providers on its cultural response workgroups.
- San Diego notes that 100 percent of SUD clients and families, whose responses are in the most recent TPS report, state they had access to written information in their primary language and/or received services in their preferred language. In June 2022, San Diego will be submitting an updated plan which will include new developments on the above-mentioned goals.

Recommendation 5: Continue to automate SanWITS workflow processes to support health providers' use of the EHR system to include client prescriptions and lab results history.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The DMC is working with its EHR vendor, FEI Systems to add electronic prescriptions and lab history modules. They expect to fully implement these by August 2022. In the EHR project schedule, this is identified with clear deadlines for different phases of planning and implementation.
- The DMC actively engages its contract providers in its EHR enhancement planning and implementation process. The management information system (MIS) has been holding weekly workgroup meetings throughout this process.

Recommendation 6: Continue plans to expand the continuum of care with RFPs as indicated with ASAM Level 3.3 residential treatment and transitional age youth (TAY) services.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- San Diego recently released an RFP for a ASAM Level 3.3 program to provide 24-hour non-medical residential treatment and withdrawal management (WM) services to adults ages 18 years and above with a presenting problem that includes a cognitive impairment.
- San Diego is also looking to expand substance use services for TAY, with the release of an RFP for outpatient treatment, recovery, and ancillary services. This project will have capacity to treat 250 clients, ages 18-25 with substance use issues, including those with co-occurring MH disorders. Services will include an emphasis on TAY peer staffing, harm reduction approaches, MAT services, outreach and engagement of the TAY population, and a focus on increasing self-efficacy and successful transition to the community.
- A separate RFP for a 24-hour non-medical residential substance use treatment program with recovery and ancillary services to TAY (ages 18-25) with substance use issues, including co-occurring MH disorders was also recently released. Service levels include ASAM level 3.1 clinically managed, low-intensity residential services, 3.2 clinically managed residential WM and 3.5 clinically managed, high-intensity residential services. Services will be specific to TAY needs and CM services will be provided to assist clients in achieving goals and transitions to the next LOC or the community.
- San Diego notes that as part of the RFP process, proposals are reviewed and evaluated for determination of award. Timelines for contract execution are still to be determined though the programs noted here are slated to begin in October 2022.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All DMC-ODSs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the DMC-ODS provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's National Provider Identification number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP) services, for youth and adults. If these standards are not met, DHCS requires the DMC-ODS to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if a DMC-ODS can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with DMC-ODS staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the DMC-ODS's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the DMC-ODS, or its subcontractors.

FINDINGS

For San Diego County, the time and distance requirements are 30 minutes and 15 miles for outpatient SUD services, and 30 minutes and 15 miles for NTP/OTP services. These

services are further measured in relation to two age groups – youth (12-17) and adults (18 and over)[1].

Alternative Access Standards and Out-of-Network Access

DHCS required the DMC-ODS to submit an AAS request for 82 zip codes for which time and distance standards were not met: 92105, 92113, 92114, 92154, 91911, 91950, 91910, 91977, 92102, 92021, 92020, 92115, 92173, 92019, 92111, 92126, 92139, 91945, 91932, 92040, 92071, 92104, 92117, 92065, 91942, 91913, 91941, 92123, 92116, 92110, 92124, 92109, 91915, 91902, 92120, 92127, 92119, 91901, 92107, 92122, 92101, 92108, 92131, 91978, 91906, 92103, 91914, 91935, 92106, 92118, 92061, 92036, 92004, 91905, 91963, 91980, 91916, 92070, 91917, 91934, 92086, 91962, 92066, 91931, 92060, 92134, 92140, 91948, 92025, 92027, 92064, 92129, 92128, 92130, 92037, 92075, 92014, 92059, 92121, 92067, 92091, 92055.

As of the time of the FY 2021-22 EQR, the DMC-ODS had not received a determination from DHCS regarding the AAS request.

The 82 zip codes were specific to youth access to OTP/NTP and represent a significant increase from the 5 zip codes the DMC was required to have an AAS. This is due, in part, to a change in the NA requirements to a stricter standard of having to meet both the time and distance standards set for the county. The previous year's determinations were based on not meeting either time or distance standards, not both.

Planned Improvements to Meet NA Standards

San Diego has amended the contract for their network provider, Stop Opiate Addiction Program (SOAP) MAT Limited Liability Company, to provide outpatient OTP services to beneficiaries aged 0-17, effective July 1, 2021. Additionally, San Diego will add an option for the provision of youth services in future OTP RFPs. It should be noted that historically, demand for these services in the impacted regions of the county are low. San Diego notes that to date, there has only been one (1) youth aged 0-17 that was seeking services at an OTP in one of the AAS zip codes listed above.

General access is enhanced as all programs, serving all populations have made services available via telehealth to ensure SUD clients stay connected and are provided treatment during pandemic. Also, both providers and clients are informed about the transportation benefit that health plans provide. San Diego has an operations subcommittee to inform the DMC-ODS about the providers' experience with accessing resources and act as a bridge between the providers and the health plans for communication. To assure both system and beneficiary awareness and education, a transportation "frequently asked questions" information sheet was developed, and

[1] AB 205 and BHIN 21-023

clients have been given a health plan contact card that provides the direct contact information for transportation for each of the health plans. The DMC-ODS notes that no issues have been brought forward by any parties over the past year. San Diego has representation on the local metropolitan transit advisory committee to advocate for transportation supports for clients and reenforce the need for safe transportation to medical appointments. Finally, a Mobile MAT pilot for is currently in development.

DMC-ODS Activities in Response to FY 2020-21 AAS

In FY 2020-21, DHCS authorized the use an alternate time or distance standard through an approved AAS Request. Specifically, DHCS authorized the DMC-ODS to offer services in five zip codes using telehealth. San Diego notes that while their SUD providers are expected to direct beneficiaries to in-network providers when arranging for services related to their care. If required treatment services are not available adequately and timely within the provider network, the beneficiary may access required services from an out of network provider. The County of San Diego contracts with an Administrative Services Organization for the execution of OON accommodation agreements. The DMC-ODS provided their existing OON Access Policy for CalEQRO which outlines process and details to facilitate these situations.

ACCESS TO CARE

BACKGROUND

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals or beneficiaries are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed. The cornerstone of DMC-ODS services must be access or beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESS IN SAN DIEGO COUNTY

SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Regardless of payment source, approximately zero percent of services were delivered by county-operated/staffed clinics and sites, and 100 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 89.1 percent of services provided are claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week operated under contract by Optum, with full time call operators and licensed clinical staff. There is ongoing communication with both San Diego and the system's contract provider network with Access Line having both protocols and workflows that ensure linkage and follow-up, handling any crisis for clients with local resources and 911. The Access Line workforce has capacity for bilingual screening and 3-way conference call to connect individuals with system treatment providers in real time. DMC-ODS beneficiaries may request services through the Access Line as well as consistent with the County of San Diego's Health and Human Services Agency's "No Wrong Door" philosophy, by directly contacting DMC-ODS providers. While San Diego is entirely comprised of SUD contracted providers, the role of the county in care coordination is to set forth standards, train contracted providers on those standards, and monitor to program compliance. As clients have the option of contacting any SUD treatment program in the community to be screened for services, with linkage to other providers occurring with a "warm hand-off" should another LOC be indicated. Once that determination has occurred, the individual will be directed to a service provider who can complete a comprehensive assessment.

In addition to clinic-based services, the DMC-ODS has capacity to provide telehealth services. Specifically, the DMC-ODS delivers medication support, crisis, group therapy, group education and support, individual therapy, CM, and new client intake and assessment services via telehealth to youth and adults. In FY 2020-21, the DMC-ODS reports having served 4,572 adult beneficiaries, 237 youth beneficiaries, and 254 older adult beneficiaries via telehealth across no county-operated sites and 64 contractor-operated sites. Among those served, 204 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which a DMC-ODS informs the Medi-Cal eligible population and monitors access, and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each Access Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 1: Key Components – Access

KC #	Key Component – Access	Rating
1A	Service Access are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	Met
1C	Collaboration and Coordination of Care to Improve Access	Met

Strengths and opportunities associated with the access components identified above include:

- Significant levels of coordination are evident between the DMC-ODS and allied partners including physical and MH service providers, the local health plans, and system of FQHCs along with local school districts and the criminal justice system. For example, with justice partners, San Diego is active in the five drug courts, MH court (with estimates that 85 percent of participating clients have a co-occurring disorder), re-entry projects and continuing work to enhance MAT efforts while individuals are in-custody. There is also an expectation that system providers will work with faith-based organizations or providers relevant to a

clients expressed need and noteworthy that formal cooperatives exist with DMC-ODS programs including within criminal justice settings.

- San Diego has allocated resources for youth treatment population, age 12-17 and in addition to the seven TRC sites, has services are available on multiple school campuses. Service utilization levels have begun to rebound since the onset of COVID-19 and associated restrictions but remain an area that the DMC-ODS is attempting to increase.
- San Diego has allocated realignment and federal Substance Abuse Block Grant funds to its contract providers to establish recovery residence beds for clients. Legal entities are required to have written procedures guiding the selection along with procedures that outline coordination of care protocols. Providers are required to track and report spending, but San Diego has yet to develop routine reporting on the bed utilization which may limit their ability to gauge need or capacity.
- Increased bed capacity for both WM and Level 3.3 residential services appears indicated with clients sharing their frustration and lag times for admissions in this year's CalEQRO focus groups. An area known to the DMC-ODS which has continued to solicit for new providers.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the DMC-ODS:

- Total beneficiaries served, stratified by age and race/ethnicity;
- Penetration rates, stratified by age, race/ethnicity, and eligibility categories;
- Approved claims per beneficiary (ACB) served, stratified by age, race/ethnicity, eligibility categories, and service categories;
- Initial service used by beneficiaries.

Total Beneficiaries Served

The following information provides details on Medi-Cal eligibles, and beneficiaries served by age and race/ethnicity.

Most clients served were in the 18-64 age group with a penetration rate of 2.09 percent, higher than other large-sized counties and statewide. Only 12.4 percent of clients served were in the youth or older adult age groups; however, the penetration rates for both age groups were higher than other medium-sized counties and statewide.

Table 2: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2020

San Diego				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	100,741	506	0.50%	0.26%	0.25%
Ages 18-64	474,859	9,929	2.09%	1.44%	1.26%
Ages 65+	86,496	896	1.04%	0.90%	0.77%
TOTAL	**662,096**	**11,331**	**1.71%**	**1.18%**	**1.03%**

The race/ethnicity group with the largest percentage of eligible clients was Latino/Hispanic (37.0 percent of all eligibles). The penetration rate for this race/ethnicity group was higher than comparable counties and statewide at 1.00 percent compared to 0.76 percent for large counties and 0.69 percent statewide. Penetration rates for remaining race/ethnicity groups were also higher compared to like-sized counties and statewide.

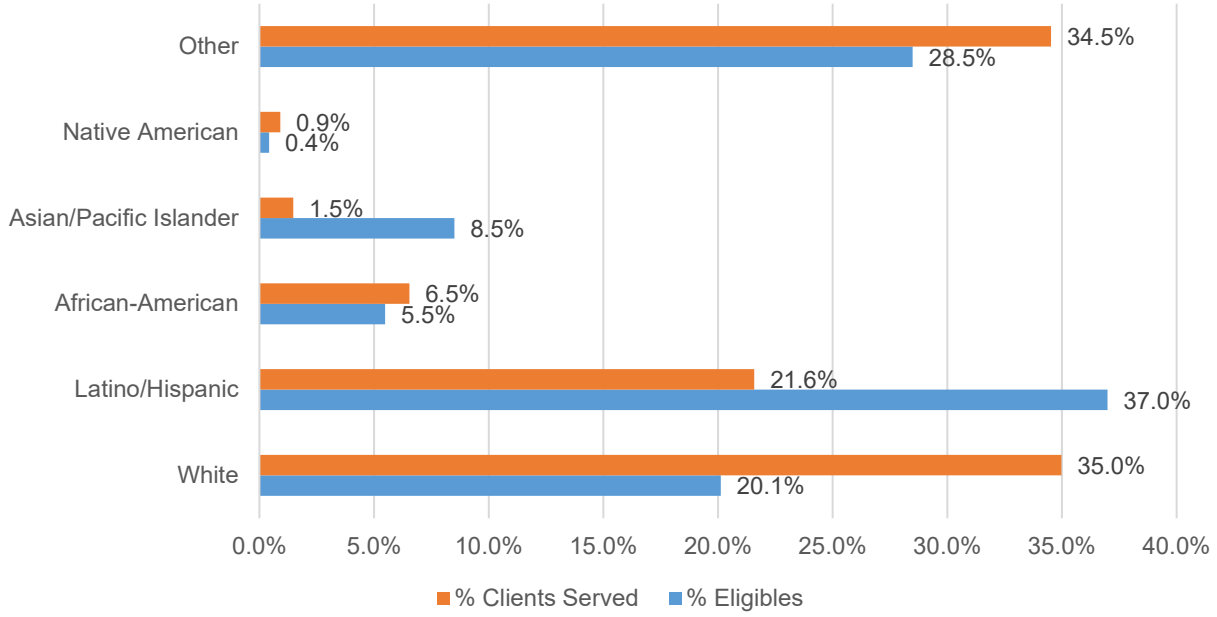
Table 3: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2020

San Diego				Large Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	133,204	3,963	2.98%	2.34%	1.96%
Latino/Hispanic	244,880	2,445	1.00%	0.76%	0.69%
African-American	36,304	741	2.04%	1.53%	1.34%
Asian/Pacific Islander	56,298	167	0.30%	0.17%	0.17%
Native American	2,792	103	3.69%	2.77%	1.84%
Other	188,619	3,912	2.07%	1.58%	1.41%
TOTAL	**662,097**	**11,331**	**1.71%**	**1.18%**	**1.03%**

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total beneficiaries served as clients.

While Latino/Hispanics were 37.0 percent of all eligibles, this race/ethnicity group comprised 21.6 percent of clients served. Conversely, while White eligibles comprised 20.1 percent of all eligibles, 35.0 percent of clients served were White. Clients designated as Other have proportionate numbers of eligibles and clients served (28.5 percent and 34.5 percent, respectively).

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Penetration Rates and Approved Claim Dollars by Eligibility Category

The average approved claims per beneficiary (ACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

Tables 4 and 5 highlight penetration rates and average approved claims by eligibility category.

Penetration rates for clients eligible through the Affordable Care Act (ACA) was 2.8 percent, nearly double the statewide rate of 1.6 percent. Most clients receiving

DMC-ODS services in San Diego County were eligible through ACA. Family Adult and Disabled were also common eligibility categories and had higher penetration rates compared to statewide. The numbers served for youth categories, that is Foster Care, Other Child, and Medicaid Children's Health Insurance Program (MCHIP), were small but with higher penetration rates compared to statewide patterns.

Table 4: Clients Served and Penetration Rates by Eligibility Category, CY 2020

San Diego				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Penetration Rate	Penetration Rate
Disabled	69,843	1,401	2.0%	1.8%
Foster Care	1,145	52	4.5%	2.3%
Other Child	61,879	333	0.5%	0.3%
Family Adult	127,041	2,113	1.7%	1.1%
Other Adult	90,370	178	0.2%	0.1%
MCHIP	42,532	190	0.5%	0.2%
ACA	267,531	7,430	2.8%	1.6%

Average approved claims by eligibility categories in San Diego are higher than statewide averages for each of the adult and youth categories. The youth categories are notably higher compared to statewide. For example, the average approved claim for MCHIP-eligible youth in San Diego was $4,555 compared to $2,748 statewide.

Table 5: Average Approved Claims by Eligibility Category, CY 2020

San Diego				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Average Approved Claims	Average Approved Claims
Disabled	69,843	1,401	$4,946	$4,559
Foster Care	1,145	52	$3,394	$2,037
Other Child	61,879	333	$4,878	$2,492
Family Adult	127,041	2,113	$4,919	$4,231
Other Adult	90,370	178	$4,651	$3,386
MCHIP	42,532	190	$4,555	$2,748
ACA	267,531	7,430	$5,903	$5,131

Most clients initially access DMC-ODS services in NTPs (37.7 percent). Outpatient treatment services and residential treatment are the next most common LOCs for initial access at 27.7 percent and 23.6 percent, respectively.

Table 6: Initial DMC-ODS Service Used by Beneficiaries, CY 2020

San Diego			Statewide	
DMC-ODS Service Modality	**#**	**%**	**#**	**%**
Outpatient treatment	2,892	27.7%	33,885	33.1%
Intensive outpatient treatment	266	2.5%	2,679	2.6%
NTP/OTP	3,935	37.7%	40,908	40.0%
Non-methadone MAT	1	0.0%	291	0.3%
Ambulatory Withdrawal	-	0.00%	22	0.02%
Partial hospitalization	-	0.00%	23	0.02%
Residential treatment	2,465	23.6%	16,620	16.3%
Withdrawal management	687	6.6%	6,790	6.6%
Recovery Support Services	202	1.9%	1,006	1.0%
TOTAL	**10,448**	**100.0%**	**102,224**	**100.0%**

Table 7 shows the percent that each type of service category contributes to the total number of client treatment episodes for CY 2020. The service category used in the most

client episodes was NTPs (25.7 percent). Outpatient treatment services were the next most common service category, used in 22.3 percent of the total client treatment episodes. Intensive outpatient treatment was used 14.6 percent compared to 6.4 percent statewide, indicating that San Diego may have employed some creative approaches to continue this LOC during the COVID-19 crisis.

Table 7: Average Approved Claims by Service Categories, CY 2020

Service Categories	% Served	Statewide % Served	Average Approved Claims	Statewide Average Approved Claims
Narcotic Tx. Program	25.7%	30.7%	$3,818	$4,097
Residential Treatment	19.8%	17.5%	$10,061	$8,846
Res. Withdrawal Mgmt.	6.0%	6.8%	$2,565	$2,057
Ambulatory Withdrawal Mgmt.	0.0%	0.0%	$0	$654
Non-Methadone MAT	7.0%	5.2%	$452	$1,093
Recovery Support Services	4.6%	2.7%	$1,719	$1,521
Partial Hospitalization	0.0%	0.0%	$0	$1,926
Intensive Outpatient Tx.	14.6%	6.4%	$577	$966
Outpatient Services	22.3%	30.6%	$2,938	$2,037
TOTAL	**100.0%**	**100.0%**	**$5,708**	**$4,894**

IMPACT OF FINDINGS

San Diego has optimized its utilization of contracted access call center and the referred clients benefit from a well-established level of interagency coordination with those organizations whose population need SUD services. The need to increase access for special populations such as youth along with recognized need to enhance bed capacity for residential treatment remain DMC-ODS priorities. Improved and regular tracking and reporting of transitional housing are suggested as beds remain limited for Medi-Cal beneficiaries even as the DMC-ODS has made efforts to increase capacity.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and PMs addressed below.

TIMELINESS IN SAN DIEGO COUNTY

The DMC-ODS reported timeliness data in aggregate. Further, timeliness data presented to CalEQRO represented the complete DMC delivery system.

San Diego's Clinical PIP aims to increase timely connections for clients discharged from a residential withdrawal management or residential program with referral to a lower LOC. The PIP implemented the Motivational Enhancement for Engagement in Therapy (MEET) intervention at the designated pilot sites which introduced a structured interview to guide clients more consistently through identifying barriers, discovering solutions and resources (with provider guidance), and giving clients a greater sense of involvement in their discharge and transition planning. As a result, timely connection rates increased from 41 percent to 62 percent. This system has workflows which significantly reduces the lag times and San Diego is currently considering broader adoption of this initiative across its system of care.

Timeliness data for offered routine appointments show they average three days and meet the DHCS standard 97.4 percent of the time across all services. For the entire system, average length of time from first request or visit is also three days and meets the 10-day standard 93.3 percent of the time.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the DMC-ODS identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 8: Key Components – Timeliness

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	Initial Contact to First MAT Appointment	Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Services after Residential Treatment	Partially Met
2E	Withdrawal Management Readmission Rates	Met
2F	No-Show Rates	Partially Met

Strengths and opportunities associated with the timeliness components identified above include:

- San Diego has a definition for urgent service requests which includes both the client perception but also any condition that disrupts normal activities of daily living and requires assessment and treatment within 48 hours. San Diego reports the average length of time from request to urgent visit as 1.5 calendar days, an improvement from the last review which was 3.7 days. The 48-hour standard is met 87.7 percent of the time, much improved from the last EQR rate of adherence, which was just 67.5 percent.
- Tracking and reporting of urgent service requests is dependent on timely and complete reporting a process overseen by assigned contract liaison, but this has been done inconsistently. While revised data became available following this review, initial discussion with CalEQRO revealed that there is a need for ongoing monitoring to assure adherence to data collection and reporting.
- Timely follow-up appointments after residential discharge occurs 33.3 percent and remained consistent with the last review cycle's improved rating, however youth follow-up contacts fell from 28.6 percent to just 10.3 percent during this EQR.
- No-show rates for initial outpatient and residential appointments are elevated with the monthly average tracked at 39.4 percent and 32.5 percent respectively.

PERFORMANCE MEASURES

DHCS has established timeliness metrics to which DMC-ODSs must adhere for initial offered appointments for non-urgent outpatient SUD services, non-urgent MAT, and urgent care. In preparation for the EQR, DMC-ODSs complete and submit the Assessment of Timely Access form in which they identify DMC performance across several key timeliness metrics for a specified time period.

Additionally, utilizing approved claims data, CalEQRO analyzes DMC performance on withdrawal management readmission and follow up after residential treatment.

In addition to the Key Components identified above, the following PMs further reflect the Timeliness of Care in the DMC-ODS:

- First Non-urgent Appointment Offered
- First Non-urgent Appointment Rendered
- Non-Urgent MAT Request to First NTP/OTP Appointment
- Urgent Services Offered
- Average Days for Follow-up Post-Residential Treatment
- WM Readmission Rates Within 30 Days
- No-Shows

DMC-ODS-Reported Data

For the FY 2021-22 EQR, the DMC-ODS reported its performance for July 2021 through March 2022 or FY to date.

- Average wait time of 1.9 days from initial service request to first non-urgent SUD appointment offered
- Average wait time of 1.2 days from initial service request to first non-urgent NTP/OTP appointment offered
- Average wait time of 1.5 days from initial service request to first urgent appointment offered
- Average follow-up appointment for youth residential discharges meets the 7-day standard 7.3 percent of the time compared to 33.3 percent for adults

Table 9: FY 2021-22 DMC Assessment of Timely Access

FY 2021-22 DMC Assessment of Timely Access			
Timeliness Measure	Average/Rate	Standard[2]	% That Meet Standard
First Non-Urgent Appointment Offered	1.9 Days	10 Business Days	98.3%
First Non-Urgent Service Rendered	1.3 Days	10 Business Days	93.5%
Non-Urgent MAT Request to First NTP/OTP Appointment	1.2 Days	3 Business Days	93.9%
Urgent Services Offered	1.5 Days (Hours n/a)	48 Hours	87.7%
Follow-up Services Post-Residential Treatment	n/a	7 Days	33.3%
WM Readmission Rates Within 30 Days	5.1%	n/a	n/a
No-Shows	34.4%	n/a	n/a

Medi-Cal Claims Data

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the FY 2020-21 claims.

Timely Access to Methadone Medication in Narcotic Treatment Programs after First Client Contact

San Diego has timely dosing for methadone, less than one median day, for NTP clients who request a first dose.

[2] DHCS-defined standards, unless otherwise noted.

Table 10: Days to First Dose of Methadone by Age, CY 2020

San Diego				Statewide		
Age Groups	Clients	%	Median Days	Clients	%	Median Days
Ages 12-17	*	n/a	<1	*	n/a	n/a
Ages 18-64	3,483	84.7%	<1	33,027	80.4%	<1
Ages 65+	*	n/a	<1	*	n/a	n/a
TOTAL	**4,110**	**100.0%**	**<1**	**41,093**	**100.0%**	**<1**

Transitions in Care

The transitions in care following residential treatment is an important indicator of care coordination.

The transitions in care following residential treatment are an important indicator of care coordination. There were 5,228 discharges from residential treatment; of those, just 11.38 percent occurred within the 7-day DHCS standard though there were 1,303 follow-up step-down appointments within any days (24.92 percent).

It should be noted that these data are from CY 2020 represent activities from Medi-Cal claims and differ markedly from the data tracked and reported by San Diego (for FY 2021-22 year to date and noted in Table 9 above), likely representing service activities that are not submitted for billing.

Table 11: Timely Transitions in Care Following Residential Treatment, CY 2020

San Diego (n= 5,228)			**Statewide (n= 49,799)**	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	595	11.38%	3,757	7.54%
Within 14 Days	723	13.83%	5,160	10.36%
Within 30 Days	858	16.41%	6,422	12.90%
Any days (TOTAL)	**1,303**	**24.92%**	**10,112**	**20.31%**

Residential Withdrawal Management Readmissions

There were 1,282 admissions into WM and with a 14.7 percent readmission rate within 30 days of discharge. Again, San Diego's own reporting which is for FY 2021-22 year to

date (represented in Table 9 above) indicates a much lower rate of readmission within 30 days of discharge.

Table 12: Residential Withdrawal Management Readmissions, CY 2020

San Diego			Statewide	
Total DMC-ODS admissions into WM	1,282		11,647	
	#	#	#	%
WM readmissions within 30 days of discharge	189	14.7%	1,291	11.1%

IMPACT OF FINDINGS

Appointments for urgent service requests are improved from the previous review cycle. San Diego's tracking of WM readmissions and post residential discharge follow-up to the next LOC show more adherence than data provided from billing claims provided by CalEQRO, though this is a disparity often seen in other counties. The DMC-ODS has an IS that allows it to track both first offered and rendered appointments, which as noted above, most appointments occur within the required timeframe. However, the data management system (SanWITS) does not collect the time (hours and minutes) of initial request and urgent request access time data is reported using a 2-calendar day standard instead of 48 hours.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

In addition, the contract between the DMC-ODSs and DHCS requires the DMC-ODSs to implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services furnished to beneficiaries. The contract further requires that the DMC-ODS's quality program "clearly define the structure of elements, assigns responsibility, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN SAN DIEGO COUNTY

In the DMC-ODS, the responsibility for QI falls under the organizational structure that includes the Executive Quality Improvement Team, QI Performance Improvement Team, QM Team, MIS Team, Quality Review Council (QRC) and QR Committees. Although San Diego is an integrated behavioral health department, there are specific DMC-ODS meetings that engage the appropriate persons involved with DMC-ODS across the system.

The DMC-ODS monitors its quality processes through the QRC, a SUD services QI Work Plan (QIWP) and the annual evaluation of the workplan. San Diego and the QRC produces regular reports through data extraction for analysis pertaining to access, timeliness, quality, and outcomes. The QRC is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities. The QRC meets bimonthly, and is comprised of county staff, providers, stakeholders from the behavioral health communities, as well as clients and family members. Since the previous EQR, the QRC met six times. Of the 10 identified FY 2021-22 QIWP goals for the DMC-ODS, a summary of findings was listed. The summary also included a meaningful analysis and obstacles related to planned objectives were identified. Results indicated that six objectives were met, one partially met and three were not met.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SUD services healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to

improve outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, utilizes data to inform and make decisions, engages in QI activities, matches beneficiary needs to appropriate services, coordinates care with other providers, routinely monitors outcomes, satisfaction, and medication practices, and promotes transparent communication with focused leadership and strong stakeholder involvement.

Each Quality Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 13: Key Components – Quality

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of an ASAM Continuum of Care	Met
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	Met
3F	ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care	Met
3G	Measures Clinical and/or Functional Outcomes of Clients Served	Met
3H	Utilizes Information from Client Perception of Care Surveys to Improve Care	Met

Strengths and opportunities associated with the quality components identified above include:

- San Diego's adoption of a Harm Reduction approach will allow them to utilize a set of strategies and initiatives that reduces the negative consequences of substance use and does not limit goals in treatment to only those only associated with abstinence.
- The DMC-ODS has long-standing initiatives to enhance coordination of client care with community based primary care service providers. In addition to the defined components to support the integration with primary care, MH, and SUD services, there is a focus on additional MAT. This focus includes prescriber

support services, addiction consultation services, client support services, and TA for primary care providers, along with facilitating an annual integration summit. There are also multiple ED Bridge grant projects for improved MAT access (in place with most local hospitals) where renewed funding is being sought to continue these efforts.

- San Diego continues its work with the Sheriff's Department regarding enhancement of existing MAT services for the incarcerated, with continuation of MAT medication for this population expected to occur at the Las Colinas Jail. This project will pilot continuation of Buprenorphine or Suboxone for identified inmates. San Diego's collaborative work to expand the MAT to more populations within the jail is recognized and more progress is anticipated in the coming year.

PERFORMANCE MEAUSRES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the DMC-ODS:

- Beneficiaries served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment
- High-Cost Beneficiaries (HCB)
- ASAM congruence
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS Discharge Status Ratings

Diagnosis Data

Table 14 compares the breakdown by diagnostic categories of San Diego and statewide by the number of beneficiaries served and total approved claims amount, respectively, for CY 2020. The most common diagnostic categories for DMC-ODS clients in San Diego were Opioid Use Disorders (44.0 percent), Other Stimulant Abuse (24.9 percent), and Alcohol Use Disorder (19.0 percent). These percentages are comparable to statewide diagnostic code distributions.

Table 14: Percentage Served and Average Cost by Diagnosis Code, CY 2020

Diagnosis Codes	San Diego		Statewide	
	% Served	Average Cost	% Served	Average Cost

Alcohol Use Disorder	19.0%	$7,100	17.6%	$5,936
Cannabis Use	9.3%	$4,471	8.0%	$2,921
Cocaine Abuse or Dependence	1.8%	$5,965	1.8%	$5,769
Hallucinogen Dependence	0.3%	$4,135	0.2%	$6,112
Inhalant Abuse	0.0%	$9,201	0.0%	$8,581
Opioid	44.0%	$5,088	47.4%	$4,788
Other Stimulant Abuse	24.9%	$6,399	23.1%	$5,269
Other Psychoactive Substance	0.1%	$5,790	0.1%	$7,114
Sedative, Hypnotic Abuse	0.5%	$8,253	0.5%	$6,077
Other	0.2%	$4,298	1.2%	$2,923
Total	**100.0%**	**$5,767**	**100.0%**	**$4,962**

There were 1,143 clients in San Diego who had at least one dose of non-methadone MAT through the DMC-ODS and 533 who had three or more services. This is higher than statewide.

Non-Methadone MAT Services

Table 15: DMC-ODS Non-Methadone MAT Services by Age, CY 2020

San Diego					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	0.0%	-	0.0%	*	n/a	*	n/a
Ages 18-64	1,073	10.8%	507	5.1%	6,698	7.6%	3,227	3.7%
Ages 65+	70	7.8%	26	2.9%	*	n/a	*	n/a
TOTAL	**1,143**	**10.1%**	**533**	**4.7%**	**7,146**	**7.0%**	**3,397**	**3.3%**

Residential Withdrawal Management with No Other Treatment

Table 16 identifies clients who enter WM multiple times without ever engaging in follow-up treatment. This measure is a proxy for lack of effective discharge planning and CM follow-up to ensure that clients engage in treatment after WM. Of the 966 WM clients in San Diego, 2.9 percent had three or more WM episodes and no other treatment, somewhat lower than the rate found statewide at 3.4 percent.

Table 16: Residential Withdrawal Management with No Other Treatment, CY 2020

San Diego			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	966	2.9%	8,824	3.3%

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving services. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a

proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

Nearly 10 percent of clients served in San Diego met or exceeded the threshold to be considered high cost, comprising 31.2 percent of total claims, both the percentage by count and total claims are well above the trend noted statewide.

Table 17: High-Cost Beneficiaries by Age, DMC-ODS, CY 2020

San Diego						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	506	26	5.14%	$20,274	$527,117	20.37%
Ages 18-64	9,929	937	9.44%	$20,137	$18,868,215	32.91%
Ages 65+	896	39	4.35%	$20,002	$780,088	16.42%
TOTAL	**11,331**	**1,002**	**8.84%**	**$20,135**	**$20,175,421**	**31.20%**

Table 18: High-Cost Beneficiaries by Age, Statewide, CY 2020

Statewide					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	3,980	53	1.33%	$19,547	$1,036,014
Ages 18-64	89,545	5,355	5.98%	$20,688	$110,786,886
Ages 65+	10,277	217	2.11%	$20,676	$4,486,743
TOTAL	**103,802**	**5,625**	**5.42%**	**$20,677**	**$116,309,644**

ASAM Level of Care Congruence

Table 19 shows the congruence between the ASAM criteria-based findings at screenings and assessments and where the prospective client was referred. Congruence was very high for initial screenings, initial assessments, and follow-up assessments, all over 90 percent congruent.

Table 19: Congruence of Level of Care Referrals with ASAM Findings, CY 2020

San Diego ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
CY 2020	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	2,871	92.6%	8,448	93.2%	11,844	94.5%
Patient Preference	51	1.6%	151	1.7%	246	1.96%
Level of Care Not Available	30	1.0%	59	0.6%	49	0.4%
Clinical Judgement	51	1.6%	157	1.7%	100	0.8%
Geographic Accessibility	16	0.5%	16	0.2%	*	n/a
Family Responsibility	0	0.0%	0	0.0%	0	0.0%
Legal Issues	0	0.0%	0	0.0%	0	0.0%
Lack of Insurance/Payment Source	*	n/a	35	0.4%	*	n/a
Other	36	1.2%	91	1.0%	121	1.0%
Mental or Physical Health	21	0.7%	54	0.6%	67	0.5%
Court Mandated	*	n/a	52	0.6%	98	0.8%
TOTAL	**3,099**	**100.0%**	**9,063**	**100.0%**	**12,538**	**100.0%**

Initiation and Engagement

For adults in San Diego, 85.0 percent initiated treatment (had at least one session within 15 days after their initial visit), which is slightly lower than the statewide percentage of 89.1 percent. For engagement (two more sessions with 30 days after the initiation visit), 77.0 percent of adults continued to engage in services, on par with the statewide rate of 78.9 percent. The numbers of youth served were smaller than adults, but with higher initiation and engagement compared to youth statewide as well as adults in San Diego and statewide. This is worth noting as youth initiation and engagement tends to lag behind that of adults.

Table 20: Initiating and Engaging in DMC-ODS Services, CY 2020

	San Diego				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	9,951		497		98,320		3,904	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	8,459	85.0%	458	92.2%	87,609	89.1%	3,179	81.4%
Clients who then engaged in DMC-ODS services	6,513	77.0%	373	81.4%	69,099	78.9%	2,230	70.1%

Length of Stay

The mean (average) length of stay for San Diego clients was 153 days (median 93 days), higher than the statewide mean of 142 (median 88 days). Of all clients, 51.8 percent had at least a 90-day length of stay; 30.7 percent had at least a 180-day stay, and 20.6 percent had at least a 270-day length of stay

Table 21: Cumulative LOS in DMC-ODS Services, CY 2020

San Diego			Statewide	
Clients with a discharge anchor event	12,270		110,817	
LOS for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	153	93	142	88
	#	%	#	%
Clients with at least a 90-day LOS	6,356	51.8%	54,782	49.43%
Clients with at least a 180-day LOS	3,763	30.7%	32,644	29.46%
Clients with at least a 270-day LOS	2,524	20.6%	20,256	18.28%

CalOMS Discharge Ratings

More clients in San Diego have positive discharge ratings compared to the statewide average (49.2 percent vs 46.0 percent). The administrative discharge rate is lower than statewide at 42.4 percent compared to 47.4 percent (see Attachment D, Table D4).

Table 22: CalOMS Discharge Status Ratings, CY 2020

Discharge Status	San Diego		Statewide	
	#	%	#	%
Completed Treatment - Referred	3,059	20.5%	16,988	17.8%
Completed Treatment - Not Referred	1,287	8.6%	5,541	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	1,742	11.7%	13,830	14.5%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,254	8.4%	7,566	7.9%
Subtotal	*7,342*	*49.2%*	*43,925*	*46.0%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	2,517	16.8%	13,918	14.6%
Left Before Completion with Unsatisfactory Progress - Administrative	4,925	33.0%	36,618	38.3%
Death	22	0.1%	341	0.4%
Incarceration	135	0.9%	722	0.8%
Subtotal	*7,599*	*50.8%*	*51,599*	*54.0%*
TOTAL	**14,941**	**100.0%**	**95,524**	**100.0%**

IMPACT OF FINDINGS

The Quality Management division for San Diego benefits from both its command over data housed in the SanWITS information system and both county and contract analytics completed with a local university research and evaluation team. Using the mantra of "learning from today to improve tomorrow" its Performance Improvement Team has developed reports, dashboards and other representations of data which are well designed visually to communicate to clients, stakeholders, contract providers and leadership. The team has since been combined with the Management Reporting and Analysis team to establish the Data Science team, which serves as the centralized, integrated data hub to coordinate across the larger department. Those dashboards

shared with CalEQRO focus on treatment completion data and client satisfaction surveys. TPS solicitation and data flyers are designed to be shared with clients and have versions in Spanish. Continued improvement to improve MAT access within the criminal justice system and improve satisfactory completions of subpopulations (such as youth) remain a system focus.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

Each DMC-ODS is required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[3] and 457.1240(b)[4]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create improvement at a member, provider, and/or DMC system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested individually by the DMC-ODS, hosting quarterly webinars, and maintaining a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Appendix C of this report. "Validation rating" refers to the EQRO's overall confidence that the PIP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINCIAL PIP

General Information

Clinical PIP Submitted for Validation: Connections After Discharge with Referral

Date Started: April 2020

Aim Statement: This PIP aimed to increase connections within 10 calendar days for clients discharged with referral from a residential or withdrawal management program to a lower LOC by 5 percent by April 2022.

Target Population: The population for this PIP are adult clients who are actively enrolled in a pilot site WM or Residential program, who are being discharged with the disposition completed discharge with a referral to a lower LOC.

[3] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[4] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Validation Information: The DMC-ODS's clinical PIP has had multiple remeasurements, was active and now considered completed.

Summary

San Diego identified a significant problem with linking clients to timely follow-up after WM and residential discharge. Data was reviewed from three quarters of FY 2019-20 indicated that timely connection rates were low and decreasing. The average timely connection rate was approximately 28 percent. Data from SanWITS has continued to be reviewed for the number of discharge transitions. As San Diego applies the Healthcare Effectiveness Data and Information Set measures physical health standard to connect 100 percent of clients after acute care into outpatient care, it was clear that there was a problem with timely connections to outpatient care after utilization of acute care.

The DMC-ODS conducted a root cause analysis which included both qualitative and quantitative input from program staff, PIP committee members and consumers. It was noted that the reasons for lack of timely follow-up was complex and multifaceted. The SanWITS database is limited in its ability to distinguish the causes of this problem. Questions added to the 2020 TPS survey cycle revealed that most clients indicated they had referred to another program and received at least one service (85 percent), while the remaining 15 percent did not. Of those who did not, barriers cited by clients varied widely. Some stated they were "not ready," were waiting for follow-up, had concerns related to the COVID-19 pandemic, issues with living circumstances, or had a relapse. Input was also requested on what might make them more likely to follow-up, though a high percentage of clients indicated "nothing" would make them more likely to receive services at a program to which they were referred (35 percent).

The PIP design included multiple interventions, though uniquely added a tool to structure interview and discussion areas between the discharging provider and the client about their goals for treatment and next steps in the client's recovery. The MEET tool was an intervention selected due to its basis in Motivational Interviewing, to better guide clients through identifying personal barriers, discovering solutions and resources (with provider guidance), and giving clients a greater sense of involvement in their discharge and transition planning.

Data indicates that during the PIP period, timely connection rates increased for both WM and residential program clients with connection rates increasing from 41 percent to 62 percent. It was clear that the goal to improve the connection rate by 5 percent was met.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the data analysis plan included reviewing the monthly Behavioral Health Dashboard Indicators (populated from SanWITS) to monitor timely connection rates across the

system for WM and Residential programs. MEET and client questionnaires were also planned for quarterly review. Analysis was scheduled and completed using University of California at San Diego's (UCSD) Health Services Research Center (HSRC) which is contracted by the DMC-ODS to lead the implementation of the PIP interventions, data collection, and data analysis. San Diego notes that the data collection plan was successfully followed. Pilot programs submitted collected forms at least monthly, and SanWITS data were available reliably each month. In those instances where client identifiers could not be reconciled with SanWITS, these were excluded from the analysis. The results from the MEET tool were also routinely reviewed.

As a qualitative observation, San Diego notes their analysis was presented at a Stakeholder Workgroup meeting where the question was posed to the group if there were any other activities taking place during the PIP that could attribute to the findings other than the MEET intervention. No other activities or changes to processes in the system could be identified by the attendees of the meeting.

The TA provided to the DMC-ODS by CalEQRO consisted of:

- Met and discussed chronology of PIP adjustments to the project design where pilot programs encountered staff turnover, inability to keep up with required documentation, and limitations of program capacity at lower levels of care to accept referrals.
- Discussed these adjustments, the need for which was identified timely, as San Diego staff worked closely with pilot programs to address individual issues as they pertained to completing PIP data collection tools and questions about the intervention.
- Stakeholder participation and input along with frequency and responsiveness to pilot sites were noted to be strengths that led to this project's success.

CalEQRO recommendations for improvement of this clinical PIP include:

- Beyond the MEET intervention, the DMC-ODS notes that future plans may include expanding this project to improve timely connections across the DMC-ODS, which CalEQRO supports.
- Formally close the PIP and select new project.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Connections to SUD Services After PERT Contact

Aim Statement: This PIP aims to improve identification of a SUD and strengthen the connections to SUD treatment among clients with a PERT interaction. We aim to:

1. increase the proportion of clients with a PERT interaction who are admitted to a SUD program by 5 percent and/or;

2. decrease the mean length of time between when a client with a SUD concern receives a PERT interaction and is admitted to a SUD treatment program by 5 percent and/or;

3. decrease the proportion of clients with a PERT interaction and a SUD concern who are admitted to a SUD program more than 30 days after their PERT contact by 5 percent.

Target Population: Adults with a PERT interaction which is related to a SUD concern (either in full or in part) who initially refuse additional SUD services in one of the three selected geographic areas (Central, East, and North regions) of San Diego County.

Validation Information: The DMC-ODS's non-clinical PIP has had multiple remeasurements, is active and now to be completed.

Summary

During a PIP workgroup it was noted by multiple SUD providers that they observed a greater proportion of clients with co-occurring MH concerns among their program's population coupled with a higher acuity level compared to their clientele before the launch of the DMC-ODS. In a review of the FY 2018-19 data, it was confirmed that there had been a 40 percent increase in clients co-served by San Diego and the Mental Health Plan (MHP). An even greater upswing in clients (from 8 percent to 15 percent) was found for those who had entered the DMC-ODS, were co-served by the MHP and had a psychiatric emergency contact through the PERT team. Admission and TPS survey data revealed a low level of SUD clients were being referred to the DMC-ODS from PERT representing an opportunity to intervene during the PERT contact and help facilitate a treatment linkage to better address their SUD issues sooner.

Protocols, documentation, and workflows were adjusted to facilitate increased linkage though the main intervention entailed PERT clinicians identifying clients with a SUD concern who initially refused services and connecting those clients with a peer support specialist (PSS) via a warm handoff. While these individualized contacts with a PSS who shared lived experience made sense at PIP launch, the intervention was designed prior to COVID-19. With the pandemic, health and safety protocols adjustments were made, and in-person contacts were replaced by telephonic and other virtual means. In April 2020, the main intervention started with one PERT clinician in the Central region of San Diego County and was expanded to a PERT clinician in the East region in April of 2021, and finally a PERT clinician in the North region in October of 2021. While there

were plans to expand the PIP to other regions and PERT teams, low enrollment and complications related to the COVID-19 pandemic prevented further expansion during the PIP project period.

As of March 2022, the PIP project yielded just 36 clients identified by the PERT clinicians, with just 14 having an SUD concern. Of these, only five were successfully contacted, two of which were referred to SUD treatment services resulting in a single admission.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because of the limited results and very small total of clients who were part of the project even as interventions were appropriately adjusted and applied in manner consistent with design planning.

The TA provided to the DMC-ODS by CalEQRO consisted of:

- Discussed chronology of PIP implementation, impacts from external factors including that of COVID-19 restrictions, various community factors including pull on law enforcement, and more focus on acute and emergent scenarios by PERT which limited sample of the project.
- CalEQRO concurs that implementation of a peer-based intervention within this client population during a non-pandemic time, (when face-to-face interactions with a peer are not limited), might yield better results and where efficacy of the face-to-face handoff to a peer could be better ascertained

CalEQRO recommendations for improvement of this non-clinical PIP include:

- Despite limited results, San Diego should consider these interventions as a necessary and ongoing best practice for the acute populations it targets.
- Formally close the PIP and select new project.

INFORMATION SYSTEMS (IS)

BACKGROUND

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the DMC-ODS meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the DMC-ODS's EHR, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN SAN DIEGO COUNTY

California DMC-ODS EHRs fall into two main categories, those that are managed by county IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the DMC-ODS is FEI/SanWITS, which has been in use for 15 years. Currently, the DMC-ODS has no plans to replace the current system, which has been in place for more than five years. At the time of the review, the DMC-ODS and their IS vendor were engaged in launching several new updates and the implementation of additional modules to meet its CalAIM goals and other functional improvement needs.

Approximately 7.2 percent of the DMC-ODS budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving DMC-ODS control and the HHSA. During the review, the plan stated that this FY's IS budget is higher because of several EHR upgrades and enhancements being implemented. They do not expect similar funding levels in subsequent years. The IS FTE remained the same from the previous FY. The plan was able to fill all vacancies created in the past year.

The DMC-ODS has 920 named users with log-on authority to the EHR, including approximately 130 county-operated staff and 790 contractor-operated staff. Support for the users is provided by 15.25 full-time equivalent (FTE) IS technology positions. Currently all positions are filled. The county was able to fill all IT vacancies that occurred during the past year.

As of the FY 2021-22 EQR, all contract providers have access to directly enter data into the DMC-ODS's EHR. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the DMC-ODS IS as reported in the following table:

Table 23: Contract Providers' Transmission of Beneficiary Information to DMC-ODS EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between DMC IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☐	Electronic batch file transfer to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☒	Direct data entry into DMC IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	100%
☐	Documents/files e-mailed or faxed to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☐	Paper documents delivered to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	0%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. San Diego currently does not have a PHR system available for its beneficiaries. Their EHR vendor is currently evaluating PHR systems for best compatibility with the FEI EHR. It will be a third-party vendor and the DMC-ODS plans to implement it within a year.

Interoperability Support

The DMC-ODS is not a member or participant in a HIE. There is a local HIE that is mostly used by the hospitals at this time. A number of privacy and technical issues will need to be resolved before the DMC-ODS can join the HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The DMC-ODS engages in electronic exchange of information with the following departments/agencies/organizations: Contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following key components related to DMC-ODS system infrastructure that are necessary to meet the quality and operational requirements necessary to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the SUD delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 24: Key Components – IS Infrastructure

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

Strengths and opportunities associated with the IS components identified above include:

- San Diego uses a combination of data analytical staff from the health agency's epidemiology unit, UCSD HSRC, its ASP, and its Data Science and QI unit. San Diego has produced a very robust data reporting infrastructure that is unique in the state.
- The DMC-ODS utilizes a number of canned reports to check data timeliness, accuracy, and completeness. QI, performance improvement team, and the MIS team for CalOMS are responsible for monitoring these.
- San Diego reported 7.2 percent IT budget for FY 2021-22. They noted that this may be temporary as the budget was increased to account for the implementation of various functionalities and enhancements to the legacy IS to bring it in line with CalAIM changes.
- The DMC-ODS is adding more functionalities to its data warehouse. This is a third-party product that works with its EHR. By August 2022, the data warehouse will have updated CalOMS outcomes measures incorporated.

- Contract providers provide 100 percent of the DMC-ODS services, and all providers have full access to the available functionalities of the EHR. The DMC-ODS actively engages its contract providers in planning for and implementing EHR functionality enhancements.
- San Diego now has the capability to provide telehealth through 64 contract provider sites and has adequate infrastructure to provide the necessary support.
- The DMC-ODS provides a number of needed IS training through both regularly scheduled events and as needed. Training on some of the essential functions are offered twice a month. Many of these trainings are conducted by the county staff in the QI division.
- The DMC-ODS currently does not have a PHR module in its EHR. The EHR vendor is currently looking for a third-party PHR vendor that will be the best fit for its system. San Diego is expecting this functionality to be added within a year.
- San Diego is not a member of any HIE at this time. To join the local HIE in which a number of the hospitals participate, the DMC-ODS will have to address a number of privacy issues, and the HIE will have to build certain infrastructure specific to the needs of the DMC-ODS EHR.

IMPACT OF FINDINGS

San Diego operates with a 15-year-old legacy IS that is used by very few counties in California. However, it is a unique system that was built specifically with the needs of SUD services in mind. The vendor, FEI Systems, Inc. has added a number of functionalities over the years to meet the needs of the DMC-ODS. San Diego has engaged the vendor to develop further functionalities that will bring its EHR capabilities in line with the needs of CalAIM. The agency has temporarily increased its IT budget to make this happen. This review was held at a time when the planning and implementation for many of these enhancements were going on in full swing. The next 12 months will be a critical time for the DMC-ODS and the FEI Systems to successfully implement these planned changes. From a beneficiary perspective, the addition of a PHR module will be a great enhancement. From a treatment quality practice, the addition of electronic prescriptions and lab orders modules will be very important.

VALIDATION OF CLIENT PERCEPTIONS OF CARE

BACKGROUND

CalEQRO examined available client satisfaction surveys conducted by DHCS, the DMC-ODS, or its subcontractors.

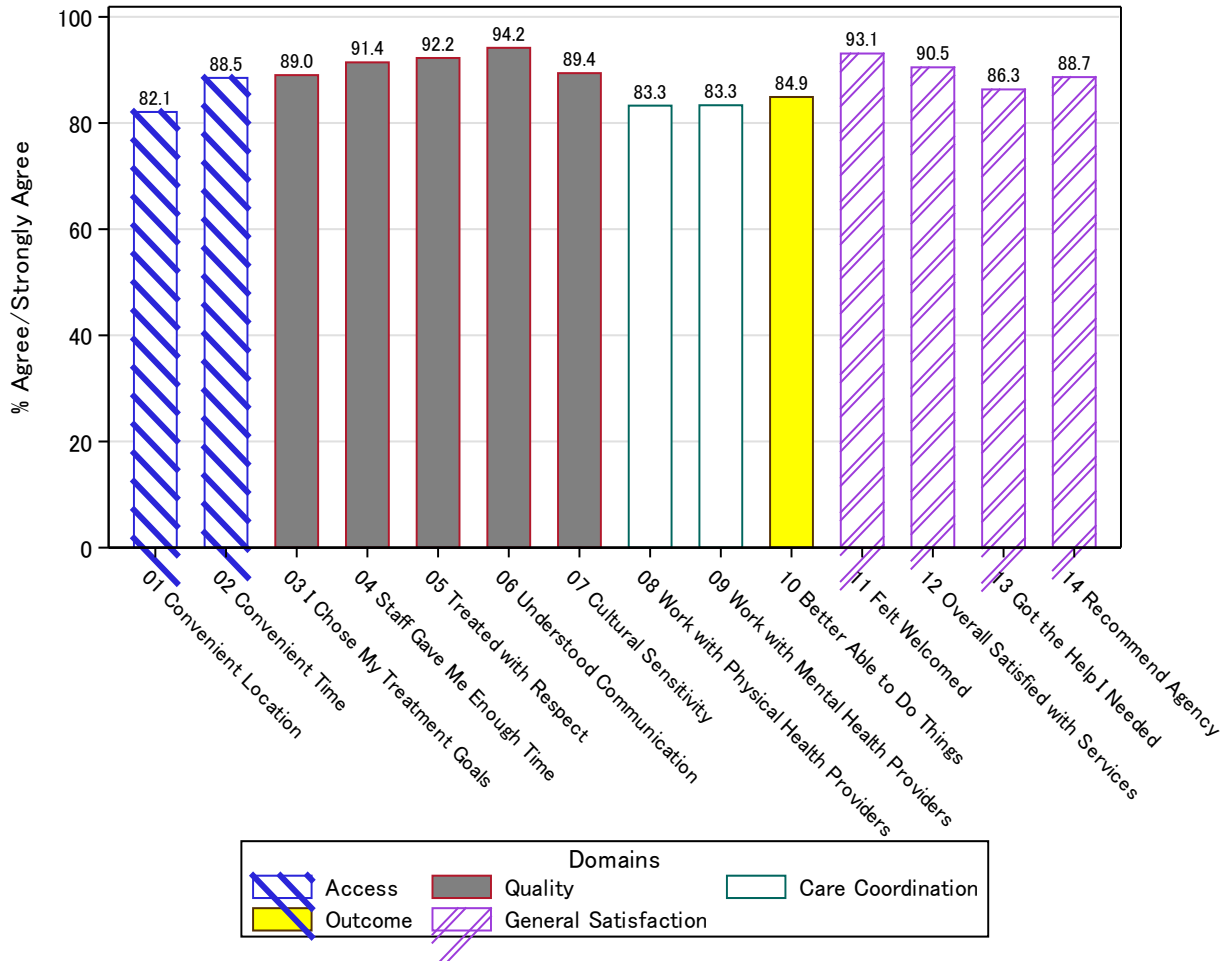
TREATMENT PERCEPTION SURVEY

The adult TPS consists of ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. DMC-ODSs administer these surveys to beneficiaries once a year in the fall and submit the completed surveys to DHCS. As part of its evaluation of the statewide DMC-ODS Waiver, the University of California, Los Angeles (UCLA) evaluation team analyzes the data and produces reports for each DMC-ODS.

The DMC-ODS adult clients gave high ratings in all five domains of Access, Quality, Care Coordination, Outcomes and General Satisfaction. Of the 1,564 respondents over 80 percent of gave positive ratings in each domain, and over 90 percent gave positive ratings to three of the five statements pertaining to the Quality domain. The 83.3 percent of clients who indicated agreement for the item regarding coordination with physical and MH care providers is consistent with levels seen statewide.

San Diego has studied the TPS results specific to the impact on clients and their perception of services and their own wellbeing during the COVID-19 pandemic. The report, issued in 2021 goes well beyond the standard statistical results of the survey, and includes supplemental data that has assisted San Diego in being responsive to client needs. Specifically, the report notes that employment, housing and basic needs were disrupted by the pandemic, and this exacerbated their SUD. Consistent with national impact studies, the majority of clients noted increases in anxiety, stress and depression increasing relapse potential and impeded progress in recovery. Given the insights the TPS supplement afforded them, the DMC-ODS has an opportunity to consider or make the necessary system adjustments to respond to clinical needs specific to these unprecedented times.

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA



CONSUMER FAMILY MEMBER FOCUS GROUP

Consumer and family member (CFM) focus groups are an important component of the CalEQRO site review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-site planning process, CalEQRO requested two 90-minute focus groups with clients and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included eight participants; all spoke English and a language interpreter was not used for this focus group. All consumers participating receive clinical services from the DMC-ODS.

CalEQRO provided instructions for participants to complete a nine-item online survey several days prior to the focus group. The instructions were given to a San Diego contact who in turn conveyed the materials to the treatment providers for handoff to the participants. The survey includes nine items for participants to rate on a five-point scale using feeling facial expressions with the happiest expression scored as five (5) and the most unhappy as one (1). The instructions explain the goal of the survey is to understand the clients' experiences in accessing and engaging in treatment.

Participants described their experience as the following:

Table 25: CFM Focus Group One

Question	Average	Range
1. I easily found the treatment services I needed.	4.3	3-5
2. I got my assessment appointment at a time and date I wanted.	4.2	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.6	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.4	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.1	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.3	2-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.4	2-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.4	3-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.2	2-5

Three of the focus group participants began treatment in the past 12 months. Most were connected to the criminal justice system at time of admission. All clients spoke highly of the counseling staff, though some felt the intake process was an issue. One client stated that to qualify for treatment, he had to relapse which then made him a candidate for a WM residential bed, securing his place into residential treatment. All noted that information was provided on the use and benefits of MAT, though there was

disagreement amongst them on its use in recovery. Care planning, coordination with outside agencies, and transportation to appointments for mental and physical health appointments is facilitated with program staff. Relapses are handled case by case, but as a residential program there is a strong sense that drug use is not tolerated and can result in a summary exit. While clients acknowledged the support and recovery skills they are gaining, they expressed concern that the program is short-staffed.

Recommendations from focus group participants included:

- Clients noted that groups are too big to be beneficial and that is because the program has a staff shortage. The lack of staff means certain structured elements such as staying up to date on their individual case or "calling me out on my behaviors" is lacking.
- Added time for individual sessions would help them to work specific issues that would assist them in recovery. Family sessions or time would be of benefit as well.
- Assistance with vocational skills, resume building and assistance with job placement, so they have this support in place when they discharge.
- Program could use updated materials for groups.

Consumer Family Member Focus Group Two

CalEQRO requested second session to include a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held at virtually and included four participants; no language interpreter was used. All consumers participating receive clinical services from the DMC-ODS.

CalEQRO provided instructions for participants to complete a nine-item online survey several days prior to the focus group. The instructions were given to a San Diego contact who in turn conveyed the materials to the treatment providers for handoff to the participants. The survey includes nine items for participants to rate on a five-point scale using feeling facial expressions with the happiest expression scored as five (5) and the most unhappy as one (1). The instructions explain the goal of the survey is to understand the clients' experiences in accessing and engaging in treatment.

Participants described their experience as the following:

Table 26: CFM Focus Group Two

Question	Average	Range
1. I easily found the treatment services I needed.	4.2	2-5
2. I got my assessment appointment at a time and date I wanted.	4.0	1-5

Question	Average	Range
3. It did not take long to begin treatment soon after my first appointment.	4.2	1-5
4. I feel comfortable calling my program for help with an urgent problem.	4.6	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	2.8	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.4	2-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.2	1-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.2	1-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.0	1-5

Just one of the participants had initiated treatment within the past 12 months. Clients report that entering the program was difficult based on capacity issues, having to call every week and having to be clean at the time of admission. One client hid her withdrawal symptoms to gain entrance and detoxed on her own. Another client noted that having to call every day while waiting for admission was problematic because the program did not have someone routinely assigned to answer the phone, so she had to call several times to finally reach someone and stay on the list. Another client noted that her intake date landed on a weekend, but then was initially denied entry because they do not have admits except Monday through Friday. In the end, she had to wait and make a scene in the parking lot before they allowed her in as an exception. Most of the session participants had either child welfare, probation, or court cases with terms that they obtain treatment. Most spoke openly about their "love" of the program and counseling staff along with being in an environment where other women are also "working hard" to obtain and sustain recovery. Coordination with physical and MH is facilitated by the program and several spoke favorably regarding the process in place for step-down and after-care planning.

Recommendations from focus group participants included:

- Open the program for weekend intakes.
- Assistance with outstanding legal issues that need to be resolved and remain a potential barrier to recovery.
- Lift the transportation restriction that doesn't allow for use to court or child welfare appointments involving child visitation.

IMPACT OF FINDINGS

Both sets of focus group participants were grateful for the program they were in along with the counseling staff. Both groups indicated that there are workforce issues that impede the program and interferes with the individual care they would like to obtain. Clients on MAT or other forms of medication were welcome though for some clients, lingering bias regarding its use in recovery remained. Clients found the intake process difficult and, in both groups, at least one participant noted having to feign symptoms to obtain entry or engage in drug use to secure a placement. Similarly, it is clear that the DMC-ODS' residential capacity still requires use of a wait list, and some noted either they or other individuals they knew had relapses or overdosed while waiting. Basic issues like outdated program materials, limits on transportation for supervised child visits, and no ability to facilitate weekend admissions should be reviewed and changes made if possible.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the DMC-ODS's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective DMC-ODS managed care system.

STRENGTHS

1. Harm Reduction principles are now being adopted and supported by leadership allowing San Diego to take a lead role in addressing harms caused by substance use and formulate initiatives and policies which are non-coercive and attendant to individuals allowing them to minimize harms and broadening the potential reach of its DMC-ODS system of care. (Access, Quality)
2. San Diego has a long history of successful coordination with allied agencies which is evidenced by the prioritizing and developing concurrent treatment of substance use and MH disorders, including several programs to provide integrated treatment within co-occurring enhanced programs. (Access, Quality)
3. MAT treatment is a system priority both in the delivery of these services and seen in the well-developed infrastructure and coordination for substance use treatment in many hospitals with ED Bridge Programs and FQHCs which frequently include behavioral health clinicians integrated into primary care teams. (Access, Quality)
4. San Diego demonstrates an active utilization of the TPS data results to guide and inform program and system adjustments, including a recent impact report on the COVID-19 pandemic and its perceived impacts of services received by ethnic and racial groups, impacts on housing and other ancillary factors that impact perception of care and service availability. (Quality)
5. San Diego has invested in numerous talented analytic staff, both internal to the department and contracted through UCSD and Optum, to generate an array of impressive data-based reports. They have combined this strength with investments in various technologies, including data warehousing and data visualization software, to produce data dashboards that are gaining widespread use throughout the organization. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Given the ongoing surge in overdose and fatalities, San Diego should continue its work to effect MAT access and continuation within the inmate population in coordination with its local Sheriff's department. (Access, Quality)
2. Additional steps should be taken to address the ongoing provider workforce issues currently limiting individual sessions, lack of caseload assignments staff which creates a lack of knowledge or consistency in addressing client presenting problems because of ever shifting staff assignments. (Access, Timeliness, Quality)
3. Assure that policies, workflows, and resources are available to assure complete and accurate tracking and reporting of time to service along with service utilization and performance trends including no-shows and monitored use of Recovery Residences in tandem with client LOC. (Access, Timeliness)
4. San Diego should consider work with system providers to allow for residential access during weekends, strengthen ancillary services such as transportation for perinatal clients needed for reunification visits with their children and update outdated program materials. (Access, Quality)
5. The DMC-ODS's EHR is in the middle of several enhancement efforts to address the CalOMS outcomes system and CalAIM requirements. In the planning and implementation efforts, San Diego will benefit from continued active engagement of their contract providers who provide all the SUD services in the county. (Quality, IS)

RECOMMENDATIONS

1. San Diego should take steps to identify and remedy protocol issues and introduce workflow solutions to assure a complete and an accurate data collection process for urgent service requests including ongoing monitoring, system adjustments and routine reporting. (Access, Timeliness)
2. The DMC-ODS needs to address performance issues pertaining to its elevated no-show rates for both outpatient and residential initial appointments, as well as timely follow-up following residential discharge. (Access, Timeliness, Quality)
3. Youth service levels need continued focus and prioritization to assure expansion and San Diego should take active steps to identify additional school locations and increase access for outpatient, intensive outpatient treatment, and residential services for the adolescent population. (Access, Quality)
4. San Diego should expand the number of goals in the QI Workplan that are QI-oriented, making sure they have stated objectives that are measurable with regards improving client experiences with access to or quality of care, and include specific action plans designed to help achieve the objectives. Revise

CCP to be more balanced to SUD services and the unique aspects of that service population. Seek TA from CalEQRO as needed. (Quality)

5. San Diego should build internal IT expertise and management capacity, including identifying key leadership positions to ensure clinical IT system improvements remain a priority and timely progress toward goals pertaining to California Advancing and Innovating Medi-Cal (CalAIM) initiative are made. (Quality, IS)

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the DMC-ODS review:

Table A1: CalEQRO Review Sessions – San Diego DMC-ODS

Table A1: CalEQRO Review Sessions – San Diego DMC-ODS
Opening session – Changes in the past year, current initiatives, status of previous year's recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of PMs
Quality Improvement Plan, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards, and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments (MATs)
MH coordination with DMC-ODS
Criminal justice coordination with DMC-ODS
Clinical supervisors group interview – county and contracted
Clinical line staff group interview – county and contracted
Client/family member focus groups: adult and special populations
Exit interview: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Patrick Zarate, Lead Quality Reviewer
Tom Trabin, Quality Reviewer
Saumitra SenGupta, Information Systems Reviewer
Diane Mintz, Client/Family Member Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and in preparing the recommendations within this report.

Sites for San Diego's DMC-ODS Review

All sessions were held via video conference.

Table B1: Participants Representing the DMC-ODS

LAST NAME	FIRST NAME	POSITION	AGENCY
Alford	Jessica	Clinician	Vista Hill Parent Care
Aston	Heather	Access and Crisis Line Manager	Optum
Blanchard	Michael	Behavioral Health Program Coordinator	SDCBHS – Quality Management
Briones	Melanie	Behavioral Health Program Coordinator, Local Opioid Treatment Authority	SDCBHS – Project Management Office
Cavanaugh	Adria	Chief, Agency Operations	Contract Support Team
Conlow	AnnLouise	Senior MIS Manager	SDCBHS – Management Information Systems
Daitch	Diana	Quality Management Supervisor	SDCBHS – Quality Management
David	Nora	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult System of Care (SOC)
Devillo	Inez	Program Supervisor	South Bay Behavioral Health Center
Eftekhari	Alisha	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Emerson	Cynthia	Administrative Analyst III	SDCBHS – Management Information Systems
Esposito	Nicole	Chief Population Health Officer	SDCBHS
Evans Murray	Cara	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult SOC
Galvan	Michelle	Executive Director	Optum
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	SDCBHS – Adult and Older Adult SOC
Gonzaga	Alfie	Program Coordinator	SDCBHS – Health Plan Administration
Gonzalo	Marc	Director	SOAP MAT

LAST NAME	FIRST NAME	POSITION	AGENCY
Guevara	Christopher	Program Coordinator	SDCBHS – Management Information Systems
Guingab	Amelia	Principal Administrative Analyst	SDCBHS – Fiscal
Hillery	Naomi	Project Manager	UC San Diego Health Services Research Center
Jackson	Shannon	Behavioral Health Program Coordinator	SDCBHS – Children, Youth, and Families SOC
Kang	Teresa	Behavioral Health Program Coordinator	SDCBHS – Children, Youth, and Families SOC
Kattan	Jessica	Medical Consultant	SDCBHS – Inpatient Health Services
Kiviat Nudd	Aurora	Assistant Director and Chief Operations Officer	SDCBHS
Kneeshaw	Stacey	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Knight	Betsy	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Koenig	Yael	Deputy Director, Children, Youth and Families System of Care	SDCBHS – Children, Youth, and Families SOC
Krelstein	Michael	Chief Medical Officer	SDCBHS – Clinical Director's Office
Lang	Tabatha	Operations Administrator	SDCBHS
Loyo-Rodriguez	Raul	Department Budget Manager	SDCBHS
Lucas	Lavonne	Medical Claims Manager	SDCBHS – Billing Unit
Marvin	Mark	Vice President, PERT	Community Research Foundation
Mendoza	Ray	Behavioral Health Intake Counselor	Optum
Mockus-Valenzuela	Danyte	Health Planning and Program Specialist	SDCBHS – Prevention and Community Engagement

LAST NAME	FIRST NAME	POSITION	AGENCY
Miles	Liz	Program Coordinator	SDCBHS – Population Health, Quality Improvement
Morgan	Maria	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC
Mullen	David	MH Clinician	Sheriff's Department
Murguia	Krystle	Principal Administrative Analyst	SDCBHS – Children, Youth, and Families SOC
Nunez-Acuna	Graciela	Advocate	Optum
O'Reilly	Kristyn	Senior Account Manager	FEI Systems
Panczakiewicz	Amy	Senior Evaluation Research Associate	UC San Diego Health Services Research Center
Pauly	Kimberly	Chief, Agency Operations	SDCBHS
Preston	Kristie	Clinical Director	Optum
Privara	Nadia	Acting Assistant Director, Chief Strategy & Finance Officer	SDCBHS
Ramirez	Ezra	Administrative Analyst III	SDCBHS – Health Plan Administration
Ramos	Nilanie	Chief, Agency Operations	SDCBHS – Clinical Director's Office
Sarvela	Donna	Quality and Compliance Manager	CRASH, Inc.
Shapira	Erin	Program Coordinator	SDCBHS – Quality Assurance
Sheaves	David	Implementation Manager	FEI Systems
Solom	Angela	Administrative Analyst II	SDCBHS – Data Science
Stephenson	Oscar	Substance Abuse Counselor	MAAC Project Nosotros
Strout	Liz	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult SOC

LAST NAME	FIRST NAME	POSITION	AGENCY
Tally	Steven	Assistant Director of Evaluation Research	UC San Diego Health Services Research Center
Thornton-Stearns	Cecily	Assistant Director and Chief Program Officer	SDCBHS
Tomic	Tatjana	Chief, Agency Operations	SDCBHS – Data Science
Tran	Phuong	Administrative Analyst III	SDCBHS – Data Science
Underhill	Allison	Field Operations Supervisor, PERT	Community Research Foundation
Valdes	Alfie	Quality Management Supervisor	SDCBHS – Quality Management
Vandarwarka	Aaron	Addiction and Substance Abuse Counselor	The Way Back
Vleugels	Laura	Supervising Psychiatrist	SDCBHS – Children, Youth, and Families SOC
White-Voth	Charity	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult SOC

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	PIP project design and interventions were adjusted as needed but followed the outlined process and review. Connection rates increased from 41 percent to 62 percent with the goal to improve the connection rate by 5 percent clearly met.
General PIP Information	
MHP/DMC-ODS Name: San Diego	
PIP Title: Connections After Discharge with Referral	
PIP Aim Statement: This PIP aimed to increase connections within 10 calendar days for clients discharged with referral from a residential or withdrawal management program to a lower LOC by 5 percent by April 2022.	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): The population for this PIP are adult clients who are actively enrolled in a pilot site WM or Residential program, who are being discharged with the disposition completed discharge with a referral to a lower LOC.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Participated in survey to identify clients that could benefit from standardized M.I. session
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Implemented client intervention with MEET interview tool, arranged follow-up, trained staff, collected data
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Designed and assisted programs with staff training, new protocols, workflows, and data collection in coordination with treatment sites

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Admissions to a lower LOC within 10 calendar days of discharge with referral	April 2020	86/210 41%	☐ Not applicable—PIP is in Planning or implementation phase, results not available November 2021	60/97 62%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): completed and closed Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Beyond the MEET intervention, future plans may include additional efforts around timely connections to treatment services across the DMC-ODS, which CalEQRO supports. Formally close the PIP and institute the process to select new clinical project.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☒ →Low confidence ☐ →No confidence	As submitted, this non-clinical PIP was found to have low confidence, because of the limited results and very small total of clients who were part of the project and had interventions applied in manner consistent with planning.

General PIP Information
MHP/DMC-ODS Name: San Diego
PIP Title: Connections to SUD Services After PERT Contact
PIP Aim Statement: This PIP aims to improve identification of a SUD and strengthen the connections to SUD treatment among clients with a PERT interaction. That is: a. increase the proportion of clients with a PERT interaction who are admitted to a SUD program by 5 percent and/or; b. decrease the mean length of time between when a client with a SUD concern receives a PERT interaction and is admitted to a SUD treatment program by 5 percent and/or; c. decrease the proportion of clients with a PERT interaction and a SUD concern who are admitted to a SUD program more than 30 days after their PERT contact by 5 percent.
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adults with a PERT interaction related to a SUD concern (either in full or in part) who initially refuse additional SUD services in one of the three selected geographic areas (Central, East, and North regions) of San Diego County.

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Identified clients specific to the PIP goals, implemented intervention and changes in protocol to assure fidelity and tracking
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Led changes to protocols with PERT team, data collection and staff understanding of changes in workflow and follow-up intervention

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Proportion of clients with a PERT service and a reported SUD who are admitted to a SUD program	7/1/2018 – 6/30/2019 (PERT) 7/1/2018-12/31/2019 (SUD)	643/3,455 19%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 3/31/2021 – 3/6/2022 (SUD)	1/13 (8%)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Sample size of clients involved provides too little statistical power to determine the extent of the intervention's impact

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Length of time between a PERT service and admission to a SUD treatment program	7/1/2018 – 6/30/2019 (PERT) 7/1/2018-12/31/2019 (SUD)	n=532 98.25 days	☐ Not applicable—PIP is in Planning or implementation phase, results not available 3/31/2021 – 3/6/2022 (SUD)	n=1 68 days	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Sample size of clients involved provides too little statistical power to determine the extent of the intervention's impact
Proportion of clients with a PERT service admitted to a SUD treatment program more than 30 days after their PERT service.	7/1/2018 – 6/30/2019 (PERT) 7/1/2018-12/31/2019 (SUD)	398/532 75%	☐ Not applicable—PIP is in Planning or implementation phase, results not available 3/31/2021 – 3/6/2022 (SUD)	n=1 100%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Sample size of clients involved provides too little statistical power to determine the extent of the intervention's impact

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): completed and closed Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Despite limited results, consider these interventions as a necessary and ongoing best practice for the acute populations it targets. Formally close the PIP and institute the process to select a new non-clinical project.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CalOMS Living Status at Admission, CY 2020

Admission Living Status	San Diego		Statewide	
	#	%	#	%
Homeless	4,291	37.1%	25,577	27.9%
Dependent Living	3,839	33.2%	22,882	25.5%
Independent Living	3,448	29.8%	43,711	46.6%
TOTAL	**11,578**	**100.0%**	**92,170**	**100.0%**

Table D2: CalOMS Legal Status at Admission, CY 2020

Admission Legal Status	San Diego		Statewide	
	#	%	#	%
No Criminal Justice Involvement	6,074	52.5%	58,971	64.0%
Under Parole Supervision by CDCR	291	2.5%	1,849	2.0%
On Parole from any other jurisdiction	*	n/a	1,305	1.4%
Post release supervision - AB 109	4,321	37.3%	23,836	25.9%
Court Diversion CA Penal Code 1000	224	1.9%	1,382	1.5%
Incarcerated	*	n/a	442	0.5%
Awaiting Trial	519	4.5%	4,348	4.7%
TOTAL	**11,576**	**100.0%**	**92,133**	**100.0%**

Table D3: CalOMS Employment Status at Admission, CY 2020

Current Employment Status	San Diego		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	1,515	13.1%	10,461	11.3%
Employed Part Time - Less than 35 hours	882	7.6%	6,784	7.4%
Unemployed - Looking for work	4,469	38.6%	28,853	31.3%
Unemployed - not in the labor force and not seeking	4,712	40.7%	46,072	50.0%
TOTAL	**11,578**	**100.0%**	**92,170**	**100.0%**

Table D4: CalOMS Types of Discharges, CY 2020

Discharge Types	San Diego		Statewide	
	#	%	#	%
Standard Adult Discharges	7,234	48.4%	40,731	42.6%
Administrative Adult Discharges	6,336	42.4%	45,247	47.4%
Detox Discharges	941	6.3%	7,946	8.3%
Youth Discharges	430	2.9%	1,600	1.7%
TOTAL	**14,941**	**100.0%**	**95,524**	**100.0%**