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2019-20
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

SAN DIEGO DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
May 12-14, 2020

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EXECUTIVE ORDER

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In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site focus group was conducted as part of CalEQRO's desk review of San Diego this year.

Consequently, the scope of validation for EQR activities and resulting recommendations were limited.

SAN DIEGO DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2018-19 — 9,574
San Diego Threshold Language(s) — Spanish, Vietnamese, Tagalog, Arabic, Farsi
San Diego Size — Large
San Diego Region — Southern California
San Diego Location — Located south of Orange and Riverside Counties, west of Imperial County, north of Mexico and east of the Pacific Ocean
San Diego Seat — San Diego
San Diego Onsite Review Process Barriers — none

Introduction

San Diego officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) on July 1, 2018 for Medi-Cal recipients as part of California's 1115 DMC Waiver. San Diego was the fourth county to launch in California's Southern Region and tenth statewide as part of eight counties who all launched in the same month. In this report, "San Diego" shall be used to identify the San Diego DMC-ODS program unless otherwise indicated.

Located on the Pacific Ocean, San Diego is deemed a large size county by way of its population size, as well as an equally large area in square miles with distinct geographic differences between regions. San Diego County has a population of 3,338,330 (US Census Bureau estimate, 2019) and a large geographic area of 4,526 square miles. San Diego is bordered on the west by the Pacific Ocean, on the north by Orange and Riverside counties and along the east by Imperial county. The southern part of San Diego is the international border between the United States and Mexico.

The San Diego-Tijuana Metropolitan Areas is the largest metropolitan area shared between the United States and Mexico. San Diego's primary employers are health care, social service, retail, aerospace, and electronics. The county is home to multiple military installations and is home port to 60 percent of the ships in the US Navy and more than one third of all active U.S. Marines.

San Diego's population makes it the second largest county in California and fifth largest in the United States. Gender ratios are about equal with .5 percent more female inhabitants in its population. San Diego county shows that 34 percent are Hispanic, and 45 percent are White (Not Hispanic or Latino). There is an overall median age of 36.1, an average annual income of $79,079 with a poverty rate of 13.3 percent. San Diego has a high level of health insurance coverage with 92.3 percent of its population insured, of which Medi-Cal insures 18.3 percent of the overall population. More than 38 percent of San Diego County citizens are speakers of a non-English language, which is

higher than the national average of 21.9 percent. Most prevalent is 24.9 percent of county residents who report that Spanish is the primary language spoken in the home. Threshold languages outside of Spanish are Vietnamese, Tagalog, Arabic, and Farsi.

The Population Health Institute ranks San Diego County 10 out of 58 counties for overall health indicators. Strengths include the availability of primary care physicians and mental health providers. Concerns include adult smoking and excessive drinking along with a disproportionate percentage of Hispanic children living in poverty at 24 percent compared to nine percent for Whites. For children under 18 years of age living in poverty, San Diego County is ranked 19th of all counties with just 14.9 percent. The high school graduation rate in San Diego County stands at 84 percent which is above the 76 percent found statewide. The unemployment rate stands at 10 percent, lower than the statewide rate of 11.7 percent. Overall social and economic factors ranked 14th out of 57. The factors reviewed include the rate of high school graduation, unemployment, and rates of children in poverty, amongst others.

As with many counties in California, San Diego has not been immune to the impacts of the drug overdose crisis and opioid epidemic. San Diego has been recognized for its multi-faceted and comprehensive approach in addressing the opioid crisis locally. One facet of this approach includes San Diego's partnership/collaboration with the Prescription Drug Abuse Task Force (PDATF). This multisector coalition was established in 2008 and includes key stakeholders from across the County's varied public and private entities with the shared goal to reduce prescription drug and other opioid-related deaths, and to educate the community about the safe use and proper disposal of prescribed medicines. To appropriately address issues within the medical community that includes safe prescribing efforts, a focused workgroup known as the Healthcare Task Force was formed in conjunction with the San Diego and Imperial Counties Medical Society and includes leaders and representatives from the local healthcare plans and healthcare administrators, hospitals and emergency departments, pharmacists, physicians and the county health department.

San Diego provided CalEQRO with the most current PDTAF report card. This provides year over year data on fatalities, emergency department visits, overdose reversals and other key data pertaining to the PDTAF established initiatives. According to the 2019 PDTAF report data, there were 246 deaths from opioid medication and other prescribed meds. 2018 also saw 478 deaths in San Diego County from heroin, alcohol, and illicit drugs. Fatal overdoses had a great impact on males with 162 of the 246 being men. Fentanyl and other synthetic opioids continue to be a concern with 92 deaths in 2018 compared to 33 deaths two years earlier in 2016. In the months since mid-2019, the Medical Examiner has continued to see more fentanyl accidental overdose deaths and the County is on track to exceed last year's statistics. Methamphetamine, which accounts for the most drug toxicity deaths in San Diego County, saw a 24 percent increase for fatal cases in the same time periods, (from 154 to 191 cases). In 2018, 328 people died in San Diego due to the acute toxicity of methamphetamine, sometimes in combination with another drug. For context, overall general unintentional fatal overdoses due to drug, medication, or alcohol increased by 7 percent, from 298 cases

mid-year 2018 to 319 this mid-year. The 2020 PDTAF report card will be released later this year.

Combined efforts between DMC-ODS, San Diego's participation in the California Opioid Hub and Spoke Project learning collaborative, and the establishment of hospital emergency department (ED) Bridge programs are thought to have contributed to an overall increase in Medication Assisted Treatment (MAT). Additionally, three driving under the influence (DUI) programs received grant funding to improve MAT coordination and provide specific case management to individuals dually engaged on both MAT and DUI programs.

San Diego has actively participated in prevention efforts, coordinated with Public Health which includes distribution of Naloxone and overdose rescue skills. The San Diego Web Infrastructure for Treatment Services (SanWITS) San Diego's electronic health record (EHR) uses the national dosing medication codes to be able to track the provision of Naloxone on an individual level, though aggregate data on system level distribution is not in place. On a system level, San Diego is educating providers that their policies need to outline clinical training and supervision addressing access to Naloxone, especially for clients who refuse a MAT referral and have an opioid use disorder. It should be noted that in the past year, San Diego has worked with a non-profit advocacy organization called A New PATH in developing a training video about Naloxone. This training is available online through the County of San Diego YouTube account. After taking the training, participants may request for Naloxone kits free of charge. This online training has been viewed over 784 times since it was uploaded in August 2019.

During this FY 2019-20 San Diego review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to DMC access, timeliness, quality, and outcomes related to the second year implementation of San Diego's DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2018-19.

Access

San Diego has established access through a "no wrong door" approach for screening and assessment into treatment. San Diego's system of care employs an Administrative Service Organization (ASO) to manage and operate the Access and Crisis Line (ACL). Clients can call the countywide toll-free ACL or access care by referral or self-referral to system providers throughout the community. The ACL, which is operated under contract with Optum, has trained clinical staff who can triage and administer a preliminary screening to make a provisional determination of what is likely the appropriate level of care. Once that determination has occurred, the individual will be directed to a service provider who can complete a comprehensive assessment. For any individual who is referred to or contacts a contracted treatment program directly, the same screening function will occur along with facilitation of any indicated need for referral, even if it is to another level of care or provider.

San Diego has multiple threshold languages including Spanish, Farsi, Arabic, Tagalog and Vietnamese. While the ACL actively recruits bilingual staff, it also utilizes the Language Line translation service as needed to assist in handling these calls.

The ACL operates 24 hours a day. They handle crisis calls, screening for mental health issues along with substance abuse requests for service. Official designation as a crisis line allows the ACL to address more acute needs in a way that avoids call transfer to another service. Third party or family calls regarding someone with a substance abuse problem are handled as a first-person screening and referrals are offered. For those calls which come in outside normal business hours or on weekends, the ACL will provide the caller with three referrals if staff are unable to make immediate contact with a provider program because outpatient programs are often closed.

As San Diego is entirely comprised of contracted Substance Use Disorder (SUD) providers, walk in or direct requests for services are required to be handled in a consistent manner across all 87 contract provider sites. County staff assigned to each program site are responsible to ensure standards are met through training, monitoring and site reviews. San Diego has created the Substance Use Disorder Provider Operations Handbook (SUDPOH) which is a comprehensive set of operational standards and workflows that includes screening, intake, care coordination requirements to ensure consistency as well as seamless transitions should that be necessary during treatment initiation. These protocols, along with programmatic and formats for cross provider communication, are designed to successfully link clients into the proper level of care (LOC). Case management starts during the intake process and continues as clients move through the system adjusting the LOC as indicated.

As part of San Diego's DMC-ODS Waiver implementation, steps were taken to address the confusing nature of health care through messaging out to the community. The message that San Diego is their health plan for SUD helped to clarify for beneficiaries the role of the department. This message has been effective as evidenced by the call volume to ACL. Optum reports that in calendar year 2019 they received 5,232 call for services, a slight decrease from the 5,976 calls for SUD services reported in the last review cycle.

While the ACL experienced a monthly average of dropped calls at just 2.7 percent and no wait time for callers, it is worth noting that data provided by Optum indicates that 86.5 percent experienced an unsuccessful warm hand-off. Of those unsuccessful calls, 43.8 percent declined services offered and 21.9 percent of the calls were listed as "screening stopped." Anecdotally, San Diego notes that in many cases, incoming callers have taken information provided to them and are following up on their own not refusing service. CalEQRO suggests that data and trends continue to be analyzed and that San Diego take meaningful steps to identify causes and solutions to address this.
Every individual seeking services receives a full ASAM assessment at intake. The ASAM is updated when a change in problem identification or focus of recovery or treatment occurs, or no later than 30 calendar days after signing the initial treatment plan or previous treatment plan for clients in residential treatment and no later than 90

days for outpatient treatment. San Diego's congruence levels for LOC referrals with ASAM findings indicate that a significant percentage of dispositions are consistent placement criteria. San Diego has a strong set of protocols and clinical workflow which are reinforced with training and monitoring resulting in a highly consistent administration of the ASAM criteria.

San Diego served 9,574 beneficiaries during FY 2018-19 according to Medi-Cal claims data provided by CalEQRO. This represents an increase from the 2,622 in claims data noted in the last review cycle, indicating that billing issues and lag time found at the provider level have been substantially mitigated. While the increase is substantial, San Diego provided data of 11,598 admissions which may indicate that steps are needed to assure full billing capacity.

Data also indicates that San Diego had an overall penetration rate of 1.47 percent, which is higher than the rate of other large counties that average 1.03 percent and significantly higher than 0.93 percent found statewide. Claims data also denotes that San Diego had a Hispanic/Latino penetration rate of 0.96 percent, somewhat higher than the 0.73 percent noted in other large counties and the statewide rate of just 0.66 percent. Hispanic/Latino are underserved with that group representing 39.3 percent of Medi-Cal eligibles and 25.6 percent of clients San Diego serves, representing a drop in the 30.9 percent of Hispanic/Latino found in the previous review cycle claims data. By contrast, Whites are overrepresented with 21.3 percent of the eligibles and 41.6 percent being served. That percentage indicates that 3,985 of the total 9,574 clients served are White. San Diego has taken multiple actions in addressing the specific needs relative to the Hispanic community and should continue to look to prevalence and other access data points to address system capacity and gaps.

Claims data indicates the presence of a comprehensive continuum of care with outpatient, intensive outpatient, residential, Medication Assisted Treatment (MAT), residential withdrawal management (WM) and recovery support services (RSS). San Diego has robust access for MAT with 42.3 percent of incoming clients initiating service at a Narcotic Treatment Provider (NTP), which is slightly higher than statewide of 39.7 percent. San Diego reports also having quite a number of individuals receiving non-methadone MAT services from non-OTP program sites, though these clients are being primarily treated under projects that do not appear in the Medi-Cal claims data available to CalEQRO. Residential WM and RSS show little activity and low billing at 0.6 percent for both compared to 4.3 percent for WM statewide and 0.36 percent statewide for RRS. San Diego notes that 27 legal entities offer RSS, but just 11 are billing. While the 11 programs which have begun billing represent 34 program sites, claims data provide by CalEQRO show RSS reflects just 2.8 percent of approved claims. San Diego also notes that only three of the legal entities, representing four of seven total residential locations, are currently billing for WM services. Claims data provided indicates that residential WM represents just 0.7 percent of total approved claims. For both WM and RSS San Diego data reflects higher service levels and notes that a percentage may not be billable under DMC. CalEQRO strongly recommends that taking additional steps to maximizing billing for services under the Medi-Cal benefit be a system wide consideration for San Diego.

San Diego has a large network of NTP providers who, provide methadone and an array of treatment medication options. There are four NTP legal entities, have a total of ten program sites arrayed across the county representing 4,685 treatment slots. Each of the legal entities is making available non-methadone forms of MAT to persons receiving services at their clinics. Unlike the previous review cycle where the number of persons receiving non-methadone MAT was small, 672 clients received alternate MAT. Claims data provided by CalEQRO indicated a dramatic increase in FY 2018-19 use and subsequent billing through Medi-Cal of non-methadone MAT. It is likely that the 5.7 percent this billing represents is the largest percentage in this service category across all counties in the state. Clients lacking Medi-Cal or who are otherwise unable to pay for MAT are referred to one of the grant funded Hub and Spoke sites, which has nine spoke access points. The largest of the NTP/OTP providers contracts with five Federally Qualified Health Centers (FQHC) and are seeing clients requesting evaluation for buprenorphine. Induction also occurs at three local EDs where San Diego has enhanced workflows on client identification, screening for MAT and the referral process defined in a local tool kit for emergency room staff. In addition, UC San Diego Health has a grant from the Public Health Institute's ED-Bridge program to help educate medical facility staff on the merits of drug treatment in order to improve and increase initiation of MAT and referrals to outpatient SUD clinics.

Accessibility was analyzed to determine compliance with Network Adequacy (NA) standards using access maps, charts and summaries. Nearly two thirds of San Diego county is undeveloped, surrounded by protected forest/desert, with a very low population density, and San Diego had requested and received in 2019 approval for Alternate Access standards (AAS) from DHCS. These standards applied to 10 zip codes regarding DMC-ODS outpatient services for both youth and adult. DHCS found San Diego in compliance with NA with the AAS approvals. To address underserved areas, San Diego implemented Roaming Outpatient Access Mobile (ROAM) services for outpatient in the north inland and rural eastern area of the county. ROAM is funded by the Mental Health Services Act as an Innovations program. An out of network contracting process was developed by San Diego to secure access to NTP and other services in surrounding counties, as needed.

Housing continues to be a challenge for San Diego residents due to low vacancy rates and high cost in most areas of the county. DMC-ODS admission data from FY 2018-19 on living status shows that 32.7 percent of incoming clients are homeless, slightly higher than the 30.5 percent in last review cycle and well over the state average of 27.5 percent. Client data also shows that there is a higher employment rate at admission however, with 16.2 percent employed full time compared to 12.6 percent statewide. Employment status data also indicates that just 40.4 percent of San Diego's admitted clients are unemployed, not in the labor force or seeking work, lower that 49.8 percent found statewide amongst this population.

Transitional housing to assist in stepped down level of care using sober living environments remain in very high demand. Though not billable under DMC, San Diego

invited facility owners to participate in a Recovery Residence Association (RRA). San Diego has established a contract with Community Health Improvement Partners (CHIP) to develop the RRA that provides oversight and support for local Recovery Residence (RR) proprietors, owners and clients to ensure quality standards are met and address any issues as they may arise. CHIP provides training to owners as well actively seeks new residences to be part of the RRA. San Diego's SUD treatment providers are encouraged, but not required, to use sites that are part of the RRA as their facilities have peer monitoring, accept clients on MAT and offer online location and bed capacity information. As to capacity, San Diego notes there has been a continued need for additional funding for recovery residences while no actual bed utilization or capacity data is available for this review cycle. They are working closely with providers to identify ways to secure details regarding ongoing utilization and need. Data for the first two months of FY 2019-20 showed an average of 200 individuals utilizing beds each month through agreements with SUD outpatient service providers and recovery residences. While specifics remain unavailable, system funding levels have increased. San Diego notes that in FY 2018-19 there was $2.5M budgeted for recovery residences through the outpatient contracts, and this figure increased to $6.3M in FY 2019-20. CalEQRO strongly recommends that San Diego develop ongoing reports to identify service level data for recovery residences. The report should include number of contractors, bed capacity, intake, and discharge volumes along with average length of stay.

San Diego partners with the criminal justice system to best identify and serve clients coming in from their single largest referral source. In addition to working with the courts directly and participating in a variety of specialty and drug courts, San Diego has assigned a single point of contact to address concerns over level of service determinations. San Diego has worked closely with criminal justice and continues to offer a "justice override" when court determinations are not in alignment with ASAM based assessments giving their partners override capability.

Despite the impact of the Coronavirus and necessary adjustments following the Governor's stay at home orders, San Diego took immediate steps to address client care and the need for continued access. From the beginning of the shutdown they recognized the need to operationalize a response to their SUD treatment providers. Regarding coordination, they had to migrate from office to teleworking as services to clients were quickly moved to a telehealth and telephone format. Extra efforts were taken to assure case management for clients, provision of MAT, and other services to avoid drop off. While they were able to leverage existing pathways for administrative communication establishing care platforms took effort between county staff and providers. This included assuring contract providers were following CDC guidelines (which changed often by the day) and also local Public Health (PH) guidance. Noting that was initially thought to be passed by April or May, they have now assured information is continuing with contract leads to providers. At present, monthly San Diego telecom calls are in place for the director to communicate directly with executives and program staff throughout the system of care. In addition, the medical/clinical lead for DMC-ODS convenes teleconferences with SUD Medical Directors every other week.

Indicators that access and service levels are being impacted were noted by San Diego in their report to CalEQRO. Impacts on workforce at contract providers included staff who got sick, people who were older and did not feel they could come to work and people affected by childcare issues. Workforce reaction shifted as more information became available.

There was less of an impact on staffing in residential (10-15 percent) than expected. Increases have been noted regarding incoming clients for residential since mid-April and there was an overall decrease of 28 percent for outpatient. This trend may be mitigated due to a shift towards individual care that can be more easily facilitated through telehealth or phone visits. Although adolescents are noted to have access to devices and to generally be comfortable with the technology, they do not necessarily desire engaging in services through this modality. By contrast, in perinatal outpatient there are many clients who would like to participate but do not have access to a mobile device, may not have internet or may not have enough data on their device to participate.

A lot of clients receiving outpatient services live in recovery residences and they are participating in self-help zoom meetings. However, for other individuals there is a need for help them gain access to technology capable of handling group platforms so they can still participate in treatment. Some clients are also not in an environment that allows them privacy to do the session. San Diego is developing a tool kit for providers for Telehealth, telecommunication as well as coaching clients and staff on use of new platforms. These tools also provide guidance on continuation billing as well as suggestions on continuation of services to clients. Looking forward, San Diego notes that for clinical services, 75 percent of workforce is telecommuting. Once some relaxing comes about they will need to determine how to phase certain aspects of traditional care back into place. This will likely begin with the provision of face to face contacts. It is possible that they will have to prioritize clients, noting that if they are not in crisis and doing well, they could stay on telehealth versus coming into a clinic that has limited capacity.

Timeliness

San Diego has timeliness standards for services which are adherent to the state requirements. San Diego's ACL has performance goals that ensure average response time to be within 45 seconds for incoming calls. Data for FY 2018-19 shows an average response time to SUD calls (both crisis and non-crisis) to be just 17 seconds. The ACL is operated by Optum and has provided beneficiaries telephone screenings, treatment referrals and brief solution focused counseling since 1997. Optum handles incoming calls for both Mental Health (MH) and SUD service requests. The ACL operates 24/7 and because it is a combined access and crisis line, Optum staff have the same priority as 911 operators and urgent or calls requiring an interpreter are given a high level of priority.

Utilizing Avaya telephonic software San Diego's capability to track timeliness metrics is well developed and Optum provides Quality Management staff with tracking, trending reports and analysis monthly. The ACL Access and Crisis Line Summary Statistics Report produced by Optum provides detailed trend lines for referral source, reason for call service type requested, linguistic needs, and service provided by ACL staff. CalEQRO notes these reports, which include performance goals, are not just informative but visually represent data in a way that can be utilized easily and may represent a best standard for call center data collection. Alternate access points collect information in the SanWITS. San Diego has required all contract providers to utilize SanWITS for the purpose of capturing the required DMC-ODS Waiver data. Universal utilization of SanWITS allows San Diego to more fully capture and report on timeliness metrics.

With calls for service and the associated data currently entered into SanWITS subsequent contacts with incoming clients gives San Diego timeliness reporting capabilities. Call logging data includes information that can link first contact data so that the system can accurately analyze timeliness metrics. San Diego has developed a report for "Average Length of Time from Initial Request to First Offered Intake/Screening Appointment" which provides both county staff and providers with monthly updates and year to date averages for individual programs and across the system. Performance in timely access across levels of care is reinforced by inclusion of it as a goal within the Quality Improvement Work Plan (QIWP) and contracts.

The annual evaluation of the QIWP indicated that for FY 2018-19 outpatient programs met the 10-business day standard for initial contact to face to face appointment 84 percent of the time. The same metric reported to CalEQRO for the first two quarters of FY 2019-20 indicated improvement with 91.1 percent of appointments meeting the 10-business day standard. Discussion of report findings occur at the Quality Review Committee (QRC), the Behavioral Health Advisory Board (BHAB) and internal leadership meetings reflected in minutes in regularly scheduled meetings.

Optum staff are online 24 hours a day, seven days a week and have access to the SanWITS system as referrals are made to providers. Optum data on its call center activities reported just 2.7 percent dropped call rate in a 12 month time frame beginning in February 2019. San Diego reports a monthly average of 436 requests for SUD service in the same time frame. For routine appointments, San Diego averages a wait time for adults to receive an offered appointment of just 3.3 days. This indicates a slight improvement from the last review cycle where it averaged four days for routine visits. When separating for youth and adults, San Diego reports that the adult average in meeting this standard occurs 90.8 percent of the time and for youth, 94.6 percent of the time. Data regarding average length of time from initial request to first MAT appointment indicated that the DHCS standard 3-days is met 95.5 percent of the time with a range of zero to one days on average.

Follow up encounters for clients discharged from residential treatment only meet the 7-day standard 25.6 percent of the time, but this is a significant improvement from 17.3 percent reported in the last review cycle. San Diego reports that of the 3,697 discharges just 612 were able to access step down treatment in seven days. When separating adults from youth, the percentage dropped slightly to 25.4 percent for adults, as adolescents were more likely to secure a timely follow-up session with 34.5 percent making a timely transition. FY 2018-19 Medi-Cal Claims data provided by CalEQRO show that the percentage of readmissions to WM within 30 days post discharge are 24.5 percent, substantially higher than the statewide average noted to be just 7.0 percent. San Diego has provided a much higher number as its denominator indicating that this may be a more complete data set. According to their report just 5.9 percent or 78 of 1,330 clients discharged from that LOC return. BHC is investigating these differences but many counties have had difficulties with Medi-Cal certification of their WM beds and a high percentage of non-Medi-Cal clients using them accounting for some significant differences.

San Diego has a documented operational definition for urgent appointment requests which adheres to the DHCS timeliness standard of 48 hours. The average length of time for urgent appointments is just 1.7 days overall and 78.9 percent of appointment requests meet the standard. This is significant as an option to capture urgent time frames was added to SanWITS well after the DMC-ODS implementation and there was no data available at the time of the last review.

Regarding system efficiency which can impact capacity, San Diego does not have an established productivity standard for SUD counselors. It is anticipated that as contract providers become more proficient in billing and rates are adjusted, there will be a move to a contract rate cap model which would lead to programs maximizing use of staff resources. Cal EQRO strongly encourages San Diego to consider ongoing use of performance indicators such as productivity and no-show standards to benefit the efficient workflows and capacity for its system of care.

Quality

The SUD-Quality Management (QM) team was created specific to DMC-ODS Waiver and mirrors one on the mental health side, though there are overlaps for specialty populations such as youth and women. The team has assigned licensed clinical staff responsible for overseeing the quality management and compliance of contract providers. Chart reviews are conducted to determine overall assurance of quality care and that associated documentation meets the parameters defined by DMC for billing and by the Waiver. That is, using clinically accepted review mechanisms to be more in line with medical standards pertaining to access times, care transitions and related ASAM criteria. San Diego also has designated Contracting Officer Representatives (COR) within the Systems of Care teams who are responsible for monitoring contract deliverables and who work closely with the QM team as part of those monitoring activities.

The Quality Improvement Work Plan (QIWP) is part of an integrated Quality Management (QM) structure along with MH. The QI Unit delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use disorder services provided. The QI Performance Improvement Team (QI PIT) is a component of the QI structure that specifically monitors and looks at aspects of client care to identify and address opportunities for improvement. Minutes reflect that the QI PIT team collects data which are analyzed over time and used to measure against goals and objectives. Development of the QIWP objectives is completed in collaboration with clients and stakeholders through the Quality Review Council (QRC). Client feedback is incorporated into the initiatives and goals of the QIWP. Communications on initiatives from the plan are provided at bi-monthly QRC meetings with reports that have been tailor made for audiences to receive information that targets their interest. A recent example was the development of an updated SUD Behavioral Health Advisory Board report featuring outcomes from the DMC-ODS system of care.

San Diego provided CalEQRO with a FY 2018-19 Substance Use Disorder Services Work Plan Evaluation that included 14 goals and initiatives specific to the population it serves under the DMC-ODS Waiver. Goal Seven of that plan pertained to developing and implementing both a clinical and non-clinical performance improvement project (PIP). The non-clinical PIP was based on the lack of grievances and appeals and research that enhancing client empowerment required investment in the quality of their own care and understanding and utilizing mechanisms in place to address concerns. The clinical PIP was based on analysis of discharge reports and designed to reduce untoward clinical outcomes by identifying relapse prevention strategies that could be used by providers across its continuum of care.

San Diego has consistently monitored core quality elements to its treatment providers provided training in use of ASAM placement criteria and the documentation standards. Utilizing the Addiction Severity Index (ASI), a standardized assessment tool, level of service recommendations based on ASAM parameters are determined. The results of the ASAM assessment is built into SanWITS and is used for all clients once triage determines a full evaluation for treatment is indicated. Language that supported the need of beneficiaries to meet requirements for service at the recommended level was incorporated into provider contracts. While San Diego requires service authorizations for residential treatment, all other services are authorized at the provider level. Capability is being enhanced and developed in SanWITS that will enhance tracking authorizations, residential stays as well as bed availability. Use of ASAM placement criteria has continued to enhance levels of communication between contract providers and San Diego staff, and steps are being taken to coordinate incoming clients to other providers when they do not meet their own programs criteria.

San Diego and its contract providers use SanWITS as its primary database, and they are in process of developing it into an electronic health record (EHR). While SanWITS provides billing, practice management, and some clinical elements, over 90 percent of providers currently utilize paper charts as their legal chart of record. There are a variety of reports available to providers and contract monitors. The Quality Improvement Unit

which includes the SUD Quality Management team, Performance Improvement team and MIS team oversee accuracy and completeness of information entered in SanWITS. San Diego QI has strong analytic capability to support quality of care efforts and data tracking. Further system analysis for internal monitoring is possible as specific data sets are provided by Optum, UCSD, Mental Health and the Medicaid Health Plans (Healthy San Diego). San Diego continues to work with its vendor to further build-out the SanWITS application to support the requirements of the DMC-ODS Waiver and several areas are being piloted or scheduled for roll out later this year. Current estimate is to complete work on planned EHR enhancements by late 2021, though the project timeline will likely be impacted by the Coronavirus pandemic.

Geo-coded service delivery mapping from Optum has resulted in data driven discussions to try to explore how to reach under-served areas in the north county or with youth and resulting in data driven decisions to improve care such as the ROAM service model noted above. Likewise, San Diego has been planning service expansion to the north regions of the county. Under contract with Interfaith Community Services, they established a WM program whose goal is to improve access to the continuum of care for SUD clients and includes those in the North County region of San Diego.

San Diego encourages coordination of care with mental health services and screens 100 percent of incoming clients for co-occurring disorders. Providers are certified as either Dual Diagnosis Capable or Dual Diagnosis Enhanced in alignment with the Comprehensive, Continuous Integrated System of Care model (CCSIC). San Diego facilitates a train the trainer model that assists in reinforcing CCSIC for which each provider must have a designee. Regional Collaborative meetings have sought to enhance the referral and care coordination with mental health. Principles and initiatives are reinforced with an annual care integration summit which includes physical health as well. San Diego benefits from a historically strong collaboration with the local health plans. The Healthy San Diego Plan Coalition represents seven managed care plans, has MOU agreements with San Diego DMC-ODS and a coalition monthly meeting with the county to discuss shared concerns. The health plan coalition has several initiatives linked to the local Whole Person Care (WPC) grant, Health Homes and a transportation project, all of which benefit the local SUD treatment population.

As with most counties, San Diego had a history of stigma within its substance use treatment continuum regarding the use of methadone and other addiction treatment medications. In the last review cycle, San Diego described the education efforts which had resulted in more general acceptance for clients on MAT. Due to limitations of a desk review no discussions took place with providers or clients to assess lingering or possible bias against those individuals who are utilizing MAT. San Diego continues to address this issue through education and has laid down contract language requiring programs to allow MAT or face contractual actions. Work on acceptance has now shifted to addressing concerns of neighbors and the broader community. San Diego has asked Opioid Treatment Providers (NTP/OTPs) to develop “good neighbor” policies and look for ways to integrate with the local business and the residents around their sites. In addition, San Diego is working on local criteria, within the scope of federal law, for siting

and operating MAT clinics. These policies would require corrective action plans for clinic sites that are not in conformance.

San Diego has continued to encourage its development of MAT to expand their capacity and make buprenorphine and other non-methadone MAT available. Consistent with ongoing support and clearly stated expectations of the NTP/OTP providers, San Diego has seen a substantial increase in the clients serviced with non-methadone forms of MAT. Combined efforts between the California MAT Expansion Project Hub and Spoke grants, along with establishment of ED-Bridge programs, are thought to have also contributed to general expansion of MAT and increase numbers of X-waivered prescribers. While these are projects that they partner with, at present San Diego has not implemented tracking of X-waivered prescribers though they are in the process of establishing such data. Finally, San Diego has assisted physician's education and comfort in prescribing buprenorphine with an updated emergency department (ED) toolkit.

San Diego completed and submitted its 2019 Cultural Competence Plan (CCP) along with a three-year Strategic Plan to DHCS. In recognition of the county's cultural and ethnic diversity, San Diego's current plan utilizes the national Cultural Linguistically Appropriate Service (CLAS) standards as its framework. San Diego worked to achieve provider compliance in having their own CCP developed following the CLAS standards checklist. Compliance with this standard was consistent amongst SUD providers at 98.7 percent. Plan components are reviewed by San Diego contract staff to assist and ensure they are integrated into their organizations system of care. Providers are expected to utilize organizational assessment tools such as the Cultural and Linguistic Competence Policy Assessment (CLCPA) and participate in the Promoting Cultural Diversity Self-Assessment Checklist (PCDSA) which is utilized for staff assessment, providing baseline data on attitudes, beliefs and how attuned individuals are to cultural needs. San Diego has continued to outreach underserved or remotely located groups such as Native Americans, and MAT expansion with the innovative ROAM project noted earlier which will reach tribal areas.

Outcomes

San Diego continues to be extremely transparent in the sharing of outcome and performance data specific to the DMC-ODS Waiver and other performance indicators with its utilization data dashboards. San Diego has an advanced level of creating data metrics that are visualized in such a manner to communicate trends to targeted audiences. These audiences include county leadership, contract managers, program providers, advisory board members, or criminal justice representatives. Example reports such as the Justice Override Authorization and Admission, SUD Units of Service by Level of Care, SUD Units of Service by Level of Care and Substance Use Disorder Service Indicator reports provide specific and trended performance, service or outcome data that is customized for intended recipients. These are then posted or distributed to

key stakeholders on a scheduled basis. These data dashboard reports are consistent with the Quality Improvement Plan in that measures are consistently collected, interpreted, and communicated out across the system.

In the last review cycle, San Diego had reset expectations on the use of CalOMS outcomes data by moving this role primarily to the contract providers and encouraging the use of multiple available reports. Progress has been made regarding any concerns around timely, accurate and complete data submissions, though it appears some lags in billing or submissions may still be present with large number of client admissions and discharges not reconciling with the much smaller number in claims data provided by CalEQRO. San Diego contract monitors continue to analyze CalOMS results for each individual program, and providers are required to adhere to data entry standards for entering CalOMS both at admission and discharge. Programs are given two weeks to make corrections in SanWITS addressing any errors. San Diego should continue to reconcile any billing or other data impacted by partial or problem submissions.

San Diego is involved in homeless outreach efforts though different programs, most notably with the inclusion of Homeless Outreach Workers (HOW) in SUD outpatient adult programs, funded by separate cost center under MH. An example showing the level of need was provided by San Diego which showed that hundreds of HOW contacts have been logged within outpatient perinatal programs since the start of the program.

CalOMS outcomes data at the time of discharge shows San Diego's level of standard discharges at 53 percent, which is higher than the 43.8 percent statewide. Administrative discharges in San Diego are at 39 percent compared to the state at 46.6 percent. Overall positive outcomes are noted with 51.1 percent of the 19,644 client discharges ranked as completed or satisfactory compared to 45.8 percent statewide. The discharge data did indicate that only 4.2 percent of discharges were youth, an area that should continue to be a focus for San Diego. CalEQRO notes that the FY 2018-19 outcome data from CalOMS reflects a strong level of program performance.

Client/Family Impressions and Feedback

There were no client focus groups (FG) scheduled for the San Diego CalEQRO review as this was a desk review. FGs would generally be conducted at contract provider sites to obtain first-hand perceptions from those individuals who are receiving treatment regarding their experience of access, time to service and the quality of services provided. However, with a desk review format for this review cycle, FGs did not occur.

San Diego has participated in the two collection cycles of the Treatment Perception Surveys (TPS) in 2018 and 2019. In each administration, San Diego has received TPS results and analyses back from UCLA. For the 2019 TPS cycle, the adult population returned 2,421 surveys, which is up from the 1591 collected in 2018. For the 2019 TPS administration, adult clients surveyed were generally very satisfied with the services they received, though there are somewhat to significantly lower scores noted at several

of the individual program sites. Youth TPS survey results are overall good for the system, though there are some marked levels of downward variance in core domains of cultural sensitivity, counselor interest and overall satisfaction with services at individual programs.

San Diego's TPS results are shared with providers through a systemwide report, a client handout, and the program-level reports which are available to each program. The results noted in the TPS systemwide report is also published for public dissemination. This summation also provides key findings across the system of care and the report is provided to programs in both English and Spanish. Providers are asked to have a printed out copy for display within each program's facility. The program-level reports are accessible to the providers through their Contracting Officer's Representative (COR) or contract monitor to facilitate discussion of their program's results compared to the system of care.

San Diego advised CalEQRO that programs are aware of the variance in scores with reports available to them that show how their programs compared to similar level of care programs, as well as how they compare to the overall scores across the system. The COR receives contracted program's results and discusses them with the individual providers. During these discussions both parties would look at a program's results compared to the overall average in the system and discuss how the program can address low or below-average results. CalEQRO strongly recommends that San Diego follow up with provider sites with low score variances and monitor them to note any developments of improvement or continued low performance in these satisfaction surveys. While San Diego notes that 932 Spanish language surveys were requested by providers, low usage by programs should be addressed so TPS results more accurately reflect the treatment population and the county's diversity.

CalEQRO reviewed the results of six test calls provided by UCLA that were conducted during FY 2018-19 and FY 2019-20. Two of the calls were conducted in Spanish and all were answered within the two-minute time frame with no calls dropped. Two of the phone numbers provided to callers were incorrect, and one resulted in the caller reaching just an answering machine though they did contact a person by using the number on the recording. Staff who answered were generally knowledgeable of services and in four calls the person answering the phone was able to screen and refer the individual for services. A request for information in Spanish was met in one case with the simple direction, "8:00 pm." Staff on the call notes were listed as being polite, helpful in providing direction, knowledgeable on process for next steps toward full assessment, asked about Medi-Cal or health insurance. Additionally, one case indicated an extended conversation and provided helpful direction for the caller who was deemed to need withdrawal management (WM).

Recommendations

In the conclusions section at the end of this report, CalEQRO prioritizes the most important opportunities for improvements into a closing set of recommendations that

suggest specific actions. As a standard EQR protocol for all counties, at the time of the next EQR San Diego will summarize the actions it took and progress it made regarding each of the recommendations.

EXTERNAL QUALITY REVIEW COMPONENTS

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). The External Quality Review (EQR) process includes the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) regulations specify the requirements for evaluation of Medicaid managed care programs. DMC-ODS counties are required as a part of the California Medicaid Waiver to have an external quality review process. These rules require an annual on-site review or a desk review of each DMC-ODS Plan.

The State of California Department of Health Care Services (DHCS) has received 40 implementation and fiscal plans for California counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act. DHCS has approved and contracted thus far with most of them, and EQRO has scheduled each of them for review.

This report presents the FY 2019-20 EQR findings of San Diego's FY 2018-19 implementation of their DMC-ODS by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

Validation of Performance Measures[1]

Both a statewide annual report and this DMC-ODS-specific report present the results of CalEQRO's validation of twelve performance measures (PMs) for year one of the DMC-ODS Waiver as defined by DHCS. The sixteen PMs are listed at the beginning of the PM chapter, followed by tables that highlight the results.

[1] Department of Health and Human Services for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR). Protocol 2, Version 2.0, September 2012. Washington, DC: Author.

Performance Improvement Projects[2]

Each DMC-ODS county is required to conduct two PIPs — one clinical and one non-clinical — during the 12 months preceding the review. These are special projects intended to improve the quality or process of services for beneficiaries based on local data showing opportunities for improvement. The PIPs are discussed in detail later in this report. The CMS requirements for the PIPs are technical and were based originally on hospital quality improvement models and can be challenging to apply to behavioral health.

This is the second year for the DMC-ODS programs to develop and implement PIPs so the CalEQRO staff have provided extra trainings and technical assistance to the County DMC-ODS staff. Materials and videos are available on the web site in a PIP library at http://www.caleqro.com/pip-library. PIPs usually focus on access to care, timeliness, client satisfaction/experience of care, and expansion of evidence-based practices and programs known to benefit certain conditions.

DMC-ODS Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which San Diego meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of San Diego reporting systems and methodologies for calculating PMs. It also includes utilization of data for improvements in quality, coordination of care, billing systems, and effective planning for data systems to support optimal outcomes of care and efficient utilization of resources.

Validation of State and County Client Satisfaction Surveys

CalEQRO examined the Treatment Perception Survey (TPS) results compiled and analyzed by the University of California, Los Angeles (UCLA) which all DMC-ODS programs administer at least annually in October to current clients, and how they are being utilized as well as any local client satisfaction surveys. DHCS Information Notice 17-026 (describes the TPS process in detail) and can be found on the DHCS website for DMC-ODS. The results each year include analysis by UCLA for the key questions organized by domain. The survey is administered at least annually after a DMC-ODS has begun services and can be administered more frequently at the discretion of the county DMC-ODS. Domains include questions linked to ease of access, timeliness of services, cultural competence of services, therapeutic alliance with treatment staff, satisfaction with services, and outcome of services. Surveys are confidential and linked

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[2] Department of Health and Human Services, Centers for Medicare, and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services, Centers for Medicare, and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

to the specific SUD program that administered the survey so that quality activities can follow the survey results for services at that site. CalEQRO reviews the UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

CalEQRO also conducts 90-minute client focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries. The client experiences reported on the TPS are also compared to the results of the in-person client focus groups conducted on all reviews. Groups include adults, youth, parent/guardians and different ethnic groups and languages. Focus group forms which guide the process of the reviews include both structured questions and open questions linked to access, timeliness, quality, and outcomes.

Review of DMC-ODS Initiatives, Strengths and Opportunities for Improvement

CalEQRO onsite reviews also include meetings during in-person sessions with line staff, supervisors, contractors, stakeholders, agency partners, local Medi-Cal Health Plans, primary care, and hospital providers. Additionally, CalEQRO conducts site visits to new and unusual service sites and programs, such as the Access Call Center, Recovery support services, and residential treatment programs. These sessions and focus groups allow the CalEQRO team to assess the Key Components (KC) of the DMC-ODS as it relates to quality of care and systematic efforts to provide effective and efficient services to Medi-Cal beneficiaries.

CalEQRO considers in its assessment of quality the research-linked programs and special terms and conditions (STCs) of the Waiver as they relate to best practices, enhancing access to MAT, and developing and supervising a competent and skilled workforce with ASAM criteria-based training and skills. The DMC-ODS should also be able to establish and further refine an ASAM Continuum of Care modeled after research and optimal services for individual clients based upon their unique needs. Thus, each review includes a review of the Continuum of Care, program models linked to ASAM fidelity, MAT models, use of evidence-based practices, use of outcomes and treatment informed care, and many other components defined by CalEQRO in the Key Components section of this report that are based on CMS guidelines and the STCs of the DMC-ODS Waiver.

Discussed in the following sections are changes in the last year and particularly since the launch of the DMC-ODS Program that were identified as having a significant effect on service provision or management of those services. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including any changes that provide context to areas discussed later in this report. This information comes from a special session with senior management and leadership from each of the key SUD and administrative programs.

PRIOR YEAR REVIEW FINDINGS

In this section, the status of last year's (FY 2018-19) EQRO review recommendations are presented, as well as changes within the DMC-ODS's environment since its last review.

Status of Prior Year Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the DMC-ODS's programmatic and/or operational areas. During this current FY 2019-20 site visit, CalEQRO and DMC-ODS staff discussed the status of those prior year recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the DMC-ODS 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 Met is assigned when the DMC-ODS performed no meaningful activities to address the recommendation or associated issues.

Prior Year Key Recommendations

Recommendation #1: Development of an effective and efficient EHR linked to SanWITS in partnership with contract providers. The solutions should include interoperability to support interfaces with contract provider data systems, thereby avoiding need for double data entry and avoiding risk for data integrity issues.

Status: Met

- San Diego is actively in the process of enhancing SanWITS to be a fully functioning EHR.
- San Diego has completed two project phases of this enhancement which included billing and data tracking for access to services and other data points.

- San Diego notes that the first of the clinical assessments has been piloted, including the initial level of care assessment, the diagnosis determination note, the ASAM screen and discharge summary. This indicates that in alignment with a phased approach, San Diego will be piloting treatment plans and progress notes in the next few months.
- Additionally, San Diego has introduced newly developed dashboards for both residential and outpatient providers. These were made available in March 2020.
- San Diego had anticipated rolling out EHR trainings for all providers in July or August 2020, though this timeline may now be delayed due to current COVID-19 activities.
- San Diego is also working with its vendor to develop interfaces with other EHRs and in March organized a kickoff meeting with OTP providers and their EHR vendors. A series of work groups will be convened by San Diego until completion of this project.

Recommendation #2: Continue expansion and development efforts in Withdrawal Management (WM), MAT and Recovery Residences, particularly for women with children and for people with access needs in the more rural areas of the county.

Status: Met

- San Diego has made continuous progress in expanding and developing WM, MAT, and Recovery Residences within San Diego County.
- In the past year San Diego increased its allocation of specific Recovery Residence funds to increase the availability of beds for clients in need.
- San Diego has also expanded MAT services within the Children, Youth, and Families (CYF) system of care. Specifically, a Perinatal outpatient program's Statement of Work (SOW) was amended with language to include specific expanded MAT requirements and to provide additional funding for new staff to support services in March 2020.
- San Diego has additional MAT services provided as part of the ROAM Innovation project in both the county's east and north inland regions to serve rural, tribal communities.
- San Diego reports that WM services began to be offered at a few additional residential SUD contracts, and they continue exploring the implementation of WM services in outpatient and OTP settings.

Recommendation #3: Make access to services easier by expanding program hours for admissions to better meet the needs for both youth and working populations.

Status: Met

- San Diego staff have worked with provider programs to adjust hours to accommodate the schedules of working individuals and youth, offering extended hours on weekdays and Saturdays. County and contract staff worked on these solutions together.
- San Diego shifted hours to later in the day to increase the availability of after-school hours for SUD programs serving youth. In addition, the San Diego perinatal programs expanded hours of operation to better accommodate the schedules of working mothers.
- San Diego stated that contracted residential programs are now expected to provide admissions on a 24/7 basis. This includes programs that have WM, Level 3.2 services. San Diego is actively monitoring to ensure compliance and address any access concerns. Additionally, Optum continues to be available for screening 24/7 and can refer to an appropriate level of care.

Recommendation #4: Continue to enhance and improve the quality and effectiveness of treatment services by meeting the performance improvement standard required by CMS of having two active and ongoing PIPs.

Status: Met

- San Diego has two active PIPs, both designed to improve quality of care and client satisfaction. Both PIPs noted improvement toward reaching their stated objective and goals.
- The clinical PIP implements a Relapse Prevention strategy. The Non-clinical PIP is designed to increase awareness and utilization of the Grievance & Appeals process. Both PIPs included interventions being implemented with clients.

Recommendation #5: Update the Cultural Competence Plan with more documentation of targeted and measurable efforts to address the specific needs of SUD treatment populations.

Status: Met

- San Diego updated its Cultural Competence Plan (CCP) in June 2019, with a focus on enhancing efforts related to SUD. The SUD updates are integrated across the different sections of the plan.
- An example of this integrated approach is the addition of language from the Substance Use Disorder Providers' Operations Handbook (SUDPOH), related to program requirements and cultural competence compliance activities.

- Another example within the CCP is the introduction of a provider training available through Responsive Integrated Health Solutions (RIHS) called *Engaging Teens in SUD Treatment*.
- San Diego is now highlighting cultural competence assessment results from the Cultural and Linguistic Competence Policy Assessment (CLCPA) and the Promoting Cultural Diversity Self-Assessment (PCDSA) for SUD providers, separately from MH providers.
- San Diego notes that within the CCP there is now an increased focus on workforce needs particularly for SUD providers after the implementation of DMC-ODS Waiver, and inclusion of an analysis of the annual client satisfaction on the Treatment Perceptions Survey (TPS).
- San Diego will be updating the CCP for the annual submittal in June 2020, which occurs in collaboration with the Cultural Competence Resource Team (CCRT). San Diego notes that the CCRT chair updates the team every month on developments in DMC-ODS Waiver implementation, and that the team plans to recruit a CCRT member specifically from the SUD services system of care to enhance SUD representation within the committee.
- Notable updates for the 2020 Cultural Competence Plan will include the successful collection and review of all SUD provider legal entities updated cultural competence plans, which is a requirement for contracted providers.

Recommendation #6: Develop a guide in collaboration with providers to assist them in developing and improving the business practices necessary to function effectively and meet requirements within a managed care system. Identify and act upon training and technical assistance opportunities to help implement the most critical elements of the guide, particularly full Medi-Cal documentation and claiming of DMC services.

Status: Met

- San Diego worked with California Institute for Behavioral Health Solutions (CIBHS) to develop and implement a "Substance Use Provider Waiver Support Series." The series encompassed three full days over the course of two months (November/December 2019) to assist providers in developing and improving business practices needed to be successful in the DMC-ODS Waiver plan. Guide resources from this series were provided to the Alcohol and Drug Services Providers' Association (ADSPA) and posted on the Optum provider's website for all SUD providers to access.
- San Diego's SUD Quality Management (QM) team updated both the SUDPOH and Substance Use Disorder Uniform Record Manual (SUDURM) in the past year to communicate best practices more effectively within the SUD service delivery continuum. Specifically, the SUDURM was updated with complete instructions for every form utilized to increase regulatory compliance and minimize disallowance risk for providers.
- The San Diego Behavioral Health Services (SDBHS) Billing Unit is currently updating the SDBHS Billing Manual, and the QI Management Information

Systems (MIS) team updated and created SanWITS guides to assist SUD providers with billing and other data entry requirements.

These SanWITS training guides include:

- *Program Enrollment for Non-BHS Contracted Clients*
- *Tracking Notice of Adverse Benefit Determination (NOABD) in SanWITS*
- *Transitional Care Services Program Enrollment*
- *Residential Bed Management Encounters and Group Modules Training Manual*
- *Outpatient Encounters and Group Modules Training Manual*
- *Intro to Admin Functions Training Manual*
- *DSM-5 Diagnostic Labels in SanWITS*
- *Steps for Disallowed Services*

- San Diego continues to offer monthly classroom trainings for outpatient and residential documentation training and claiming of Medi-Cal services, and has created and posted “Outpatient and Residential Documentation Training” webinars for on-demand viewing by providers.

Recommendation #7: Develop priorities for contract agencies related to training and staffing of core operations such as DMC billing, and postponing non-essential in-service requirements to reduce burnout and resistance to culture and system change.

Status: Met

- San Diego conducted a review of requirements and priorities related to core operations and compliance with the Intergovernmental Agreement with the Department of Health Care Services (DHCS). As a result, some training requirements were re-evaluated and streamlined during the past year.
- San Diego reconfigured the training website to demonstrate what was a "one-time only" training versus what was an annual training requirement, in order to minimize provider confusion on training requirements and allow them to prioritize as needed.
- San Diego developed webinars to create “on demand” availability to ensure provider schedule flexibility. The webinars are located on the DMC-ODS Required Trainings webpage and hosted on the SDBHS website. There is no restriction to access, as it is available to all with internet access.
- Other trainings are also available through San Diego’s workforce training contractor, Responsive Integrated Health Solutions (RIHS, a project of the San Diego State University’s Academy for Professional Excellence) at no cost to

SUD providers. This is a resource provided to reduce the administrative burden of providers having to locate and purchase trainings that are either required or of benefit to service delivery and operational success.

- San Diego cites notable examples of RIHS trainings include the *ASAM Overview, DMC Certification, Enhanced Case Management, and Overview of the 'Risk Assessment and Safety Management Plan' for Substance Use Providers*. A full list of RIHS' DMC-ODS trainings is available on the DMC-ODS Waiver page of the RIHS website.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

None.

Past Year's Initiatives and Accomplishments

- Peer training plan was submitted to DHCS and approved on 1/31/20 per DHCS Information Notice 17-008. Peer workforce partners will be trained to provide recovery services within the DMC-ODS Waiver. Recovery services are a required and important service under the 1115 Waiver. The plan requires that peers complete a minimum 75-hour peer support training program; have a high school diploma, GED or higher; and have a minimum of one year of recovery from lived experience in SUD and/or co-occurring mental health disorders (self-attested). The following curriculum areas and methodology were identified in the plan:

    - *Documentation* – topics include didactic and skill building sessions to master and apply DMC-ODS Waiver documentation standards for all services provided by peer support staff.

    - *Advocacy Skills* – topics include how to promote leadership and skills to advocate for the needs and desires of the client in treatment team meetings, community and services, living situations including with family, and development of their knowledge of legal resources and advocacy organizations to build an advocacy plan.

    - *Ethical issues* – topics included dual-relationships and appropriate boundaries as a peer support staff, confidentiality and privacy regulations, and adherence to a code of conduct as paraprofessionals.

    - *Development of personal recovery skills* – topics include how and when to relate their own recovery stories to inspire hope; recognition of the need for ongoing personal efforts to enhance health, wellness and recovery, and; use of personal recovery practices to help the client discover recovery practices that work for them;

    - *Additional curriculum areas include* communication skills, diversity training (including assessment and understanding of personal values, culture, biases); and trauma/resilience (such as recognizing signs of distress and threats to safety among peers; providing reassurance to peers in distress, how to create safe spaces when meeting with peers; etc.).

- San Diego executed contract amendments for additional MAT services and two new staff positions with a SUD Perinatal Outpatient program. San Diego also began amending the ACTION East contract to provide additional MAT services, but those efforts are on hold due to the COVID-19 crisis.
- San Diego began piloting various assessment forms in the EHR including the initial level of care assessment, the diagnosis determination note, and the ASAM screen and discharge summary. In alignment with a phased approach, San Diego will also be piloting new treatment plans and progress notes in the next few months.
- Newly developed clinical dashboards for residential and outpatient providers were made available in March 2020. San Diego anticipates rolling out EHR trainings for all providers in July or August 2020.
- San Diego is working to develop interfaces with other EHRs and organized a kickoff meeting with NTP/OTP providers and their EHR vendors in March 2020. This will be followed by a series of work groups until completion of this project.
- San Diego created recorded documentation trainings and webinar modules to allow providers with flexibility in accessing training modules, to support their new EHR project.
- San Diego created documentation trainings and webinar modules for the SUD provider training website to create “on demand” availability to ensure provider schedule flexibility. The trainings are available on the DMC-ODS Required Trainings webpage hosted on the BHS website. The webinar modules include topics such as Beneficiary Rights and Program Integrity. There is no restriction to access, and it is available to all with internet access.
- San Diego established credentialing processes for SUD providers and facilities in alignment with DHCS Information Notice 18-019, requiring all DMC-ODS licensed, registered, or certified providers that provide direct billable services must be credentialed. San Diego implemented a process whereby Optum (acting as the Administrative Services Organization) credentials providers per requirements specified.
- The SanWITS contact and intake screens were modified to include the second and third available intake/screening appointments along with the existing first available and first accepted intake/screening appointment, reporting the access to service metrics beginning July 2019.
- San Diego participated in the 2019 administration of the Treatment Perception Survey (TPS) as required. Results of the TPS are a primary data source to evaluate client satisfaction and therapeutic alliance.
- For more information about TPS and the CalOMS outcomes, go to:

1. CalOMS Treatment Data Collection Guide: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

2. TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf
3. ASAM Level of Care Data Collection System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

San Diego Goals for the Coming Year

- **Implementing Initial Peer Training and incorporation of peers into Recovery service delivery in alignment with the approved Peer Plan.**

  Currently, the CORs that monitor the SUD programs are working with providers on contract amendments that incorporate peer support staff into existing programs after receiving DHCS approval in late January 2020. Note: next steps in implementing Initial Peer Training have been put on hold due to the COVID-19 public health crisis, and planning will resume once the crisis has subsided, with an anticipated implementation date in the second half of FY 2020-21.

- **Expanding the SUD system with WM-1 and WM-2 Additional MAT and Residential 3.3**

  San Diego has made continuous progress in expanding and developing WM and additional MAT, while planning for the implementation of local Residential 3.3 level of services. San Diego has expanded MAT services within the SUD outpatient system in both the Children, Youth, and Families (CYF) system and the Adult/Older Adult (AOA) system. This expansion occurred on March 1, 2020.

  Additional MAT services are also now provided as part of the ROAM Innovation project in both east and north inland regions to serve rural, tribal communities.

  WM services have begun to be offered at a few additional residential SUD programs, and San Diego is studying options for the implementation of WM services in outpatient and OTP settings.

- **Continuing the Electronic Health Record build and testing phases.**

  San Diego is enhancing SanWITS to be a fully functioning EHR. Two project phases, which included billing, data tracking for access to services and other data points, have been completed. San Diego anticipates EHR trainings for all providers in July or August 2020, although this timeline may be delayed due to current COVID-19 activities.

- **Developments on efforts in advancing the Behavioral Health Continuum of Care.**

  In 2020 the San Diego County Board of Supervisors took many actions to enhance and expand behavioral health programs available in the region, referred to broadly as the Behavioral Health Continuum of Care. San Diego participates with diverse stakeholders and partners including criminal justice, hospitals, community health centers, and other community-based providers to create system changes to ensure clients can be quickly provided the appropriate level of mental health and substance use disorder services. Services are designed to meet clients immediate and long-term needs.

- **Ensuring compliance with 274 requirements and for NACT submission.**

  Per the Medicaid Managed Care Final Rule, DMC-ODS pilot counties completed the Network Adequacy Certification Tool (NACT) for all providers at the organizational (Exhibit A-1), site (Exhibit A-2) and rendering provider (Exhibit A-3) level in April 2019 and recently in 2020. These documents were submitted and also made available during this review. AAS form was submitted and approved for 2019, no determination from DHCS has been received yet on the required AAS for 2020 at the time of the review.

  Since 2019, San Diego has been preparing for the 274-file submission by purchasing the 274 Health Care Provider Directory Implementation Guide and X12 274 reference document through its reporting partner, Optum. Optum has been participating in weekly 274 Work Group Meetings in which the companion guides are discussed, and questions and answers are noted, enhancing productivity.

  Currently, the project is transitioning from the use of Excel files to collect information, to an online web application (named the System of Care application) where providers can submit data online. The System of Care application hosts all the fields for current Network Adequacy Requirements and allows providers to submit their information seamlessly online.

  At this time, San Diego is awaiting confirmation from DHCS to finalize and clarify 274 requirements before a massive release of the System of Care application, which will be followed by training and registration of all providers.

PERFORMANCE MEASURES

The purpose of PMs is to foster access to treatment and quality of care by measuring indicators with solid scientific links to health and wellness. CalEQRO conducted an extensive search of potential measures focused on SUD treatment, and then proceeded to vet them through a clinical committee of over 60 experts including medical directors and clinicians from local behavioral health programs. Through this thorough process, CalEQRO identified twelve performance measures to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, CalOMS, and the ASAM level of care data for these measures.

The first six PMs are used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal levels of care based on ASAM assessments, and outcomes. The additional six measures could be modified in subsequent years if better, more useful metrics are needed or identified.

As noted above, CalEQRO is required to validate the following PMs using data from DHCS, client interviews, staff and contractor interviews, observations as part of site visits to specific programs, and documentation of key deliverables in the DMC-ODS Waiver Plan. The measures are as follows:

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries.
- Number of days to first DMC-ODS service after client assessment and referral.
- Total costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services to beneficiaries.
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes).
- Coordination of Care with physical health and mental health (MH).
- Timely access to medication for NTP services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).

- Percentage of clients with three or more WM episodes and no other treatment to improve engagement.

For counties beyond their first year of implementation, four additional performance measures have been added. They are:

- Use of ASAM Criteria in screening and referral of clients (also required by DHCS for counties in their first year of implementation).
- Initiation and engagement in DMC-ODS services.
- Retention in DMC-ODS treatment services.
- Readmission into residential withdrawal management within 30 days.

HIPAA Guidelines for Suppression Disclosure:

Values are suppressed on PM reports to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (* or blank cell), and where necessary a complimentary data cell is suppressed to prevent calculation of initially suppressed data. Additionally, suppression is required of corresponding percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Year Two of Waiver Services

This is the second year that San Diego has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 2018-19), and from UCLA for TPS, ASAM, and CalOMS data from FY 2018-19. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2018-19 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS, and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2018-19

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

Table 1 shows San Diego's number of clients served and penetration rates overall and by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties.

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary 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.

San Diego's penetration rate is 1.47 percent, above the 1.03 percent in other large counties and well above the 0.93 percent seen statewide.

Table 1: Penetration Rates by Age, FY 2018-19

Table 1: Penetration Rates by Age, FY 2018-19					
San Diego				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	99,877	599	0.60%	0.29%	0.27%
Ages 18-64	468,385	8,198	1.75%	1.24%	1.12%
Ages 65+	82,490	777	0.94%	0.78%	0.69%
TOTAL	**650,751**	**9,574**	**1.47%**	**1.03%**	**0.93%**

Table 2 below shows San Diego's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. Average approved claims for San Diego are slightly lower than statewide averages for adults and well above those for youth.

Table 2: Average Approved Claims by Age, FY 2018-19

Table 2: Average Approved Claims by Age, FY 2018-19			
San Diego			Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	$1,701,061	$2,840	$1,834
Ages 18-64	$30,470,574	$3,717	$3,951
Ages 65+	$3,768,433	$4,850	$4,643
TOTAL	**$35,940,068**	**$3,754**	**$3,921**

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.

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19

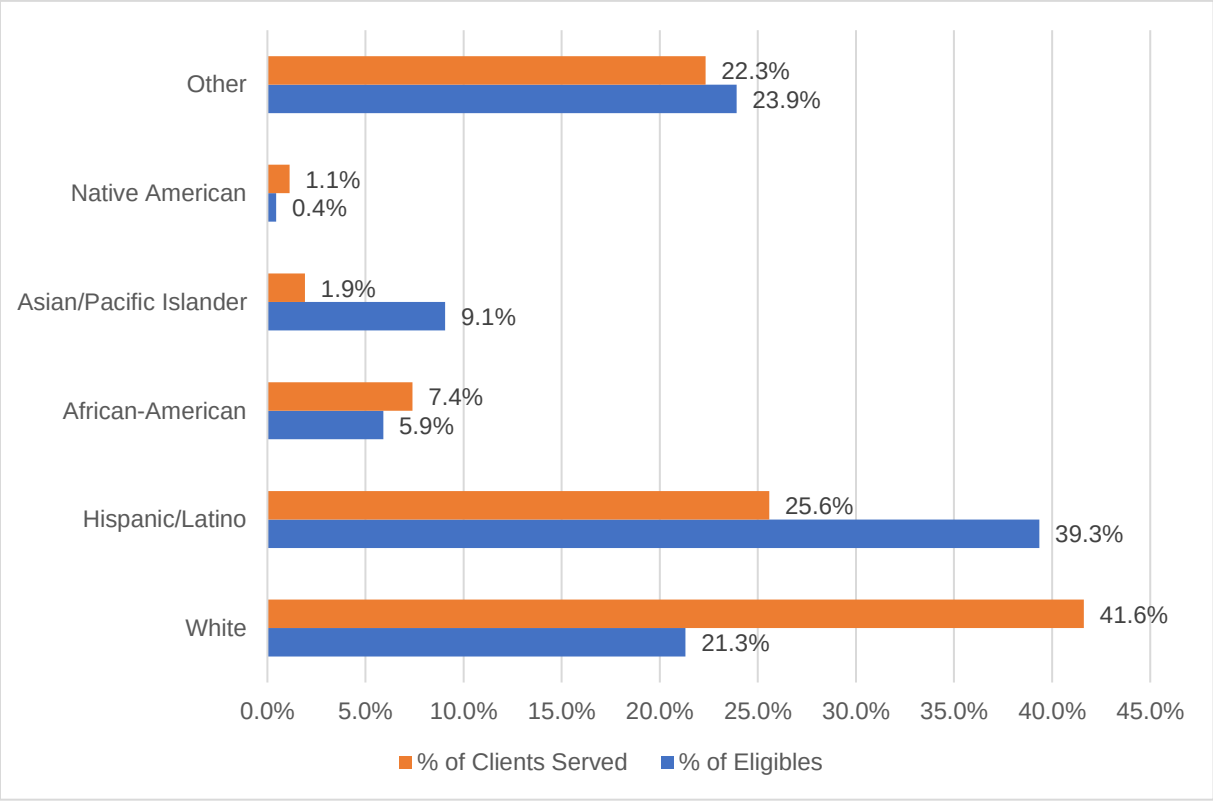


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Penetration rates for Latino/Hispanic is at 0.96 percent, above that of other large counties at .73 percent and well above the .66 percent indicated statewide

while the rate for Whites is comparatively high in San Diego at 2.87 percent, well above the 1.77 percent seen statewide.

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19					
San Diego				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	138,672	3,985	2.87%	2.14%	1.77%
Latino/Hispanic	256,067	2,449	0.96%	0.73%	0.66%
African American	38,461	708	1.84%	1.36%	1.27%
Asian/Pacific Islander	58,984	184	0.31%	0.17%	0.16%
Native American	2,923	109	3.73%	2.53%	1.62%
Other	155,646	2,139	1.37%	1.08%	1.05%
TOTAL	**650,753**	**9,574**	**1.47%**	**1.03%**	**0.93%**

Table 4 below shows San Diego's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. San Diego has been favorably impacted by increased Medi-Cal beneficiaries as reflected in elevated penetration of 2.35 percent in the ACA eligibility category compared to just 1.46 statewide.

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19				
San Diego				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	69,738	1,282	1.84%	1.63%
Foster Care	1,171	53	4.53%	1.77%
Other Child	60,219	392	0.65%	0.29%
Family Adult	127,873	1,817	1.42%	0.95%
Other Adult	89,198	128	0.14%	0.10%
MCHIP	43,071	199	0.46%	0.20%
ACA	257,907	6,067	2.35%	1.46%

Table 5 below shows San Diego's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties.

Table 5: Average Approved Claims by Eligibility Category, FY 2018-19

Table 5: Average Approved Claims by Eligibility Category, FY 2018-19				
	San Diego			Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	69,738	1,282	$4,065	$4,259
Foster Care	1,171	53	$1,940	$1,157
Other Child	60,219	392	$2,764	$1,770
Family Adult	127,873	1,817	$3,442	$3,321
Other Adult	89,198	128	$4,163	$4,344
MCHIP	43,071	199	$2,629	$1,884
ACA	257,907	6,067	$3,664	$3,911

Children 12 and under rarely need treatment for SUD. Foster Care, Other Child and Maternal and Child Health Integrated Program (MCHIP) include children of all ages contributing to a low penetration rate.

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2018-19. Claims by service category indicate a judicious use of outpatient and NTP/OTP services, good utilization of intensive outpatient and rather low use of residential WM at 0.7 percent overall of clients served.

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19			
Service Categories	**# of Clients Served**	**% Served**	**Average Approved Claims**
Narcotic Tx. Program	4,152	35.1%	$4,147
Residential Treatment	1,555	13.1%	$6,547
Res. Withdrawal Mgmt.	84	0.7%	$771
Ambulatory Withdrawal Mgmt.	-	-	-
Non-Methadone MAT	672	5.7%	$230
Recovery Support Services	331	2.8%	$664
Partial Hospitalization	-	-	-
Intensive Outpatient Tx.	1,439	12.2%	$1,692
Outpatient Drug Free	3,610	30.5%	$1,570
TOTAL	**11,843**	**100.0%**	**$3,754**

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

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

Methadone is a well-established evidence-based practice for treatment of opiate addiction using a narcotic replacement therapy approach. Extensive research studies document that with daily dosing of methadone, many clients with otherwise intractable opiate addictions are able to stabilize and live productive lives at work, with family, and in independent housing. However, the treatment can be associated with stigma, and usually requires a regular regimen of daily dosing at an NTP site.

Persons seeking methadone maintenance medication must first show a history of at least one year of opiate addiction and at least two unsuccessful attempts to quit using opioids through non-MAT approaches. They are likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they may soon resume opiate use and an addiction lifestyle that can be life-threatening. For these reasons, NTPs regard the request to begin treatment with methadone as time sensitive.

Table 7: Days to First Dose of Methadone by Age, FY 2018-19

Table 7: Days to First Dose of Methadone by Age, FY 2018-19						
	San Diego			Statewide		
Age Groups	Clients	%	Median Days	Clients	%	Median Days
Ages 12-17	*	n/a	n/a	*	n/a	n/a
Ages 18-64	3464	84.84%	<1	29,072	80.27%	<1
Ages 65+	*	n/a	n/a	*	n/a	n/a
TOTAL	**4,083**	**100.0%**	<1	**36,219**	**100.0%**	<1

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Services for Non-Methadone MATs Prescribed and Billed in Non-DMC-ODS Settings

Some people with opiate addictions have become interested in newer-generation addiction medicines that have increasing evidence of effectiveness. These include buprenorphine and long-acting injectable naltrexone that do not need to be taken in as rigorous a daily regimen as methadone. While these medications can be administered through NTPs, they can also be prescribed and administered by physicians through other settings such as primary care clinics, hospital-based clinics, and private physician practices. For those seeking an alternative to methadone for opiate addiction or a MAT for another type of addiction such as alcoholism, some of the other MATs have the advantages of being available in a variety of settings that require fewer appointments for regular dosing. The DMC-ODS Waiver encourages delivery of MATs in other settings additional to their delivery in NTPs.

Expanded Access to Non-Methadone MATs through DMC-ODS Providers

Tables 8 display the number and percentage of clients receiving three or more MAT visits per year provided through San Diego providers and statewide for all actively implemented DMC-ODS counties in aggregate. Three or more visits were selected to identify clients who received regular MAT treatment versus a single dose. The numbers for this set of performance measures are based upon DMC-ODS claims data analyzed by EQRO.

San Diego claims data indicates strong use of non-methadone forms of MAT with 672 or 7.02 percent of all clients served compared to just 1.59 percent statewide.

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2018-19

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2018-19								
	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	*	n/a	-	-	*	n/a	*	n/a
Ages 18-64	626	7.6%	286	3.5%	3,251	4.20%	1,360	1.76%
Ages 65+	*	n/a	*	n/a	*	n/a	*	n/a
TOTAL	**672**	**7.02%**	**299**	**3.12%**	**3,545**	**3.86%**	**1,461**	**1.59%**

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Transitions in Care Post-Residential Treatment – FY 2018-19

The DMC-ODS Waiver emphasizes client-centered care, one element of which is the expectation that treatment intensity should change over time to match the client's changing condition and treatment needs. This treatment philosophy is in marked contrast to a program-driven approach in which treatment would be standardized for clients according to their time in treatment (e.g. week one, week two, etc.).

Table 9 show two aspects of this expectation — (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days, and 30 days after discharge from residential treatment. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, IOT, partial hospital, MAT, NTP, outpatient WM, case management, recovery supports, and physician consultation. CalEQRO does not count re-admission to residential treatment in this measure. Additionally, CalEQRO was not able to obtain and calculate FFS/Health Plan Medi-Cal claims data at this time.

San Diego continues to make progress in timely transitions following residential discharge to another level of care, though above the statewide average, just 151 or 9.7 percent of the 1,550 clients obtaining linkage within seven days.

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2018-19

Table 9: Timely Transitions in Care Following Residential Treatment FY 2018-19				
	San Diego (n= 1,550)		Statewide (n= 25,123)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	151	9.7%	2,067	8.2%
Within 14 Days	180	11.6%	2,787	11.1%
Within 30 Days	213	13.7%	3,447	13.7%
Any days (TOTAL)	**278**	**17.9%**	**4,677**	**18.6%**

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment of a person's reaching out for help to address a SUD represents a critical crossroad in that person's life, and the opportunity may pass quickly if barriers to accessing treatment are high. A county DMC-ODS is responsible to make initial access easy for prospective clients to the most appropriate treatment for their particular needs. For some people, an Access Line may be of great assistance in finding the best treatment match in a system that can otherwise be confusing to navigate. For others, an Access Line may be seen as impersonal or otherwise off-putting because of long telephone wait times. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

Table 10 shows Access Line critical indicators from February 1, 2019 through February 29, 2020. San Diego continued to provide good consumer experience of quick response to calls and a low dropped call rate yet has had a low rate of clients linking from this contact to treatment services.

Table 10: Access Line Critical Indicators, February 1, 2019 through February 29, 2020.

Table 10: San Diego Access Line Critical Indicators 02-01-19 through 02-29-20	
Average Volume	436 calls per month
% Dropped Calls	2.7%
Time to answer calls	19 seconds
Monthly authorizations for residential treatment	891
% of calls referred to a treatment program for care, including residential authorizations	12% of callers are linked to treatment through the Access Line
Non-English capacity	2 FTE Access Line staff are bilingual (English/Spanish) and San Diego has contracts with two language vendors

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services in San Diego. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $10,589 in approved claims per year. The table lists the average approved claims costs for the year for San Diego HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

San Diego has done a good job of managing high cost beneficiaries as indicated by just 4 percent in 18-64 age range compared to 6 percent statewide and 3.6 percent overall compared to 5.3 percent statewide.

Table 11a: High Cost Beneficiaries by Age, San Diego, FY 2018-19

Table 11a: San Diego High Cost Beneficiaries by Age, FY 2018-19						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	599	*	n/a	n/a	n/a	n/a
Ages 18-64	8,198	326	4.0%	$13,822	$4,505,860	14.8%
Ages 65+	777	*	n/a	n/a	n/a	n/a
TOTAL	**9,574**	**342**	**3.6%**	**$13,846**	**$4,735,367**	**13.2%**

Table 11b: High Cost Beneficiaries by Age, Statewide, FY 2018-19

Table 11b: Statewide High Cost Beneficiaries, FY 2018-19					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	4,161	34	0.8%	$14,208	$483,063
Ages 18-64	77,411	4,607	6.0%	$15,604	$71,888,322
Ages 65+	8,729	265	3.0%	$15,601	$4,134,267
TOTAL	**91,853**	**4,906**	**5.3%**	**$15,594**	**$76,505,653**

Residential Withdrawal Management with No Other Treatment

This PM is a measure of the extent to which the DMC-ODS is not engaging clients upon discharge from residential WM. If there are a substantial number or percent of clients who frequently use WM and no treatment, that is cause for concern and the DMC-ODS should consider exploring ways to improve discharge planning and follow-up case management.

The rate of re-admissions at 4.11 percent is only slightly higher than statewide and inline with many other counties.

Table 12: Residential Withdrawal Management with No Other Treatment, FY 2018-19

Table 12: Withdrawal Management with No Other Treatment FY 2018-19				
	San Diego		**Statewide**	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	73	4.11%	5,170	2.38%

Use of ASAM Criteria for Level of Care Referrals

The clinical cornerstone of the DMC-ODS Waiver is use of ASAM Criteria for initial and ongoing level of care placements. Screeners and assessors are required to enter data for each referral, documenting the congruence between their findings from the screening or assessment and the referral they made. When the referral is not congruent with the LOC indicated by ASAM Criteria findings, the reason is documented.
San Diego shows strong adherence to the use of ASAM placement criteria and working with clients to obtain the indicated level of care across all three areas of the screening and assessment process. Given the size and complexity of its SUD system of care, this indicates proper placement for 90.38 percent of the 19,521 clients seen.

Table 13: Congruence of Level of Care Referrals with ASAM Findings, 07/01/18 – 02/14/20

Table 13: Congruence of Level of Care Referrals with ASAM Findings, 07/01/18 – 02/14/20						
San Diego ASAM LOC Referrals	**Initial Screening**		**Initial Assessment**		**Follow-up Assessment**	
07/01/18 – 02/14/20 (20 Months)	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	17,881	91.6%	3,852	84.7%	12,687	94.84%
Patient Preference	567	2.90%	297	6.53%	298	2.23%
Level of Care Not Available	94	0.48%	47	1.03%	44	0.33%
Clinical Judgement	177	0.91%	72	1.58%	45	0.34%
Geographic Accessibility	129	0.66%	28	0.61%	23	0.17%
Family Responsibility	-	-	-	-	-	-
Legal Issues	212	1.09%	96	2.11%	140	1.05%
Lack of Insurance/Payment Source	34	0.17%	*	n/a	*	n/a
Mental Health	146	0.75%	68	1.50%	34	0.25%
Physical Health	22	0.11%	*	n/a	*	n/a
Other	259	1.33%	76	1.67%	89	0.66%
Actual Referral Missing	-	-	-	-	-	-
TOTAL	**19,521**	**100.00%**	**4,546**	**100.00%**	**13,377**	**100.00%**

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Initiating and Engaging in Treatment Services

Table 14 displays results of measures for two early and vital phases of treatment—initiating and then engaging in treatment services. They are part of a set of newly adopted measures by CalEQRO for counties in their second year of DMC-ODS implementation. An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them. Research suggests that those who are able to engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. Several federal agencies and national organizations have encouraged and supported the widespread use of these measures for many years.

The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client's SUD is identified. Since CalEQRO does this through claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. This second day or visit is what in this measure is defined as "initiating" treatment.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service. San Diego has an adult client initiation and engagement rate consistent with that seen statewide. San Diego's initiation for youth is 94.4 percent and engagement rate for youth is 79.1 percent, markedly higher than the 78.9 percent for initiation and 70.2 percent for engagement seen statewide. The youth population engagement is often very challenging thus these results are very positive indicating the strength of the youth programs.

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2018-19

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2018-19								
	San Diego				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	8,933		597		90,926		4,303	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	7,701	86.2%	564	94.4%	80,346	88.4%	3,397	78.9%
Clients who then engaged in DMC-ODS services	6,062	78.7%	446	79.1%	64,232	79.9%	2,386	70.2%

Table 15 tracks the initial DMC-ODS service used by clients to determine how they first accessed DMC-ODS services and shows the diversity of the continuum of care. San Diego shows a strong utilization of Intensive Outpatient at 11.7 percent compared to 6.85 percent statewide but also indicates a very low use of WM residential at 0.6 percent compared to 4.3 percent statewide.

Table 15: Initial DMC-ODS Service Used by Clients, FY 2018-19

Table 15: Initial DMC-ODS Service Used by Clients, FY 2018-19				
	San Diego		Statewide	
DMC-ODS Service Modality*	**#**	**%**	**#**	**%**
Outpatient treatment	2,991	31.4%	30,508	32.04%
Intensive outpatient treatment	1,116	11.7%	6,526	6.85%
NTP/OTP	4,033	42.3%	37,789	39.7%
Non-methadone MAT	-	-	191	0.20%
Ambulatory Withdrawal	-	-	43	0.05%
Partial hospitalization	-	-	16	0.02%
Residential treatment	1,281	13.4%	15,754	16.5%
Withdrawal management	55	0.6%	4,057	4.3%
Recovery Support Services	54	0.6%	345	0.36%
TOTAL	**9,530**	**100.0%**	**68,436**	**100.0%**

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Retention in Treatment

Table 16 is a measure of how long the system of care is able to retain clients in its DMC-ODS services, and counts the cumulative time that clients were involved across the system of care without interruption of more than 30 days. Defined sequentially and cumulatively in this way, research suggests that retention in treatment and recovery services is predictive of positive outcomes. To analyze the data for this measure, CalEQRO first identified all the discharges during the measurement year (in this case FY 2018-19), defined as the last billed service after which no further service activity was billed for over 30 days. Then for these clients, CalEQRO identified the beginning date of the service episode by counting back in time to the date before which there was no treatment for at least 30 days. The claims data used for these calculations covers 18 months of utilization data, going back six months prior to the year in which discharges are counted. Clients in outpatient programs are counted as having seven days per week if they had at least one outpatient visit in a week.

The mean (average) length of stay for San Diego clients was 143 days (median 94 days), compared to the statewide mean of 128 (median 83 days). 51.9 percent of clients had at least a 90-day length of stay; 33.1 percent had at least a 180-day stay, and 24.3 percent had at least a 270-day length of stay.

San Diego's LOS exceeds statewide in all date ranges. This is impressive for the second year of DMC-ODS services.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2018-19

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2018-19				
	San Diego		Statewide	
Clients with a discharge date	8,755		86,896	
Length of stay (LOS) for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	143	94	128	83
	#	%	#	%
Clients with at least a 90-day LOS	4,546	51.9%	40,481	46.6%
Clients with at least a 180-day LOS	2,900	33.1%	22,302	25.7%
Clients with at least a 270-day LOS	2,128	24.3%	13,194	15.2%

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential withdrawal management readmissions within 30 days of discharge. Of 102 clients admitted into residential WM in San Diego, 24.5 percent were readmitted within 30 days of discharge as compared to the 7.0 percent statewide average for all DMC-ODS counties. San Diego has low rate of admissions; the data indicates a high level of clients returning within 30 days of discharge compared to statewide. San Diego has provided CalEQRO with more recent data that shows a higher number of WM admissions and lower rate of readmissions. CalEQRO is investigating this discrepancy to see if the data is due to late billing or non-Medi-Cal members being counted or programs not being Medi-Cal certified.

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2018-19

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2018-19				
	San Diego		Statewide	
Unduplicated clients of the DMC-ODS	9,574		91,853	
	#	%	#	%
Total DMC-ODS clients who were admitted into WM	102	1.1%	6,392	7.0%
Clients admitted into WM who were readmitted within 30 days of discharge	25	24.5%	446	7.0%

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the San Diego and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2018-19. Both the diagnostic codes pertaining to Alcohol and Opioids are elevated compared to statewide percentages of beneficiaries served.

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19				
Diagnosis Codes	**San Diego**		**Statewide**	
	% Served	**Average Cost**	**% Served**	**Average Cost**
Alcohol Use Disorder	20.3%	$4,682	15.7%	$4,370
Cannabis Use	5.3%	$2,658	8.7%	$2,029
Cocaine Abuse or Dependence	1.0%	$3,284	2.1%	$4,719
Hallucinogen Dependence	0.1%	$2,189	0.2%	$3,651
Inhalant Abuse	0.0%	$0	0.0%	$3,733
Opioid	54.7%	$5,637	47.0%	$4,307
Other Stimulant Abuse	16.4%	$4,920	24.4%	$3,868
Other Psychoactive Substance	1.3%	$4,642	0.4%	$3,757
Sedative, Hypnotic Abuse	0.5%	$6,217	0.5%	$4,291
Other	0.3%	$2,398	0.9%	$2,627
Total	**100.0%**	**$5,118**	**100.0%**	**$4,001**

Client Perceptions of Their Treatment Experience

CalEQRO regards the client perspective as an essential component of the EQR. In addition to obtaining qualitative information on that perspective from focus groups during the onsite review, CalEQRO uses quantitative information from the TPS administered to clients in treatment. DMC-ODS counties upload the data to DHCS, it is analyzed by the UCLA Team evaluating the statewide DMC-ODS Waiver, and UCLA produces reports they then send to each DMC-ODS County. Ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction.

San Diego had positive rating for Adult participants in care with understood communication and felt welcome being rated the highest. And coordination with physical health and mental health being rated in the low eightieth percentiles.

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

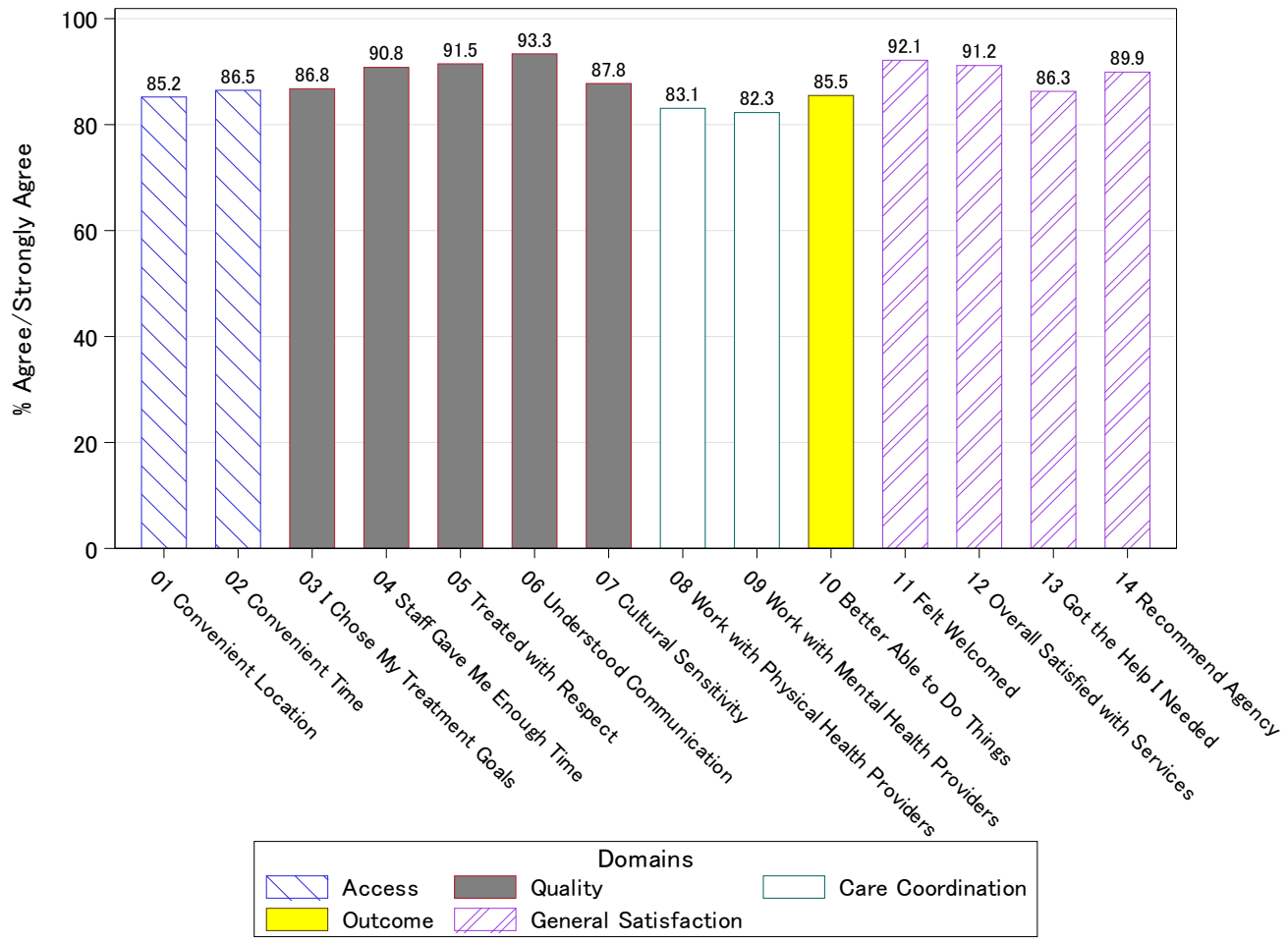
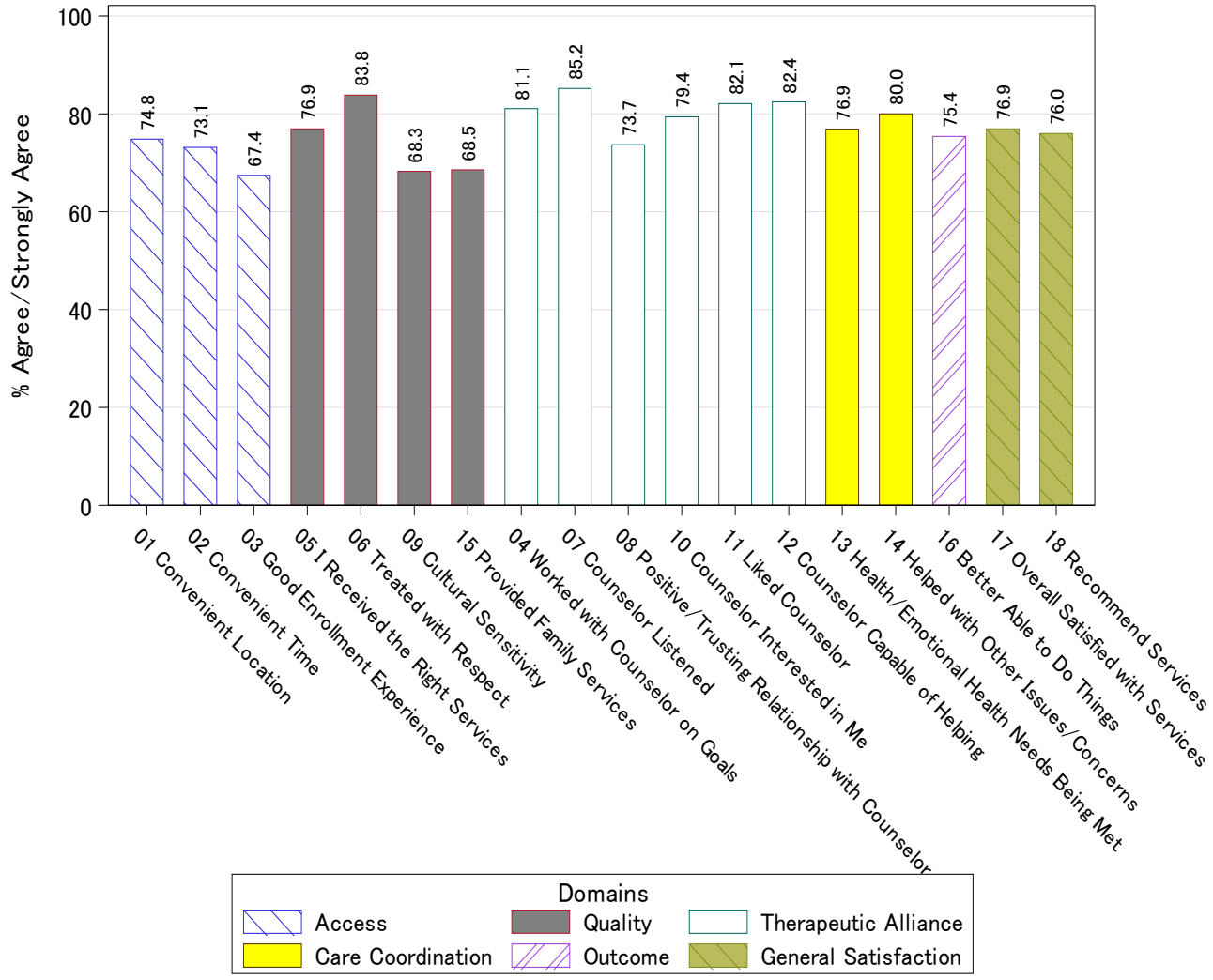


Figure 2b: Percentage of Youth Participants with Positive Perceptions of Care, TPS Results from UCLA

For youth, the San Diego ratings were somewhat lower which is typical, with counselor listened and felt treated with respect rated the highest and good enrollment experience and cultural sensitivity being rated the lowest in the mid-sixty percentile.



CalOMS Data Results for Client Characteristics at Admission and Progress in Treatment at Discharge

CalOMS data is collected for all substance use treatment clients at admission and the same clients are rated on their treatment progress at discharge. The data provide rich information that DMC-ODS counties can use to plan services, prioritize resources, and evaluate client progress.

Tables 19-21 depict client status at admission compared to statewide regarding three important situations: living status, criminal justice involvement, and employment status. These data provide important indicators of what additional services San Diego will need to consider and with which agencies they will need to coordinate. CalOMS data indicates a higher level of homelessness, lower level of clients who live independent and more clients who are involved in the criminal justice system.

Table 19: CalOMS Living Status at Admission, FY 2018-19

Table 19: CalOMS Living Status at Admission, FY 2018-19				
Admission Living Status	**San Diego**		**Statewide**	
	#	**%**	**#**	**%**
Homeless	5,537	32.7%	34,316	27.8%
Dependent Living	5,224	30.8%	32,097	26.0%
Independent Living	6,187	36.5%	57,048	46.2%
TOTAL	**16,948**	**100.0%**	**123.461**	**100.0%**

Table 20: CalOMS Legal Status at Admission, FY 2018-19

Table 20: CalOMS Legal Status at Admission, FY 2018-19				
Admission Legal Status	**San Diego**		**Statewide**	
	#	**%**	**#**	**%**
No Criminal Justice Involvement	9,690	57.1%	77,761	62.4%
Under Parole Supervision by CDCR	309	1.8%	2,232	1.8%
On Parole from any other jurisdiction	*	n/a	1,597	1.3%
Post release supervision - AB 109	5,899	34.8%	34,542	27.7%
Court Diversion CA Penal Code 1000	387	2.3%	2,188	1.8%
Incarcerated	*	n/a	720	0.6%
Awaiting Trial	552	3.3%	5,509	4.4%
TOTAL	**16,948**	**100.0%**	**124,549**	**100.0%**

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Table 21: CalOMS Employment Status at Admission, FY 2018-19

Table 21: CalOMS Employment Status at Admission, FY 2018-19				
Current Employment Status	San Diego		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	2,751	16.2%	15,683	12.6%
Employed Part Time - Less than 35 hours	1,391	8.2%	9,910	8.0%
Unemployed - looks for work	5,973	35.2%	36,869	29.6%
Unemployed - not in the labor force and not seeking	6,833	40.4%	62,119	49.8%
TOTAL	**16,948**	**100.0%**	**124,581**	**100.0%**

The information displayed in Tables 22-23 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 22 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment. San Diego has 53 percent standard adult discharges which is above the statewide at 43.8 percent. There are also fewer administrative discharges at 39 percent compared to 46.6 percent statewide indicating a high level of program completion in accordance with the treatment plan.

Table 22: CalOMS Types of Discharges, FY 2018-19

Table 22: CalOMS Types of Discharges, FY 2018-19				
Discharge Types	San Diego		Statewide	
	#	%	#	%
Standard Adult Discharges	10,691	53.0%	58,885	43.8%
Administrative Adult Discharges	7,860	39.0%	62,542	46.6%
Detox Discharges	760	3.8%	9,882	7.3%
Youth Discharges	848	4.2%	3,011	2.2%
TOTAL	**20,159**	**100.0%**	**134,320**	**100.0%**

Table 23 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs. The first four rating options are positive. "Completed Treatment" means the

client met all their treatment goals and/or the client learned what the program intended for clients to learn at that level of care. “Left Treatment with Satisfactory Progress” means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options indicate lack of satisfactory progress for different types of reasons.

Table 23: CalOMS Discharge Status Ratings, FY 2018-19

Table 23: CalOMS Discharge Status Ratings, FY 2018-19				
Discharge Status	**San Diego**		**Statewide**	
	#	**%**	**#**	**%**
Completed Treatment - Referred	4,349	22.1%	25,720	19.3%
Completed Treatment - Not Referred	2,284	11.6%	8,374	6.3%
Left Before Completion with Satisfactory Progress - Standard Questions	1,891	9.6%	17,486	13.1%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,536	7.8%	9,419	7.1%
Subtotal	*10,060*	*51.1%*	*60,999*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	3,470	17.7%	19,485	14.6%
Left Before Completion with Unsatisfactory Progress - Administrative	5,865	29.9%	50,941	38.2%
Death	45	0.2%	207	0.2%
Incarceration	204	1.0%	1,633	1.2%
Subtotal	*9,584*	*48.8%*	*72,266*	*54.2%*
TOTAL	**19,644**	**100.0%**	**133,265**	**100.0%**

Performance Measures Findings—Impact and Implications

Access to Care PM Issues

- Penetration rates exceed those of large counties and statewide including with youth.
- San Diego beneficiaries have benefitted from the expansion policies afforded under the ACA and with the expansion of many treatment services.

- Access line response to incoming calls is strong but there is a low percentage of calls resulting in treatment referrals bearing investigation.

Timeliness of Services PM Issues

- While higher than the statewide average, client engagement in treatments following residential discharge result in more than 90 percent not continuing in any ongoing treatment in a timely manner, putting them at risk of relapse.
- Timeliness of services is generally within state standards and systems with Optum have allowed for good tracking systems.

Quality of Care PM Issues

- There is a strong congruence between the level of care placement with ASAM assessment results across all three points of screening and assessment.
- Clients length of stay and retention in care is slightly higher than that found statewide and standard and satisfactory discharge status is more favorable.
- Initiation and engagement scores for their first year of measurement are positive showing efforts to retain clients in care and improve outcomes.
- Elevated ratings in the TPS scores found in the aggregate tables above do not reflect issues at the individual program level.

Client Outcomes PM Issues

- Client elopement is lower than statewide as reflected in strong levels of initiation and engagements along with lower administrative or summary discharges.

INFORMATION SYSTEMS REVIEW

Understanding the capability of a county DMC-ODS information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the responses to standard questions posed in the California-specific ISCA, additional documents provided by the DMC-ODS, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment Information Provided by the DMC-ODS

The following information is self-reported by the DMC-ODS through the ISCA and/or the site review.

ISCA Table 1: Distribution of Services, by Type of Provider

ISCA Table 1: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	0%
Contract providers	100%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 7.1 percent.

The budget determination process for information system operations is:

☐ Under DMC-ODS control
☐ Allocated to or managed by another County department
☒ Combination of DMC-ODS control and another County department or Agency

DMC-ODS currently provides services to clients using a telehealth application:

☐ Yes ☒ No ☐ In Pilot phase

Although DMC-ODS had not implemented telehealth, in response to the COVID-19 crisis, it is temporarily using telehealth, under federal and state guidance, to ensure uninterrupted service delivery to its beneficiaries. It is strongly encouraged to continue this delivery modality after the medical crisis is resolved.

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported technology staff changes in Full-time Equivalent (FTE) staff since the previous CalEQRO review are shown in ISCA Table 2.

ISCA Table 2: Summary of Technology Staff Changes

ISCA Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
12	3	2	0

DMC-ODS self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in ISCA Table 3.

ISCA Table 3: Summary of Data and Analytical Staff Changes

ISCA Table 3: Summary of Data and Analytical Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
11.2	2	2	0.25

The following should be noted regarding the above information:

- DMC-ODS will continue to require robust IS and analytical staffing as the implementation of FEI/SanWITS is projected to continue into Fall of 2021 and is concurrent with the MHP's implementation of the new Millennium EHR.
- IT staffing numbers include staff from DMC-ODS, the Health Agency MIS, and Optum.
- Data and Analytical staff include staff from DMC-ODS, Optum, and University of California, San Diego Research Center (UCSD).
- Optum provides Help Desk support.

Current Operations

San Diego and its contract providers use SanWITS, hosted and supported by FEI Systems, as its primary EHR. It uses an application service provider (ASP) model. SanWITS provides billing, practice management, clinical, and medical record functionality to the agency and its contract providers. SanWITS' database is maintained outside of California and supported by multi-point network connectivity.

DMC-ODS estimates that 7.1 percent of its annual budget is dedicated to support IT operations. Its budget determination process is controlled by combination of MHP/DMC-ODS and another county department.

Contract provider agencies deliver all of San Diego's direct services. Approximately 530 contract provider staff use the EHR, delivering services to 9,574 unique clients in FY 2018-19. Additionally, several contract providers also use separate EHRs: San Diego Health Connect, Tower Systems, Dosing Pro, and Metasoft.

New employee orientation and monthly EHR trainings are offered by the Quality Improvement (QI) team in a classroom setting. EHR user guides and video instructions are available on the QI website. Optum Training Department provides training for SanWITS Introduction to Admin Function and Encounters.

FEI Systems continues to build-out SanWITS application to support the 1115 Demonstration Waiver requirements for DMC-ODS pilot. The project plan includes three phases. Current estimate is to complete work on the significant EHR activities by late 2021.

ISCA Table 4 lists the primary systems and applications the DMC-ODS county uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third-party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

ISCA Table 4: Primary EHR Systems/Applications

ISCA Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
San Diego Web Infrastructure for Treatment Services (SanWITS)	Billing/Reporting	FEI Systems Inc.	13	FEI Systems Inc.

Priorities for the Coming Year

- Enhanced billing capabilities for MAT split-dosing on the encounter and claim.
- Adding additional validation rules, alerts and messages, while modifiing screens as part of onging enhancements.
- The treatment plan has been added to SanWITS and will be rolled out to providers in 2021.Developing integration between SanWITS and OPT/NTP EHRs (Tower Systems, Metasoft, and Dosing Pro) anticipated early 2021.
- A recovery plan is being developed with a planned system release in 2021.

- SanWITS data fields required for state reporting and billing protocols will be uploaded to Health Agency data warehouse, which will also include mental health data from Millennium EHR.

Major Changes since Prior Year

- Assessments for Adult Initial Level of Care, Adolescent Initial Level of Care, Parent/Guardian Initial Level of Care, Risk and Safety, Diagnostic Determination Note, and Discharge Summary have been added to the system.
- There have been pilots in both residential and outpatient programs providing input to make modifications. Expectation is to roll out in July/Aug 2020 and to be phased in as staff are trained.
- Electronic signature for counselors, Licensed Practioners of the Healing Arts (LPHA), and clients on specifc documents has been added to the sytem and will be rolled out to the providers with the assessments in 2020.
- Implemented clinical dashboards in the system.
- Added an LPHA dashboard to the system – it will be rolled out to providers with assessments in 2020.
- Various reports have been built for billing and reconciliation, monitoring compliance, and data integrity. This will be an on going process as needs are identified.
- Added Direct Messaging/Referral Management to the system. It will be rolled out to providers after assessments.
- Additional billling enhancements have been made for the billing unit such as search screens.
- Added additional access to service fields for collecting second and third available appointments.

Other Significant Issues

- DMC-ODS organizational chart relegates the MIS unit four layers down, inside the Quality Improvement Division. The optics of MIS/EHR being so remote from executive decision making is telling. MIS is not a utility, but the basis for management to make data-driven decisions. Its support has an immediate impact on day-to-day operations and would benefit from having direct representation in upper management.

- Implementing two unique EHRs, Millennium for the MHP, and FEI for DMC-ODS does not promote the integration and coordination of client care and services.

- SanWITS continues to lack integration of the Monthly Medi-Cal Eligibility File (MMEF) to determine beneficiary eligibility status. DHCS informed the DMC-ODS that the MMEF is not included in their current Intergovernmental Agreement. It should be noted that DHCS routinely provides counties monthly eligibility data via the MMEF, which automates the process to determine client's eligibility status for mental health services.

Plans for Information Systems Change

- DMC-ODS is in the process of enhancing SanWITS to be a fully functional EHR. Two project phases, which included billing and data tracking for access to services, have been completed. Timelines for rolling out EHR trainings for all providers in July or August 2020, may be delayed due to current COVID-19 activities. Completion of full EHR functionality is not expected until the last quarter of 2021.

Current Electronic Health Record Status

ISCA Table 5: EHR Functionality

ISCA Table 5: EHR Functionality					
		Rating			
Function	System/ Application	Present	Partially Present	Not Present	Not Rated
Alerts	FEI/SanWITS	X			
Assessments	FEI/SanWITS	X			
Care Coordination	FEI/SanWITS	X			
Document imaging/storage	FEI/SanWITS	X			
Electronic signature—client	FEI/SanWITS			X	
Laboratory results (eLab)	FEI/SanWITS			X	
Level of Care/Level of Service	FEI/SanWITS	X			
Outcomes	FEI/SanWITS	X			
Prescriptions (eRx)	FEI/SanWITS			X	
Progress notes	FEI/SanWITS			X	
Referral Management	FEI/SanWITS		X		

Treatment plans	FEI/SanWITS			X	
Summary Totals for EHR Functionality:		**6**	**1**	**5**	**0**

Progress and issues associated with implementing an EHR over the past year are discussed below:

- The amount of resources being allocated, 7.1% to IT, is above state averages. In relation to the buildout of both the DMC-ODS EHR and the support of the two MHP EHRs (CCBH and Millennium) this enhanced funding seems realistic but may need to be augmented.
- FEI is working on a Treatment Plan module and will be doing a Pilot with Outpatient teams.
- FEI has implemented a Clinical Dashboard and will be adding more functionality to it.
- FEI added a module for Available Appointments to make scheduling easier.
- FEI/DMC-ODS host a monthly planning group to obtain feedback from their providers in order to make corrective changes to the EHR.

Clients' Chart of Record for county-operated programs (self-reported by DMC-ODS):

☐ Paper ☐ Electronic ☒ Combination

Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings			
	Yes	**No**	**%**
ASAM Criteria is being used for assessment for clients in all DMC Programs.	X		
ASAM Criteria is being used to improve care.	X		
CalOMS being administered on admission, discharge, and annual updates.	X		
CalOMS being used to improve care. Track discharge status. Outcomes.	X		
Percent of treatment discharges that are administrative discharges.			29.9
TPS being administered in all Medi-Cal Programs.	X		

Highlights of use of outcome tools above or challenges:

- San Diego has a high level of congruence between assessed LOC and referred level (84.7 percent). Follow-up assessment congruence is even higher at 94.84 percent.
- TPS surveys rate 14 items regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. The surveys have resulted in consistently high levels of satisfaction for the adult population, less so for the youth population.

Drug Medi-Cal Claims Processing

- The statements here were not related to claims processing. The claims processing systems were working in efficient manner.

Special Issues Related to Contract Agencies

- 100 percent of the DMC-ODS services are provided by contract providers.
- Plans for documentation training for contract-provider staff was disrupted by COVID-19 resulting in reconceptualizing this process. Training will now be

provided virtually with one-on-one technical assistance as needed. They have recorded over 2,000 people viewing the training webinars.

- The contract providers do not have a contracted productivity rate level expectation as the goal is to have a cost reimbursement strategy with a rate cap. It should be noted that a 5 percent productivity baseline is used to determine rates.
- The contract provider's Handbook is thorough and well organized.

Overview and Key Findings

Access to Care

- As a response to the COVID-19 crisis, DMC-ODS is temporarily encouraging its contract providers to use telehealth to ensure uninterrupted service delivery to its beneficiaries. It is strongly encouraged to continue this delivery modality after the medical crisis is resolved.
- Twenty-two contract providers have expanded their weekend and after-hours availability so that each region has at least one provider with extended hours.
- DMC-ODS has established a roaming access mobile team for co-occurring disorders using Mental Health Services Act (MHSA) Innovation funding.
- The Access Call Center has 24/7 coverage by Optum staff with 32 percent being Spanish bi-lingual. They handle an average of 436 calls a month.

Timeliness of Services

- DMC-ODS tracks data on a monthly basis on the timeliness of initial requests, first offered, first accepted, and face-to-face appointments, NTP after request for MAT, follow-up services post-residential treatment and withdrawal management readmissions.
- DMC-ODS tracks urgent appoint requests and time to face-to-face, defining urgent as "Urgent Care -A condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 48 hours."

Quality of Care

- San Diego has a "no wrong door" policy. There is no waiting list; providers are encouraged to provide warm hand-offs and connect clients to available programs within the system. Optum's access line utilizes SanWITS reports to refer clients to residential programs that have open beds.

- There will be a large data migration, from July 2018 and forward, to a newly created Data Warehouse. The goal is to capture all fields that need to be reported to the state.
- CalOMS data indicates that a high percentage of clients are discharged with satisfactory or completed status.
- San Diego's response to the difficulty in finding qualified staff has been to focus on retention of current staff with thorough training of new staff. Staff turnover has been a challenge and the culture shift in documentation and billing standards has had an impact. It is updating rates, staffing structure and clinical assumptions that relate to staffing expectations.

Client Outcomes

- San Diego reports that a total of 2,412 TPS adult surveys were completed, which is 61 percent of consumers who had a billed face to face service during the survey period. There were 137 Youth TPS forms submitted, this was 80 percent of clients seen during reporting period.
- San Diego uses CalOMS and TPS as their outcome tools.

NETWORK ADEQUACY

CMS has required all states with managed care plans to implement new rules for network adequacy as part of the Final Rule. In addition, the California State Legislature passed AB 205 which was signed into law by Governor Brown to specify how the Network Adequacy requirements must be implemented by California managed care plans, including the DMC-ODS plans. The legislation and related DHCS policies assign responsibility to the EQRO for review and validation of the data collected by DHCS related to Network Adequacy standards with particular attention to Alternative Access Standards.

DHCS produced a detailed plan for each type of managed care plan related to network adequacy requirements. CalEQRO followed these requirements in reviewing each of the counties which submitted detailed information on their provider networks in April of 2019, and will continue to do so each April thereafter to document their compliance with the time and distance standards for DMC-ODS and particularly to Alternative Access Standards when applicable.

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Diego, the time and distance requirements are 30 minutes or 15 miles for outpatient services and 30 minutes or 15 miles for NTPs. The two types of care that are measured for compliance with these requirements are outpatient treatment services and narcotic treatment programs. These services are separately measured for time and distance in relation to two age groups—youth and adults.

CalEQRO reviews the provider files, maps of clients in services, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the county DMC-ODS plan must submit a request for an alternate access standard for that area with details of how many individuals are impacted, and access to any alternative providers who might become Medi-Cal certified for DMC-ODS. They must also submit a plan of correction or improvement to assist clients to access care by: 1) making available mobile services, transportation supports, and/or telehealth services, 2) making possible the taking of home doses of MAT where appropriate, and 3) establishing new sites with new providers to resolve the time and distance standards.

CalEQRO will note in its report if a county 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 will review grievance reports, facilitate client focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Network Adequacy Certification Tool (NACT) Data Submitted in April 2019

Discussion and review of NACT data was limited due to no on-site review by CalEQRO. San Diego County staff did discuss with CalEQRO elements of the special form created for alternative access standard (AAS) zip codes and any efforts to resolve these access issues. It should be noted that San Diego has received approval from DHCS for their 11 designated AAS zip codes since the submission of the NACT in 2019 and the last CalEQRO review. The 2020 NACT submission will now require that the county meet time and distance standards and DHCS has not given the county their decisions about which zip codes will need an AAS approve to be in line with state standards and what steps will be needed to get approval. It was also not clear what out of network providers San Diego had contracted with to enhance access for clients living in the impacted zip codes as required by Information Notice 20-12 and other requirements related to out of network providers.

Plan of Correction to Meet NA Standards

For 2019 the AAS proposal submitted by San Diego to DHCS was approved by DHCS and had expanded time and distance proposals for the eleven zip codes that did not meet time or distance. It also referenced using programs in the neighboring counties which were closer for NTP/OTP and outpatient access. Eleven of the zip codes did not meet time or distance for NTP/OTP services according to AB 205 (91905, 91934, 92028, 92065, 91906, 91963, 92036, 92086, 92061, 92059, and 92028) and these had proposed alternate standards in more minutes to the nearest NTP/OTP and/or miles approved by the DHCS. Closest NTP/OTP locations ranged from 57 to 23 miles from these zip codes. Medi-Cal eligibles in the zip codes ranged from 722 to 45 individuals. Eight of the same zip codes did not meet AB 205 standards for adult SUD outpatient time or distance and two of the same zip codes did not meet youth outpatient standards. These were also approved for similar expanded time and distance standards.

Since there was no determination yet by DHCS on the 2020 NACT just submitted by San Diego it was not possible to review these issues at the time of the FY 2019-20 review.

It is suggested that a formal review of these designations be completed by CalEQRO on the next site review cycle.

San Diego has continued work on expanding services in areas that have been challenged by a paucity of service options, primarily in the northern and eastern part of the county which is rural and sparsely populated. These are the same areas identified in these zip codes mentioned above. Expansion of additional MAT services are also now provided as part of the ROAM Innovation project, noted earlier, in both eastern and northern regions to serve rural, isolated communities.

In the North Inland region of the County, the Indian Health Council, Inc. provides cultural practices including sweat lodge as a culturally appropriate approach to SUD treatment in combination with other traditional treatment models. They utilize the White Bison approach as well as the Red Road to recovery in coordination with native health centers. Both of the FQHC's have established relationships with the NTP/OTP in their community. Southern Indian Health Council was recently approached about participating in a "hub and spoke" model with Acadia (a County contracted program) as part of a SAMHSA grant to support MAT in rural communities.

Withdrawal management services have been expanded to a few additional residential SUD contracts. San Diego also continues to improve access by exploring the implementation of WM services in both outpatient and NTP/OTP settings. To increase MAT services for youth, there are plans to utilize the Center for Child and Youth Psychiatry (CCYP) program, a program funded by Innovations, as a possibility to assist with access.

Telehealth services are now offered by contracted providers in all zip codes across San Diego County and can reach persons in these remote zip codes if they have phones and/or internet.

Regarding access issues for physically disabled clients, San Diego monitors the SUD provider adherence to those areas of the American Disabilities Act (ADA) that apply and assure an ability to provide alternative access by coordination with other service providers and reinforced through expectations articulated in contracts. San Diego staff does investigate complaints and conducts annual on-site reviews of contractor sites. Any issues identified in monitoring require providers to provide San Diego with a plan to correct it. Some programs cannot remove barriers, such as those with a facility built prior to ADA regulations or those who cannot financially make the changes to be compliant. These programs then must use a special referral list to assist the client with identifying an equivalent facility in their same geographic region who can provide services. A bi-annual Disabled SUD Service Report is used for monitoring and ensuring there is a sufficient number of providers available in the system of care.

San Diego also requires contracted providers to offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to services. Expectations and guidance for providers are laid out in the SUD provider operations handbook.

San Diego also contracts with Deaf Community Services (DCS) for outpatient services for the deaf and hard of hearing. DCS provides specialized, culturally, linguistically, and developmentally appropriate outpatient mental health and SUD services for Medi-Cal and unfunded clients of all ages who are deaf and hard of hearing with serious mental illness, as well as those who may have a co-occurring substance use disorder.

To better coordinate transportation for beneficiaries, San Diego works with a liaison from Healthy San Diego representing the seven local health plans (HP) within the county. Given the inherently complex nature of working with so many entities, transportation has been an issue that San Diego has had to highlight as a requirement under Medi-Cal for health plans.

San Diego has taken steps to make dealing with so many entities easier for programs and clients including recently refining an FAQ document and information sheet. They have also been able to improve accessing the benefit by listing a number to call on a contact sheet. While still not seamless, San Diego is clearly making progress towards refining the message. That said, each of the health plans have a different criteria and coordination efforts remain complicated. This also makes it hard for SUD providers who may have to navigate multiple rules and pathways for transportation for a single group of clients. At present, San Diego asks CalEQRO to have someone from DHCS provide them with the specific regulatory requirements for health plans so they can more factually approach them with concerns. San Diego knows the service is being utilized but have no mechanism to determine level of use.

San Diego has continued to take steps in order to ensure compliance with NACT guidelines, specifically pertaining to preparing of the 274-file submission. This included the purchasing the 274 Health Care Provider Directory Implementation Guide and X12 274 reference document through its reporting partner Optum. The System of Care application hosts all the fields for current Network Adequacy Requirements and allows providers to submit their information seamlessly online. San Diego is awaiting confirmation from DHCS to finalize and clarify 274 requirements before a massive release of the System of Care application, which will be followed by training and registration of all providers.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CalEQRO has a federal requirement to review a minimum of two PIPs in each DMC-ODS county. A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care and that is designed, conducted, and reported in a methodologically sound manner." PIPs are opportunities for county systems of care to identify processes of care that could be improved given careful attention, and in doing so could positively impact client experience and outcomes. The Validating Performance Improvement Projects Protocol specifies that the CalEQRO validate two PIPs at each DMC-ODS that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. One PIP (the clinical PIP) is expected to focus on treatment interventions, while the other (non-clinical PIP) is expected to focus on processes that are more administrative. Both PIPs are expected to address processes that, if successful, will positively impact client outcomes. DHCS elected to examine projects that were underway during the preceding calendar year.

San Diego PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. Following are descriptions of the two PIPs submitted by San Diego and then reviewed by CalEQRO as required by the PIP Protocols: Validation of PIPs.[4]

Clinical PIP— Relapse Prevention Evidence-Based Practice

Date PIP Began: 10/04/2018 **Date PIP Will End or Has Ended**: 05/01/2020

Status of PIP: Active and ongoing

Brief Description of the problems the PIP is designed to address:

Noting a significant prevalence of unsatisfactory discharges, San Diego reviewed literature and took note of a National Institute on Drug Abuse (NIDA) estimate that, of those who do receive addiction treatment, relapse rates range between 40 percent and 60 percent. Since clients who receive less care are more likely to relapse, not unusual but with potentially negative even lethal consequences, an analysis of local data was completed. San Diego found that 5,099 treatment episodes, or 37 percent ended with a discharge status of "left before completion with unsatisfactory progress" during FY 2017-18. To account for clients who were admitted to a program but didn't receive an adequate dose of treatment, clients with a discharge date less than one week after their admission date were subsequently excluded, leaving 3,417 treatment episodes, or 25

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

percent, with this discharge status. Further analysis revealed that certain levels of care are overrepresented with this unsatisfactory status. For example, Intensive Outpatient (IOP) programs (651 discharges or 43 percent) and Outpatient programs (1,413 discharges; 38 percent), compared to other levels of care.

San Diego's PIP team notes that an intervention widely supported as a strategy for decreasing the likelihood and severity of a relapse after substance abuse treatment is relapse prevention (Hendershot, Witkiewitz, George, & Marlatt, 2011). The relapse prevention model focuses on helping clients navigate high-risk situations, and practice healthy coping responses by increasing self-efficacy and changing attitudes and beliefs about a lapse.

The observed rates of early discharges from treatment without satisfactory progress led the PIP Advisory team to consider implementation of a Relapse Prevention Evidence-Based Practice (EBP) model across DMC-ODS service providers in San Diego County as a potential Clinical PIP. The Advisory team hypothesized that a greater emphasis during treatment on the development of skills central to the relapse prevention model would help facilitate 1) greater engagement in treatment, 2) a reduction in the frequency and/or severity of relapses, and 3) decreased rates of early discharges without satisfactory progress among clients exposed to the concepts in the relapse prevention model.

The goal of this PIP is to facilitate the development of relapse prevention skills among clients receiving substance use disorder treatment, ultimately decreasing the rates of early discharges without satisfactory progress by implementing a Relapse Prevention EBP.

PIP Question:
San Diego presented its study question for the clinical PIP as follows:

Will development and implementation of a Relapse Prevention Evidence-Based Practice model in San Diego County decrease rates of early discharges without satisfactory progress from treatment programs by five percent?

Indicators:

San Diego listed the following PIP indicators:

1. Percentage of discharged clients that were discharged without satisfactory completion of services.
2. Percentage of clients discharged from a residential program with a "completed treatment/ recovery plan goals/ referred/standard" discharge disposition that were connected to a lower level of care within 30 days.

Interventions:

San Diego cited the following interventions:

1. Soft introduction to Relapse Prevention EBP (concept training for SUD providers)
2. Pilot of a Relapse Prevention curriculum

Results/Impact upon Clients:
San Diego cited the following client outcomes:

1. Indicator 1: The proportion of clients from the three pilots discharged without satisfactory completion of services reduced from 31 percent (pre baseline) to 19 percent.
2. Indicator 2: The proportion from one residential program that had completed recovery plan/goals and were connect to a lower LOC within 30 days increased from nine percent (pre baseline) to 23 percent (post intervention).

The sample size from this preliminary data is admittedly small and conclusions drawn based on this data should be interpreted with caution. Nonetheless, these preliminary results provide initial support for the efficacy of the Relapse Prevention EBP to reduce unsatisfactory completion and increase number of clients completing residential and connecting to a lower LOC.

Technical Assistance Provided: Technical assistance was provided by CalEQRO to San Diego via a telephone meeting scheduled in March 2020. Feedback in this single requested session included a brief overview of data and completion results that would be presented in the upcoming onsite review. Time was expended primarily on the upcoming PIP topics for the next review cycle.

PIP Score: 88%

Non-Clinical PIP—Grievances and Appeals Utilization

Date PIP Began: 10/12/18 **Date PIP Will End or Has Ended**:6/12/20

Status of PIP: Completed

Brief Description of the problems the PIP is designed to address:

After DMC-ODS Waiver launched in San Diego County on July 1, 2018, it was observed that zero grievances or appeals were filed across the entire SUD system of care (SOC).

This observation led the PIP Advisory team to consider increasing utilization of the grievances and appeals processes as a potential Non-Clinical PIP.

To gather more baseline data, clients were surveyed about their familiarity and comfort with filing a grievance and appeal, as a supplement to the annual state-wide Treatment Perception Survey (TPS) during the first week of October 2018.

While many clients agreed or strongly agreed with statements presented in the survey, 19 percent disagreed or strongly disagreed that they understood how to file a grievance, 22 percent disagreed or strongly disagreed that they understood how to file an appeal, and 35 percent reported that their provider did not inform them, or they did not know if their provider had informed them, of the grievance and appeals process.

Interventions included contact with clients, use of the client advocates, and program staff on the value and process of filing a grievance or an appeal. A large number of small and large forums were held to reach the intended audience. It was expected that increased awareness, familiarity, and comfort with the grievances and appeals process among consumers of the DMC-ODS Waiver in San Diego County would lead to increased utilization of the processes, followed by increased feelings of empowerment, consequently leading to increased engagement in treatment and better client outcomes among utilizers.

This was anticipated because an increased awareness and comfort of these processes would lead to an increase in the number of grievances filed. Those filings would then highlight areas of a program or system improvement that could be addressed, while simultaneously increasing client empowerment and patient activation. With the level of feedback and continuous improvement driven by consumer involvement, it was hoped that improving the system and increasing positive outcomes for clients would occur. The PIP team also relied on the expertise of the client advocates participating in the PIP workgroup to share their lessons learned from their experience with client advocacy in the mental health system of care.

PIP Question:
San Diego presented its study question for the clinical PIP as follows:

Will improving accessibility of materials and educating clients on the grievances and appeals processes increase awareness and comfort with the processes among clients in the SUD SOC by five percent, as measured by responses on the TPS Supplemental survey?

Will increasing comfort and awareness with the grievance and appeals processes among clients in the SUD SOC increase utilization of these processes by five percent, as measured by the number of grievances filed and reported to DHCS

Indicators:
San Diego listed the following PIP indicators:

1. Percentage of TPS respondents who do not know how to file a grievance.
2. Percentage of TPS respondents who do not know how to file an appeal.
3. Percentage of TPS respondents that were not informed of the grievances and appeals process by their provider.
4. Number of grievances received.

Interventions:
San Diego cited the following interventions:

1. Presentations to consumers at the programs by client advocates.
2. Providers trained on beneficiary rights by San Diego and began informing consumers about the grievances and appeals processes.
3. Presentation at a consumer conference/summit.
4. "Office hour" sessions established for consumers to confidentially meet with client advocates to address concerns/file a grievance at the programs.

Results/Impact upon Clients:
San Diego cited the following client outcomes:

Knowledge of how to file an appeal*:* **The proportion of** clients who disagreed or strongly disagreed that they knew how to file an appeal was reduced from 22 percent at baseline to 19 percent at follow-up. This is a significant change as determined using Fishers exact test for the comparison of proportions.

Provider informed them of the grievances and appeals processes: The proportion of clients who reported that their provider did not inform them or they did not know if their provider informed them of the grievances and appeals process was reduced from 35 percent at baseline to 29 percent at follow-up. This is a significant change as determined using Fishers exact test for the comparison of proportions ($X^2 = 12.11$ $p = .0005$) and meets the threshold of at least a five percent reduction as hoped for by the PIP team.

Technical Assistance Provided: Technical assistance was provided by CalEQRO to San Diego via a telephone meeting scheduled in March 2020. Feedback in this single requested session included a brief overview of data and completion results that would be presented in the upcoming onsite review. It appears that San Diego followed a previous suggestion from CalEQRO to enhance and obtain consumer input in defining the PIP. They also took steps to determine and note how a change in the administrative processes would be expected to benefit the client and client

care. Time was expended primarily on the upcoming PIP topics for the next review cycle.

PIP Score: 96%

PIP Table 1, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially M (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

PIP Table 1: PIP Validation Review

PIP Table 1: PIP Validation Review					
				Item Rating	
Step	PIP Section	Validation Item		Clinical	Non-clinical
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	PM	PM
		6.6	Qualified data collection personnel	PM	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	M
		8.2	PIP results and findings presented clearly and accurately	M	M
		8.3	Threats to comparability, internal and external validity	M	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	PM	M
		9.3	Improvement in performance linked to the PIP	PM	M
		9.4	Statistical evidence of true improvement	PM	M
		9.5	Sustained improvement demonstrated through repeated measures	PM	PM

PIP Table 2 provides a summary of the PIP validation review.

PIP Table 2: PIP Validation Review Summary

PIP Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	19	23
Number Partially Met	6	2
Number Not Met	0	0
Number Unable to Determine	0	0
Number Not Applicable	3	3
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating Clinical: ((19*2)+(6P)/(25*2) Non-clinical: ((23*2)+(2))/(25*2)	**88%**	**96%**

PIP Findings—Impact and Implications

Overview

San Diego has used this review cycle to work on and complete two active PIPs. These had only recently started just prior to the last CalEQRO visit, and no data or conclusions could be reached at that time. Both PIPs addressed relevant issues that San Diego expected would result in improvement for clients through the course of treatment. The clinical PIP was implemented to gauge relapse prevention strategies that would increase client retention. The non-clinical PIP was anticipated to improve awareness and utilization of client grievances and appeals. The consumer-based input would identify problems and lead to solutions regarding client care issues that may have previously led to elopement and unsuccessful completions of treatment.

Access to Care Issues related to PIPs

Both PIPs were designed to improve the initial access processes so that clients will feel more empowered and will more likely become engaged and persist in treatment. The clinical PIP was designed to enhance identification of potential relapse issues and use remediation efforts to address them in a focused manner, giving those clients accessing treatment the support they need to achieve favorable outcomes. The non-

clinical PIP would address the current void of client input into quality improvement processes through an established mechanism that is underutilized. By making client empowerment a priority across the system, San Diego expected those who access care to be able to speak to concerns they have from their admission process onward throughout treatment.

Timeliness of Services Related to PIPs

It is anticipated that by reducing relapse, client dissatisfaction and elopement a favorable impact would come about. San Diego notes that by improving the use of a client process to voice their concerns, there would be an increasing number of persons who persist in treatment. By keeping clients involved in treatment and avoiding relapse, favorable outcomes could be realized but this would avoid readmission patterns which impact timely access for incoming clients.

Quality of Care Related to PIPs

San Diego notes that research supports the use of an evidence-based practice to improve quality of care and clinical outcomes. The framework San Diego introduced prioritizes identification and mitigation of clients' likely relapse triggers and limits untoward clinical events, thereby enhancing the potential for client satisfaction.

Studies have shown that an activated client is informed, empowered, and engaged in their own health care. By utilizing a set of strategies designed to increase use of patient grievances and appeals, a provision of individualized care is introduced that was previously missing. It had been anticipated that such positive health behaviors and care decisions would improve the overall satisfaction, retention, and quality of client care.

Client Outcomes Related to PIPs

San Diego looked at study indicators for their Clinical PIP to measure discharge status rates and show increased client retention, and thereby improved clinical outcomes. San Diego expected the increased assistance in the identification of relapse risk factors to benefit individual clients. These clients would in turn take an active hand in learning essential disease management skills and be more successful in treatment. Due to issues such as delays in training, staff turnover, and other workflow and program level concerns, it may be too soon to draw conclusions about the effectiveness of the Relapse Prevention EBP on decreasing rates of discharges with unsatisfactory progress. As more time passes San Diego anticipates that more clients will be exposed to the full curriculum, and this will provide a clearer picture of the impact this PIP project is having on discharge

status and rates. Nonetheless, the high rates of client satisfaction and endorsement of the curriculum by providers serve as a promising sign and as indications that the PIP project did have a positive impact on the clients who were exposed to it.

San Diego expected the study indicators for their Non-Clinical PIP to show increased utilization of the grievance and appeal process, and a resulting increase in client satisfaction measured by the supplemental TPS client perception survey. Despite the limitations described by San Diego, such as staff turnover, competing administrative priorities, new programs and hours of operation that impeded certain activities, the PIP was successful in increasing awareness and utilization of the grievances and appeals processes. Furthermore, based on the direct feedback received from clients who participated in the office hour sessions, satisfaction with the sessions was very high.

CLIENT FOCUS GROUPS

CalEQRO conducted no client focus groups during this desk review.

Client Focus Group Findings and Experience of Care

Overview

No groups were conducted during this desk review because of COVID 19 and safety concerns.

Access Feedback from Client Focus Groups

No groups were conducted during this desk review, and therefore no feedback was obtained.

Timeliness of Services Feedback from Client Focus Groups

No groups were conducted during this desk review, and therefore no feedback was obtained.

Quality of Care Issues from Client Focus Groups

No groups were conducted during this desk review, and therefore no feedback was obtained.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the county DMC-ODS use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

KC Table 1 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to clients and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	M
In 2013, San Diego HHSA set a unified standard for both Mental Health (MH) and SUD that all service providers would maintain and update a Cultural Competence Plan (CCP). San Diego provided CalEQRO with a Cultural Competence Plan (CCP) that was updated in July 2019. While the document is shared with MH, which is often the primary focus of analysis and initiatives, SUD is woven in through many of the targeted areas. Data analysis, stakeholder input, and year over year service provision data assist in targeting underserved populations that are expansive, well beyond the cultural or ethnic and age areas required. This is important given the diversity and unique nature of San Diego County. Targeted populations such as refugees, military veterans, Middle Eastern, Native American, and international victims of torture reflect the diverse make-up of this large county. In addition, SUD has relevant presence within the CCP. Some example areas include the focus on how to engage youth in treatment, working with gender diversity, working with court partners and criminal justice sub-populations, linguistic competency, co-occurring disorders, training, and staff self-assessment surveys on cultural diversity. San Diego maintains an addendum specific to cultural competence in all SUD provider contracts, and standards within the provider handbooks are routinely updated and serve as a way for San Diego to keep its contractors up to date on new or changing		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
requirements for the provision of services. These efforts on Cultural Competence are guided by the framework of Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS Standards are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. Cultural initiatives and standards are reinforced with staff in annual training and a cultural competence component is requiring in all the trainings provided by San Diego. Overall, San Diego assures that Spanish and other threshold language capabilities exist in their continuum of services. Their ACCESS line includes a response to any language by utilizing a language line service, but also actively recruits for individuals who are bi-lingual. Their provider services include bilingual staff as well as Spanish and other language and culturally informed programs. Clients experience low wait times and very few calls are abandoned, though Optum reports that 86.5 percent of calls end with an unsatisfactory hand-off (to providers) and 43.8 percent of those calls where the caller declined services. CalEQRO strongly encourages San Diego to work with Optum staff to identify root causes and solutions for this level of performance. San Diego HHSA has begun a ten-year effort called “Building Better Health Program” to align County services to promote both physical and mental health in collaboration with community partners and businesses. The goals are to build a better system, support healthy choices, and pursue policy changes for a healthy environment. This service has evolved into a greater, long-term Live Well San Diego which envisions activities that will improve the health, safety, and quality of life of all County residents.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
San Diego has completed a thorough assessment with ongoing network capacity adjustments to meet the requirements of the 1115 Waiver and Managed Care Final Rule. They had requested several Alternative Access Standards which were subsequently authorized, and DHCS has provided San Diego with a notice that they are currently in compliance with Network Adequacy standards. With the current increase in telehealth service provision due to the Coronavirus restrictions, San Diego hopes to learn from and leverage current efforts to increase its use, which has helped to overcome a variety of time and distance issues. Noting some of the upcoming fiscal impacts due to the drop in state funding, San Diego will also be looking to work on the likely fiscal ramifications on services. San Diego utilizes a single electronic system at the provider level to track service utilization data along with a well-developed system for analysis to identify any system challenges and gaps. San Diego’s identification of rural areas in need are providing a catalysis in the development of additional MAT capacity through projects like ROAM. WM services have been expanded to a few additional residential SUD contracts, and there is work being done to look at possibly implementing those services in outpatient and OTP settings. San Diego has provided its contract SUD programs with		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
a resource page to assist them in addressing the various system, program, contact and billing adjustments that are in place addressing the Coronavirus pandemic. These tools are designed to give SUD providers the necessary guidance on emerging information and practices. This web-based resource is routinely updated, and client information is provided in Spanish as well as English.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
San Diego has excellent collaboration with many partner organizations and agencies. They collaborated with the local health plans and FQHCs to expand MAT services. MAT grants foster collaboratives between San Diego, UCSD Hillcrest Medical Center and Scripps Mercy Hospital through the California Bridge Program. The Bridge grants focus on patients in the health care system in need of opioid treatment, provide round the clock access points, and coordinate with local SUD providers in an attempt toward changing the trajectory of the overdose epidemic. Designated emergency departments in the county are conducting buprenorphine inductions with support from San Diego's MAT tool kit, which has assisted in facilitating referrals and overcoming bias or stigma. San Diego also has an extremely robust relationship with criminal justice, a primary referral source. Beyond care coordination and regular communications on system and case issues, San Diego worked to develop the Justice Involved Training Academy (JISTA) to train providers on the various aspects of criminogenic and other skills in order to enhance informed care for the justice involved treatment population. The County has taken formal steps to move forward on establishing the Behavioral Health Continuum of Care, designed to broaden use of MH and SUD services in partnership with the community. These actions bring together diverse stakeholders including justice partners, hospitals, community health centers, and other community-based providers to create systemwide changes to ensure clients can be quickly provided the appropriate level of both MH and SUD services that are commensurate with their diverse level of need.		

Timeliness of Services

As shown in KC Table 2, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to DMC-ODS services. This ensures successful engagement with clients and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

KC Table 2: Timeliness of Care Components

KC Table 2: Timeliness of Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
San WITS supports the SUD system including the data, tracking, and reporting of timeliness standards. As noted on the Timeliness Self-Assessment, San Diego reports that in the first and second quarter of FY 2019-20 the average length of time from first request for service to first face to face appointment was just 3.3 days. Utilizing the ten-day standard from DHCS for routine appointments the percentage of clients seen in a timely fashion was 91 percent overall. Accounting for age, this dropped to 90.8 percent for adults seeking initial contact, but rose to 94.6 percent for youth. Adolescent first appointments had an average of 3.4 days. CalEQRO notes that the expediency with which clients receive their first face to face appointment shows an excellent level of performance across the SUD system of care, resulting in nearly immediate access to care.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
San Diego tracks and trends initial contact to first Methadone contact for its NTP providers. San Diego adheres to the DHCS standard of three business days for routine appointments and meets this standard 95.5 percent of the time. The average length of time is one day. San Diego also tracks from first contact to first face to face intake appointment for OTP and this improves overall adherence with the DHCS standard to 99.7 percent. Medi-Cal claims data provided by CalEQRO demonstrated that 4,083 clients received dose within three days 100 percent of the time. It is worth noting that San Diego OTP sites were previously in contracts directly with the state, so inclusion in the SanWITS data base was quite a large undertaking that was completed since DMC-ODS implementation.		
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment:	NR
San Diego is currently not tracking the timeliness of non-methadone appointments but has indicated that it will henceforth run these reports. NTP/OTP claims data and those performance levels noted above are likely to include all forms of MAT; however, consistent with information shared with CalEQRO by other county contract staff, billing for non-methadone MAT is complex and likely a cause for some incomplete data in this area.		
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	M
San Diego has established a definition for urgent appointments whereby a condition perceived by the client is serious but not life threatening and likely to involve a condition that is disruptive requiring an assessment of a health care provider and possibly treatment. That treatment, if deemed necessary, would be provided within 48 hours. San Diego can track urgent requests across its system and report that an average time to initial face to face is just 1.7 days. For adults, the standard is met 77.8 percent of the time. During the report period individuals seeking youth services meets the urgent standard 100 percent of the time. San Diego reports that time of		

KC Table 2: Timeliness of Care Components		
Component		**Quality Rating**
contact is collected but time of intake is not, therefore the data is limited to average number of days as complete hourly data is not possible at this time. San Diego also notes that it will continue to reinforce the need for input and tracking of urgent service requests as the current high percentage of adherence reported could be due to a low volume reported by providers. They note that in this reporting period just 19 contacts out of 10,464 total contacts were deemed urgent. CalEQRO recognizes the improved tracking from San Diego which had just begun tracking urgent appointment requests in the last review cycle and recommends that it continues to review any changes in volume of urgent reporting with its ongoing monitoring process.		
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	PM
Data provided by San Diego indicates that of the 2,659 clients who were discharged from residential care, just 612 clients, or 25.6 percent, received a timely appointment within the established seven-day standard. Of those clients who obtained a contact within seven days, the average length of time for the first follow up session after residential discharge was just 3.5 days. San Diego did not calculate the percentage overall, but the range of days is noted to be one to 112 days. Claims data provided by CalEQRO for FY 2018-19 indicates that just 17.9 percent of discharged clients to any other lower level of care occurs within any number of days. At present San Diego is calculating the timeliness of follow-up care based on residential discharges not admissions. It is requested that San Diego track this data with same methodology as CalEQRO in the future.		
2F	Tracks and Trends Data on Follow-up and Readmissions to Residential Withdrawal Management	M
WM readmission data is tracked by San Diego as with residential follow-up, by using discharge as the numerator, not admission. Of the 1,330 discharges from WM, just 78 or 5.9 percent were readmitted within 30 days of a previous discharge. Claims data provided by CalEQRO for FY 2018-19 shows just 102 admissions to WM of which 25 or 24.5 percent were readmitted within 30 days of discharge. The rate shown in the claims data indicated a level of readmission significantly higher than the statewide rate of seven percent. The low level of WM reported in the claims data is an area that San Diego may wish to review, though billing for their report period may show a more complete use of the Medi-Cal benefit for reimbursement than was seen in FY 2018-19. As San Diego is calculating the WM readmission rate based on discharges not admissions, it is requested that this data be tracked consistent with the same methodology as CalEQRO in the future. More data analysis is needed to compare San Diego's data with the CalEQRO Medi-Cal claims data measures.		
2G	Tracks Data and Trends No Shows	PM
San Diego has not required that providers establish no-show standards. There are some providers that are very attentive to tracking no-shows and cancellations, but at present most providers are not utilizing a calendar for scheduled appointments. Providers have traditionally used a drop-in approach for activities, which have		

KC Table 2: Timeliness of Care Components	
Component	**Quality Rating**
primarily been group based. While this ostensibly allows clients to obtain care when they need it and de-facto eliminates concerns over no-shows or capacity issues with staff time, San Diego has been working to reshape expectations with providers. SUD contractors are being asked to enhance a low level of face to face contacts and there is a sense that programs are holding on to a long-standing social model approach, which San Diego is actively trying to address. It should be noted that contract liaisons relate that providers are attentive to capacity issues and show rates of clients. CalEQRO supports the ongoing efforts of San Diego to continue its training, monitoring, and advancing new expectations with its SUD system of care.	

Quality of Care

CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including client/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, 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 service delivery system and organizational operations.

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
San Diego's QI Work Plan (QIWP) utilizes a framework which borrows from the MHP plan but is a separate document. The goals are targeted measures that are designed to address six primary areas regarding service delivery and efficacy of that care. All the goals align with state and local priorities that guide department strategies and guiding principles. The QIWP is well written, with meaningful and clearly stated goals and objectives. There are SUD specific area including administration and review of TPS, coordination of care, connection with ancillary services, readmission rates and rural service access. The QIC meetings are structured in part to monitor progress in meeting the QI Plan objectives. Minutes of the QI council meetings indicate routine review of current goals, discussion points, pending actions and analysis of results. Part of the QI Plan process is to report annually on each of the stated objectives and their associated action plans. As noted earlier, CCP along with staff competencies in servicing diverse populations is measured annually and tools and system assessments are reported with program level and system wide analysis. The SUD		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
provider handbook guides them on how to craft plans that are individual to their needs but consistent with expectations.		
3B	Data is used to inform management and guide decisions	M
San Diego makes good use of an extremely well-developed data collection and reporting process that includes partnerships with local academic institutions such as University of California at San Diego (UCSD) Health Services Research Center in formulating data analyses. The Performance Improvement Team provides routine reports on a variety of indicators that include initiation and engagement reports, demographic reports, and drug of choice at admission. Often these reports are disaggregated to the program or service level to be more meaningful for its intended audience. As noted earlier, San Diego also has data provided for leadership or providers that include language, interpreter, and access line data all of which is detailed and specific often trending month over month throughout a 12-month period of time. The SUD service indicators dashboards provide timely analysis each month. The dashboard indicators include a designation to indicate for providers or contract liaisons that any given area has a status of positive, that there is a need to review, or that a concern is indicated. A similar report for justice partners and providers is also produced. CalEQRO notes that San Diego has done excellent work in providing well designed graphically interesting displays of data to assist management, providers, and policy makers in visualizing and understanding the reports. These documents clearly indicate that data is aiding and guiding them in decision making regarding multiple defined areas of quality improvement across the system of care.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
San Diego has demonstrated an open and collaborative level of communication with its consumers and providers. Line staff and supervisors receive ongoing and frequent communication from management. Involvement of consumers and other community stakeholders is evident in a variety of projects and workgroups, including securing that input from surveys and project development meetings for the non-clinical PIP. The anticipated implementation of the peer staff into Recovery Services will train 75 individuals and will likely improve not just communication between those with lived experience and treatment staff, but also help make services more informed and effective. It was clear throughout Phase I and II of the SanWITS implementation that San Diego has involved and supported its provider network. SUD providers not only meet each month but also hold meetings specific to specialty areas such as residential, criminal justice and quality improvement designed to include input from program staff and leadership. San Diego has provided ongoing support to effectively transition SUD provider treatment practices to meet the DMC-ODS Waiver requirements. CalEQRO notes that this work is ongoing and while both billing and service delivery expectations have improved, there is a stated need by San Diego to continue its work of engaging and guiding providers to realize change more fully.		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3D	Evidence of an ASAM continuum of care	M
San Diego appears to be underutilizing or under-billing WM as noted above in the claims data for FY 2018-19 data provided by CalEQRO. Table 17 above notes that out of 9,574 unique clients just 102 clients were admitted to WM. Data provided by San Diego shows that 2,720 clients were admitted to WM. San Diego has made progress since the last review cycle in developing WM with new service sites at residential level of care and is looking to implement in both outpatient and OTP settings. San Diego has increased the amount of funded beds for Recovery Residences (RR) and estimates that 200 clients access those beds each month, but only recently established a mechanism to track usage and report figures at a system level. Recovery Residences have an established level of oversight provided in their own association and through a contract with Community Health Improvement Partners. Recruitment to secure more RR providers to join the association is ongoing and SUD providers are encouraged to utilize RRs who are association members. As San Diego enters the next phase of the EHR implementation, it is expected that this will afford them with an ability to improve and monitor their progress in adopting the ASAM continuum of care. Full EHR implementation for all treatment providers is expected in 2021.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
San Diego beneficiaries have access to MAT services through their OTP network of opioid treatment programs who provide full spectrum outpatient treatment along with methadone. OTP's also offer non-methadone forms of MAT and have been expanding their assessment and prescribing practices as evidenced by increase in claims data noted earlier. San Diego receives grant funding for a Hub and Spoke program that contracts with local OTPs and are providing services at several FQHC sites. Local ED Bridge grants have also increased x-waivered prescribers and linkage between health care and SUD programs. San Diego notes that it has made inroads towards reducing MAT related stigma in its own system of care, though it currently is challenged by the push back its OTP clinics have been experiencing in the larger community. OTPs are working to institute good neighbor policies, correct any existing deficiencies and develop ways to elevate local business and community support. OTPs have also been implementing CSAT waivers, including an increase in take home or curbside dosing, medication delivery and telehealth since the onset of the pandemic related restrictions. In addition to a naltrexone program coordinated with the Drug Court, San Diego participates in the MAT Learning Collaborative, which is designed to educate justice partners and assist in the adoption of MAT service within local jails. Involvement in the Prescription Drug Abuse Taskforce (PDATF) and other groups associated with the County of San Diego Prescription Drug Abuse Plan, has given San Diego visibility on the broader issues and efforts. PDATF activities are well defined and link to prevent, screen, and treat substance use disorders. The current PDATF report card indicates that fentanyl overdose		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
deaths have increased 68 percent comparing the same time period from the prior year and the county is currently tracking a continued rise in these fatalities. Methamphetamine, which accounts for most of the drug toxicity deaths, saw a 24 percent increase in fatal cases as well. Overall, unintentional fatal alcohol or other drug overdoses has increased by seven percent, from 298 cases in mid-year 2018 to 319 this mid-year. Naloxone distribution efforts are enhanced by the involvement of San Diego's efforts to educate treatment providers and enhance efforts to deal with clients who have an opioid use disorder but refuse MAT. CalEQRO applauds the strong work by PDATF, the system providers, the expansion of MAT in all the various projects. We recommend that San Diego look to establish a mechanism to track enrollment patterns of X-waivered prescribers and naloxone distribution. These data will enhance the excellent year over year tracking already in place.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
San Diego has been extremely successful regarding the use of ASAM Criteria for individualized placement and treatment planning. This has been accomplished through an organized and intentional set of training and learning experiences along with recalibrating contracts and expectations as noted earlier. Training goals are woven into the QIWP as individualized care, connecting clients through care coordination along with skill building in clinical documentation, establishing medical necessity, and billing are emphasized. San Diego has a system for monitoring, feedback and continuous feedback that reinforces the core principles of ASAM within its continuum of SUD service sites. New resources have been developed on the web, making it possible for staff to access training on demand.		
3G	Measures clinical and/or functional outcomes of clients served	M
San Diego has a set of dashboards and reports that emphasize health equity indicators, including substance use disorder diagnosis and admission characteristics including age, gender, race, and level of care designation. Effectiveness of programs can include clinical outcomes but also denote level of functioning in relation to housing or employment status. Residential authorizations, readmissions, and length of stay across all levels of care are reported monthly and by service type. San Diego also monitors timeliness and access data in alignment with state expectations and reports in the QI minutes reflect discussion and program adjustments. Client initiation and engagement is also reported and reflect strong level of service performance. For FY 2019-20 San Diego notes 9,881 intakes in the first and second quarters. Of these admitted clients, 87.3 percent had a second treatment appointment and of the 8,594 clients with a second appointment, 90.9 percent or 7,813 engaged in at least two additional treatment visits in a 30-day period. This indicated a high level of client engagement and retention which is a strong indicator for positive outcomes in treatment.		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3H	Utilizes information from client perception of care surveys to improve care	PM
San Diego has participated in two collection cycles of the TPS, in 2018 and 2019. In each administration, San Diego has received TPS results from UCLA. Response rates have improved year over year for clients in all treatment settings. For the 2019 TPS cycle, the adult population returned 2,421 surveys, which is an increase over the 1,591 collected in 2018. San Diego also saw a larger number of clients in the OTP programs surveyed in 2019, increasing from just 110 in 2018 to 763 during this cycle. Spanish adult surveys remain low, with only 44 collected in 2019 compared to 36 for the previous TPS administration. Overall ratings for the domains remained the same or slightly above. In 2019 Access (4.3), Quality (4.4), Care Coordination (4.3), Outcome (4.3) and General Satisfaction (4.5). Individual survey questions within each domain remain very positive with improvement from 2018 in 13 of the 14 questions. The strongest level of improvement was overall satisfaction with service at 3.3 percent higher and got help needed at 3.9 percent. There were 137 responses in 2019 from youth, which is somewhat lower than the 153 who participated in the last TPS cycle. In both years, the majority of clients surveyed were male, Latino, and from an outpatient or intensive outpatient level of care. Overall ratings for the six domains remained the same or slightly lower. In 2019 Access (3.9), Quality (4.1), Therapeutic Alliance (4.2) Care Coordination (4.1), Outcome (4.0) and General Satisfaction (4.1). While youth surveyed were generally satisfied with the services they received, lower ratings were noted across half the 18 questions of the specific to domains compared to 2018. While some drops are low if not insignificant, a 6.9 percent drop pertaining to being treated with respect and a 9.8 percent drop regarding cultural sensitivity should be a concern, and a review of individual programs reflects some very low performance by providers in these areas with the adolescent population. CalEQRO suggests that San Diego COR or contract monitor facilitate ongoing discussions and mitigation efforts with both adult and youth providers regarding TPS results where indicated looking at outliers. The number of Spanish language TPS collected are not in keeping with the county demographics and stepped up attention to correct this is strongly encouraged by CalEQRO.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- San Diego saw an increase in clients served and billed under the DMC-ODS from 4,487 in the last review which was San Diego's first year of DMC-ODS services, to 9,574 clients served in this year's review by CalEQRO.
- San Diego's beneficiary access line receives an average of 436 calls per month and has dropped call rate of just 2.7 percent.
- San Diego notes that 22 of its SUD providers have expanded their weekend and after-hours availability so that each region has at least one provider with extended hours to help with admissions and access.
- San Diego increased its Recovery Residence budget from $2.5M last fiscal year to $6.3M in FY 2019-20 and add beds for this critical service.
- San Diego has executed a contract amendment for MAT services to perinatal outpatient including the provision of two FTE (a nurse practitioner/physician assistant and an LVN).
- San Diego's ROAM project was established using a mobile clinic to reach out to rural areas with a focus on culturally responsive care to isolated Native American communities. This was part of the effect to improve access to zip codes that did not meet time and distance standards in remote areas requiring an exception under a state approved AAS for 2019.
- San Diego continues to look at improving access to treatment for both working clients and youth including the expectation that all adolescent service providers will have evening hours.
- As a response to the COVID-19 crisis, DMC-ODS is encouraging its contract providers to use telehealth to its beneficiaries and this will also assist with client access in remote and rural areas.
- San Diego's website is functional and easy to use by computer.

Opportunities:

- San Diego has experienced a slight decrease in admissions year to date (YTD) compared to FY 2018-19, likely due to a program closure in early 2020.
- San Diego has had issues in recruiting staff which can impact program capacity to provide service.

- San Diego noted a 28 percent decline in DMC billable outpatient services during the first full month of restrictions due the COVID-19 pandemic.
- San Diego reports that program and system timelines on new services or technology are going to be delayed due to the impact of the pandemic restrictions and response.
- San Diego notes that 75 percent of the provider's clinical staff are telecommuting and while providers have been able to adjust, long range planning is likely needing to occur.
- San Diego's access line data indicates that 86.5 percent of calls end with an unsuccessful warm hand off and that when service are offered, 43.8 percent of callers decline that offer. More study of this issue to encourage treatment is needed, as these are lost opportunities to link individuals to critical care.

Timeliness of DMC-ODS Services

Strengths:

- San Diego notes that most providers serve clients on demand allowing them to drop into treatment as they can, avoiding concerns regarding no-shows.
- Requests for appointments due to an urgent request met the timeliness standard 78.9 percent of the time.
- San Diego has developed a set of dashboard reports that profile a variety of core indicators for their providers including those pertaining to efficiency.
- For routine appointments San Diego averages a wait time for adults to receive an offered appointment of just 3.3 days.
- Participation in the Hub and Spoke project and ED Bridge programs has increased the number of x-waivered prescribers, improving timely access to MAT and expanded access to non-methadone MAT.
- Homeless outreach staff are embedded in outpatient programs and their contacts and linkage data is tracked and reported.
- Clients have access to transportation services from the seven different Health Plans in San Diego County helping to link clients more quickly to treatment.

Opportunities:

- San Diego has a legacy of social-model programs that have been informally addressing capacity issues yet lacking basic performance expectations.
- San Diego has had no formal mechanism to obligate providers to measure program performance factors such as productivity.

- San Diego reported just 19 urgent contacts out of 10,464 contacts which is a very low volume and indicates under reporting by providers.
- Just 9.7 percent of all client discharged from residential had a timely follow up appointment at a lower level of care within seven days.
- San Diego staff and providers note that accessing, coordinating, or tracking transportation services for their clients is inherently complex due to the large number of health plans in the County and each of them having different procedures and rules.

Quality of Care in DMC-ODS

Strengths:

- San Diego shows strong adherence to the use of ASAM placement criteria and working with clients to obtain the indicated level of care across all three areas of the screening and assessment process. Given the size and complexity of its SUD system of care, this indicates proper placement for 90.38 of the 19,521 clients seen.
- Recovery Services and case management have seen increased utilization and billing since the last review cycle.
- Providers and program staff have access to a myriad of technical, clinical, and administrative training including a well-organized Provider handbook.
- Online training opportunities are being monitored with analytics and currently show high level of usage of over 2,000 contacts going through the materials.
- San Diego has a high level of congruence between assessed LOC and referred level (84.7 percent). Follow-up assessment congruence is even higher at 94.84 percent.
- San Diego's standard discharge rate is 53 percent compared to 43.8 percent statewide. For adults, 89 percent of clients discharged were either employed, in structured employment preparation program, school or enrolled in an eligibility program.
- San Diego has a long-standing relationship of collaboration with criminal justice, a primary referral source, that is continuing to make inroads on expanding MAT access within inmate service facilities.
- San Diego's percentage of clients served reflect that 672 clients, or 7.2 percent of all clients served, were receiving, and billed for non-methadone forms of MAT.
- San Diego has completed two active PIPs, both of which saw anticipated improvement of client care.

- Peer training plan submitted by San Diego has been approved by DHCS and an implementation plan has been developed. Support for recovery services is strong and the plan can be implemented as the pandemic is stabilized.
- San Diego benefits from its long-standing involvement in opioid, drug overdose and methamphetamine task force collaboratives. Efforts from this work include raising community awareness, secure coordination across multiple agencies, educate partners on addiction and the value of treatment, and provide data report cards with analyses on the current state of these issues.

Opportunities:

- San Diego continues to have challenges in shifting the provider paradigm and more fully captures Recovery Services and case management as not just program activities, but as a service that can be billed and can be individually tailored to client needs and goals. Program driven versus client driven treatment is still quite evident in many program models.
- Workforce retention and staff turnover has made it difficult to maintain gains made in documentation and billing standards.
- San Diego's RFP for peers along with MAT expansion for perinatal has been delayed due to the pandemic.

Client Outcomes for DMC-ODS

Strengths:

- San Diego has effectively utilized certain job classifications such as support staff or embedded Homeless Outreach Workers to improve linkage and care coordination.
- Clinical and documentation training has been made available to staff online and they can now access skills training on demand.
- San Diego had 2,421 Adult TPS surveys submitted in the last administration cycle.
- Adult and youth TPS scores for San Diego in 2019 were favorable in the aggregate with a slight increase in most domains in comparison with 2018.
- San Diego is making progress in phased approach to enhance SanWITS. Clinical elements were designed and implemented with a comprehensive training plan for providers.
- San Diego is taking meaningful steps through its MAT Learning Collaborative to move beyond medication specific nomenclature regarding various MAT projects and make care about clinical and medication needs, period.
- San Diego notes progress in SUD providers being more open and accepting of MAT including methadone, indicating a reduced level of stigma.

- San Diego will participate in the CDC grant funded Overdose Data to Action which will utilize nearly $2.2 million over three years to expand surveillance activities and strategically coordinate data driven mitigation strategies in the county.

Opportunities:

- San Diego has 27 legal entities providing Recovery Services, but just 11 are billing under DMC.
- Utilization of non-billable staff such as support staff and HOWs who provide case management type activities has been a factor in relatively low billing for CM.
- The progression anticipated by ongoing clinical training has been impacted by a high staff turnover rate.
- San Diego disseminated over 900 Adult TPS Spanish language surveys to its providers, but only 44 them were returned and available for the last analysis cycle.
- Individual program variances in Adult TPS scores showed that some provider issues persist regarding cultural sensitivity, convenient time, clients feeling that they are getting the help they need. Some variances by specific programs for youth also show poor ratings in domain questions pertaining to establishing a therapeutic alliance.
- San Diego has become aware of the need to address stigma within neighborhoods and business community regarding its NTP/OTP clinics, both existing and proposed.
- San Diego's SanWITS development plan and implementation of various clinical modules and training for providers is delayed due to the pandemic.

Recommendations for DMC-ODS for FY 2019-20

- San Diego should review trends and data from its call center to identify unsuccessful call interactions where callers decline service, screening has stopped or there was no hand off referral made. These are critical lost opportunities for client engagement in critical lifesaving care.
- San Diego should identify the root cause of very low urgent service appointment requests as reported by its SUD provider network and enhance training and monitoring to assure that urgent issues of clients are being fully identified and addressed in a timely fashion.
- San Diego should address the low usage rate of Spanish language TPS surveys and take steps to identify issues that cause downward variances within the individual program sites impacting client's perception of care.

- San Diego should track and report timely follow-up from residential discharge and WM readmission data in a manner that is consistent with CalEQRO.
- San Diego should establish a framework to guide, develop and establish productivity standards to measure performance, system capacity and gauge efficiency in treatment programs.
- San Diego should take active steps to ensure its process of enhancing SanWITS to be a fully functional EHR is resourced at a level to assure completion timelines.
- San Diego should continue to seek opportunities to expand access in the eastern and northern rural and remote areas of the county for residents with SUD in partnership with surrounding counties, FQHC clinics, mental health and using telehealth and mobile services such as the ROAM service.

ATTACHMENTS

Attachment A: On-site Review Session

Attachment B: Review Participants

Attachment C: Performance Improvement Plan (PIP) Validation Tools

Attachment D: County Highlights

- None at this time

Attachment E: Continuum of Care Form

Attachment F: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: On-site Review Sessions

This was a Desk Review with no on-site sessions held.

A list of phone conference call sessions is noted below while several other topic areas were covered by written correspondence and less formal discussions.

Attachment A: Review Sessions
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 performance measures
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards, and other reports
PIPs
Contract managers group interview – county – regarding current services under Covid19

Attachment B: Review Participants

CalEQRO Reviewers

Patrick Zarate, Lead Reviewer
Maureen Bauman, Second Quality Reviewer
Bill Ullom, Lead Information Systems Reviewer
Lamar Brandysky, Information Systems Reviewer
Robyn Walton, 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

DMC-ODS Sites

San Diego County Behavioral Health Service
3255 Camino Del Rio South
San Diego, CA 92108

Contract Provider Sites

Table B1: Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Amidon	William	Research Analyst	BHS - QI - Performance Improvement Team
Blanchard	Michael	Quality Management Supervisor	BHS - QI - Quality Management
Briones-Espinosa	Ana	Director of Finance and Business Operations	Optum
Conlow	Ann Louise	Senior MIS Manager	BHS - QI - Management Information Systems
Emerson	Cynthia	Administrative Analyst III	BHS - QI - Management Information Systems
Escamilla	Adrian	Administrative Analyst II	BHS - QI - Management Information Systems
Esposito	Nicole	Assistant Clinical Director	BHS - Clinical Director's Office
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	BHS - Adult and Older Adult System of Care
Gonzaga	Alfie	Program Coordinator	BHS - Clinical Director's Office
Guevara	Christopher	Principal Administrative Analyst	BHS - QI - Management Information Systems
Hayes	Skylar	Manager of I.T.	Optum
Hillery	Naomi	Project Manager	UCSD - Health Services Research Center
Jackson	Shannon	Behavioral Health Program Coordinator	BHS - Children, Youth, and Families System of Care
Kang	Teresa	Quality Management Supervisor	BHS - QI - Management Information Systems
Kneeshaw	Stacey	Behavioral Health Program Coordinator	BHS - Adult and Older Adult System of Care
Koenig	Yael	Deputy Director, Children, Youth & Families System of Care	BHS - Children, Youth, and Families System of Care
Koenig	Yael	Deputy Director, Children, Youth & Families System of Care	BHS - Children, Youth, and Families System of Care
Lang	Tabatha	Assistant Medical Services Administrator	BHS - Quality Improvement
Lansang	Cheryl	Administrative Analyst III	BHS - QI - Management Information Systems
Lucas	Lavonne	Medical Claims Manager	Fiscal Services

Table B1: Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Marin	Paul	Program Manager	Teen Recovery Center
Marquez	Samantha	Office Assistant	BHS - QI - Performance Improvement Team
Miles	Liz	Principal Administrative Analyst	BHS - QI - Performance Improvement Team
Mockus-Valenzuela	Danyte	Prevention and Planning Manager	BHS - Prevention and Community Engagement
O'Reilly	Kristyn	Senior Account Manager	FEI Systems
Panczakiewicz	Amy	Project Manager	UCSD - Health Services Research Center
Pauly	Kimberly	Behavioral Health Program Coordinator	BHS - Children, Youth, and Families System of Care
Ramirez	Ezra	Administrative Analyst II	BHS - QI - Performance Improvement Team
Rodriguez	Lourdes	Administrative Analyst II	BHS - QI - Management Information Systems
Ruiz	Olivia	Patient Advocate	Jewish Family Service of San Diego
Spickard	Ashleigh	Administrative Analyst II	BHS - QI - Management Information Systems
Stone	Danny	Program Manager	South County Center for Change
Tally	Steven	Assistant Director of Evaluation Research	UCSD - Health Services Research Center
Tormey	Timothy	Principal Administrative Analyst	BHS - QI - Quality Management
Tran	Phuong	Administrative Analyst	BHS - QI - Performance Improvement Team
Woodruff	Caitlin	Patient Advocate	Jewish Family Service of San Diego

Attachment C: PIP Validation Tools

GENERAL INFORMATION	
DMC-ODS: San Diego	☒ Clinical PIP ☐ Non-Clinical PIP
PIP Title: Relapse Prevention Evidence-Based Practice	
Start Date: 10/04/2018 **Completion Date:** 05/01/2020 **Projected Study Period:** 12 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review:** 05/12-14/2020 **Name of Reviewer**: Patrick Zarate	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP
Brief Description of PIP: This PIP aims to develop and implement a Relapse Prevention Evidence-Based Practice model for the San Diego DMC-ODS Waiver, to decrease rates of early discharges without satisfactory progress.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A multi-functional team was assembled to help guide the implementation of the PIP. The team includes subject matter experts and staff from San Diego County Behavioral Health Services (SDCBHS), the Health Services Research Center (HSRC) at UCSD, Responsive Integrated Health Solutions (RIHS, formerly BHETA), and substance use disorder (SUD) providers from the DMC-ODS Waiver continuum. Clients were involved by responding to a survey after each exposure to the Relapse Prevention EBP and those responses were monitored throughout the duration of the PIP.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	In San Diego 3,417 (25 percent) treatment episodes, who had at least one-week dose of treatment, were discharged with "left before completion with unsatisfactory progress". These discharges were particularly likely from IOP and OP programs.

Select the category for each PIP:	
Clinical: ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions	*Non-Clinical:* ☐ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	It was suspected that many of the unsatisfactory discharges could be due to factors related to a relapse, such as ineffective coping skills or damaging attitudes and beliefs about the meaning of a lapse. The Advisory team hypothesized that a greater emphasis during treatment on the development of skills central to the relapse prevention model would help facilitate 1) greater engagement in treatment, 2) a reduction in the frequency and/or severity of relapses, and 3) decreased rates of early discharges without satisfactory progress among clients exposed to the concepts in the relapse prevention model.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP was designed with a few selected programs as pilots. These programs are representative of the DMC-ODS Waiver levels of care and representative of county wide demographics. They include a women's OP program, IOP, Perinatal OP, Teen Recovery Center, and court program. Demographics collected include age, gender, race/ethnicity, mental health diagnosis, primary drug of choice, living situation and discharge status.
	Totals 4	**4** Met **0** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will development and implementation of a Relapse Prevention Evidence-Based Practice model in San Diego County decrease rates of early discharges without satisfactory progress from treatment programs by 5%?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is stated clearly and has a measurable impact (change the rates of early discharge without satisfactory progress from treatment).

	Totals 1	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☒ Other mental health diagnosis, primary drug of choice, living situation and discharge status.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP clearly defined all Medi-Cal enrollees to who the study question applied. It was to be tested on all program participants, who had been in treatment for at least one week, in the six programs identified above for four months from May – August 2019. As some programs started late the deadline was extended to assure for data collection so the PIP workgroup had enough data to make a recommendation.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Participants who had been in treatment for at least one week during the data collection period.
	Totals 2	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Percent of discharged clients that were discharged without satisfactory completion of services 2. Percent of clients discharged from a residential program with a “completed treatment/ recovery plan goals/ referred/standard” discharge disposition that were connected to a lower level of care within 30 days	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators are objective, clearly defined, and measurable

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators will measure whether treatment outcomes for clients have improved as a result of the interventions.
	Totals 2	**2** Met **0** Partially Met **0** Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used. c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable

Totals 3	**0** Met **0** Partially Met 3 Not applicable 0 Not Met 0 UTD **0**

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Treatment episode data was collected and entered into SanWITS.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☒ Other: CalOMS, Supervisor Check List, Client Surveys	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CalOMS was identified as the data source, Supervisors monitored one treatment session monthly and filled out a supervisor checklist, and client surveys.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Treatment episode data was collected and entered into SanWITS and the research team at HSRC received monthly SanWITS extracts. The CalOMS fields remained consistent between FY 2017-18 through the end of the PIP as did the process at the programs to enter the data. Data was collected after each session using the RoadMAP Toolkit, clients from the pilot completed a short survey gauging exposure to key elements of the curriculum

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☒ Outcomes tool ☐ Level of Care tools ☒ Other: CalOMS data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The research team at HSRC maintained contact with the pilot programs during the pilot to ensure that the curriculum was being used as designed. The clinical supervisors at the pilot programs completed the Supervisor Checklist monthly to ensure adherence to the curriculum content. The research team at HSRC reached out to the program managers at each of the pilot programs when a lapse in the completion of the monthly supervisor checklists occurred, and when the rates of the client survey completion were low.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Discharge data from the pilot programs during FY 2017-18 and the first half of FY 2018-19 (prior to implementation of the RoadMap Toolkit curriculum) was compared with discharge data from clients at the pilot programs who received the curriculum. The unexpected results were reported but not anticipated.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Liz Miles, Ed.D. Title: Principal Administrative Analyst Role: Performance Improvement Project lead *Other team members:* Names: Health Services Research Center from UCSD, Staff from SDCBHS SUD program	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Staff working on the project were not specifically named
	Totals 6	**4** Met **2** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 3. Soft introduction to Relapse Prevention EBP (concept training for SUD providers) 4. Pilot of a Relapse Prevention curriculum	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	To introduce the San Diego's providers to the curriculum (when they had been utilizing a different model for several years) a concept training was developed and offered to providers. This was offered 11 times between October 2018 and March 2020 and was attended by 183 unique providers from 57 unique treatment programs. RIHS is exploring the use of trainings virtually because of the COVID order to Shelter-in-Place and plans to continue the remaining scheduled trainings through the current fiscal year and FY 2020-21. In addition, to ensure the curriculum content was received by clients, clients participating in the program received a short survey after each session asking about their exposure to key components of the Relapse Prevention EBP.
	Totals 1	**1** Met **0** Partially Met **0** Not Met 0 NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Delays in provider training did not allow for sufficient discharge data to be available for analysis during the initial planned mid-way check. The PIP workgroup requested that providers include SAWITS IDs on the client survey – allowing HSRC to link client survey data to discharge data in SanWITS.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Tables were clearly labeled, and data was easy to understand.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: FY 2017/18 Baseline, DMC-ODS Q 1 and 2 FY 2018/19 Baseline, DMC-ODS Q 2 and first half of Q 3 FY 2019/20. Indicate the statistical analysis used: Fishers exact test Indicate the statistical significance level or confidence level if available/known: See Comments _____% _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Three time points were selected for comparison, Pre DMC-ODS Waiver Baseline, DMC-ODS Pre-Intervention Baseline and DMC-ODS Waiver post-Intervention. The analysis of the interventions, although positive, was considered preliminary as only a small subset of the clients was able to be counted for either indicator. Indicator 1: The proportion of clients from the three pilots discharged without satisfactory completion of services reduced from 31 percent (pre baseline) to 19 percent. This did not meet statistical significance (X^2 =2.68 p=.1016). The comparison was repeated from baseline and a statistically significant change was observed (X^2= 4.12 p=.0424). Indicator 2: The proportion from one residential program that had completed recovery plan/goals and were connect to a lower LOC within 30 days increased from nine percent (pre baseline) to 23percent (post intervention), however this did not meet statistical significance (X^2=1.28 p=.2586).

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Data analysis did not occur as planned. Delays in provider training did not allow for sufficient discharge data to be available for analysis during the initial planned mid-way check. *Conclusions regarding the success of the interpretation:* The sample size from this preliminary data is admittedly small and conclusions drawn based on this data should be interpreted with caution. Nonetheless, these preliminary results provide initial support for the efficacy of the Relapse Prevention EBP to reduce unsatisfactory completion and increase number of clients completing residential and connecting to a lower LOC. *Recommendations for follow-up:* The PIP workgroup relied on the results of the client surveys and reports from providers implementing the curriculum to gauge interim success of the pilot. The PIP team felt comfortable continuing with administration of the pilot without any adjustments to the interventions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP team will not make a final recommendation about offering the curriculum to the rest of the DMC=ODS until further data can be analyzed with additional results.
	Totals 4	**4** Met **0** Partially Met **0** Not Met **0** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Data was collected at three intervals from the same sources. The method of data collection stayed the same. The same client groups were used throughout the study. Measurements tools were consistent. The client survey provided consistent positive feedback and showed clients had discussed, understood, and found the curriculum helpful.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☒ No Clinical significance: ☐ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There was consistent improvement in the measures, although the numbers were too small to always show statistical significance.
9.3 Does the reported improvement in performance have internal validity, i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP team felt the limited data was promising but that additional data needed to be collected to affirm the improvement was the result of the planned quality improvement intervention.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The numbers are small, and although some data showed statistical significance others did not. However, there was positive change with outcomes even with the small sample.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP plans to be continued to allow for additional data to inform the question of whether this new curriculum should be extended across all programs.
	Totals 5	**1** Met **4** Partially Met **0** Not Met **0** NA **0**UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	Not validated

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

The PIP shows promise the implementation of EBP Relapse Prevention model will decrease the percent of clients who are discharged without satisfactory completion of service, and increase the number of clients discharged from residential treatment with completion of treatment goals and a connection to lower LOC. The implementation of various aspects of this PIP was delayed and so additional data needs to be collected to confirm the promising early results.

Recommendations:

Continue the PIP as a pilot until enough data can be reviewed to determine if this program should be implemented across all county programs.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☒ Confidence in PIP results cannot be determined at this time

PIP item scoring

19 Met

6 Partially Met

0 Not Met

3 Not Applicable

PIP overall scoring

((19 x 2) + 6) / (25 x 2) = 88%

GENERAL INFORMATION	
DMC-ODS: San Diego	☐ Clinical PIP ☒ Non-Clinical PIP
PIP Title: Grievances and Appeals Utilization	
Start Date: 10/12/18 **Completion Date:** 4/30/20 **Projected Study Period:** 18 months **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review:** 5/12-14/20 **Name of Reviewer**: Patrick Zarate	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established, and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

This PIP aims to improve accessibility of the grievances and appeals processes materials at all programs in the SDCBHS DMC-ODS to increase 1) awareness and usage of and 2) comfort with these processes among clients, which will help identify programmatic and system-wide issues.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A multi-functional team was assembled to guide the implementation of the PIP. The team included subject matter experts, San Diego staff, Jewish Family Service (JFS), Consumer Center for Health Education and Advocacy (CCHEA)) and the Health Services Research Center (HSRC) at UCSD.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	After July 1, 2018, it was observed that zero grievances or appeals were filed across the entire SUD SOC during July 2018. More baseline was gathered with client surveys about their familiarity and comfort with filing a grievance and/or appeals. Results indicated 19 percent did not understand how to file a grievance, 22 percent understood how to file an appeal and 35 percent reported the provider did not inform them, or they did not know if their provider informed them, of the grievance/appeal process. In addition, of the 782 comments on the TPS, 124 (16 percent) were coded as potential grievance while only 36 grievances/appeals were files across SUD SD from July 1, 2018 to September 30, 2018.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-Clinical:* ☒ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	While information around the specific impact of the grievances and appeals processes on client treatment outcomes is lacking, San Diego argued that increased utilization of these processes could lead to greater feelings of empowerment and patient activation among utilizers. Empowerment, active collaboration with healthcare providers, and a perception of having control over one's treatment is documented to leading to better engagement in treatment, and better outcomes among clients receiving physical health treatment. The PIP Advisory team felt that successful navigation of these processes is an example of clients actively engaging in their treatment; therefore, it is expected that increased awareness and comfort with the grievances and appeals process will lead San Diego consumers to increased utilization of the processes, followed by increased feelings of empowerment, consequently leading to increased engagement in treatment and better client outcomes among utilizers.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP is relevant to the target population because 1) the entire population has a right to file a grievance and/or an appeal, and 2) it has been widely documented in the scientific literature that increased empowerment and active participation in one's health (physical and behavioral) treatment is related to better client outcomes.
	Totals 4	**4** Met **0** Partially Met **0** Not Met **0** UTD **0**

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* 1. Will improving accessibility of materials and educating clients on the grievances and appeals processes increase awareness and comfort with the processes among clients in the SUD SOC by 5%, as measured by responses on the TPS Supplemental survey? 2. Will increasing comfort and awareness with the grievance and appeals processes among clients in the SUD SOC increase utilization of these processes by 5%, as measured by the number of grievances filed and reported to DHCS?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is clear and concise and has potential to have a measurable impact on the defined study population.
Totals 1		**1** Met **0** Partially Met **0** Not Met 0 UTD **0**
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This project aimed to address all clients receiving SUD treatment services as part of the SDCBHS DMC-ODS. Demographic data from unique clients receiving SUD services from San Diego during 1) FY 2017-18 and 2) the first two quarters of FY 2018-19 serve as baseline data. In addition to age, race/ethnicity and gender demographics included mental health diagnosis, primary drug of choice, living situation, Medi-Cal status, and veteran status.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: TPS survey supplemental questions and grievance/appeals filed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study applied to the entire population and data collection represented the entire population with the TPS survey supplemental questions and actual number of grievance/appeals filed.
	Totals 2	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. % of TPS respondents who do not know how to file a grievance 2. % of TPS respondents who do not know how to file an appeal 3. % of TPS respondents that were not informed of the grievances and appeals process by their provider 4. # of grievances received	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Clearly defined and measurable.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	It has been widely documented in the scientific literature that increased empowerment and active participation in one's health (physical and behavioral) treatment is related to better client outcomes. Although not measured, the goal is to improve client outcomes by measuring an increase in grievances/appeals and client feedback to show that there is increased comfort with the process.
	Totals 2	**2** Met **0** Partially Met **0** Not Met **0** UTD **0**

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used. c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
	Totals 3	**0** Met **0** Partially Met **0** Not Met **3** NA UTD **0**

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	TPS Supplemental surveys results and the number of grievances filed.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: TPS supplemental surveys and number of grievances filed	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, same as above
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	SUD providers administered the supplemental survey along with the State-mandated TPS survey, to all clients across the DMC-ODS Waiver continuum that were receiving services during the first week of October in both 2018 and 2019. The number of grievances filed prior to the first intervention, and during/after all interventions, were reported by JFS and CCHEA and compiled by San Diego staff.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: grievance/appeals files	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	San Diego staff sent a log of the filed grievances to the HSRC research team monthly via a secure, encrypted email. The process for logging grievances remained unchanged throughout implementation of the PIP~~,~~ for consistency. JFS and CCHEA~~,~~ had a San Diego Program Monitor who ensured the quality of the services provided and that the statement of work for each entity was met.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study design included data collection processes and review, monthly data collection of grievances/appeals and assured ongoing review of data. The HSRC research team ensured the quality of data entry and analysis using rigorous quality assurance procedures developed within this group. An additional client feedback form was added at the suggestion of the EQRO last year responding to the need for more feedback. The plan did not discuss contingencies.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Liz Miles, Ph. D, MPH, MSW Title: Principal Administrative Analyst Role: Performance Improvement Project lead *Other team members:* Names: Research team at HSRC	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The research team at HSRC ensured the quality of the data entry and analysis, using rigorous quality assurance procedures employed at the HSRC.
	Totals 6	**5** Met **1** Partially Met **0 Not** Met 0 **NA 0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Presentations to consumers at the programs and program staff 2. Providers trained on beneficiary rights by San Diego, and began informing consumers about the grievances and appeals processes 3. Presentation at a consumer conference/summit 4. "Office hour" sessions for consumers to confidentially meet with client advocates to address concerns/file a grievance at the programs	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Interventions were undertaken that would reasonably address the causes and barriers identified through thorough analysis.
Totals 1		**1** Met **0** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Comparisons between pre and post responses on both the TPS supplemental survey and the Advocacy Summit survey were analyzed, and the results were presented as planned.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Results were presented clearly with comparison charts so the reader could easily see the change in total number and percentages.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: 12 months Indicate the statistical analysis used: pre/post comparison Indicate the statistical significance level or confidence level if available/known p=.0040, .0151, .0005 _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The study evaluated the actual number of grievances filed by breaking out the time frame after understanding that the holidays historically have lower filings. However, since the increase was not as robust as anticipated further analysis and hypothesis were suggested and barriers were identified, including lack of available space for office hours, unwillingness of clients to stay after their group session for office hours, and an alternative was developed. Unfortunately, COVID delayed the intervention but it is still planned to be launched when possible.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Barriers to implementation of the office hour sessions at the outpatient and OTP levels of care (LOC), staff turnover, end of fiscal year activities impacting office space, and new programs not having the same level of training* *Conclusions regarding the success of the interpretation:* Despite barriers identified there is evidence to support the claim that the interventions administered through the PIP did increase awareness of and comfort with the grievances and appeals processes *Recommendations for follow-up:* None	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP was determined to be successful, but no specific recommendations were made.
	Totals 4	**4** Met **0** Partially Met **0** Not Met **0** NA **0** UTD

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data and collection processes were designed to remain the same and there were quality assurance activities to assure this took place.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☐ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The increase of grievance/appeals indicated an increase comfort by clients to use this process and with that step, they would feel more engaged and empowered in their treatment.
9.3 Does the reported improvement in performance have internal validity, i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☒ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The study considered if outside factors could have resulted in the improved results and determined the outcomes were related to the interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☒ Strong	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Yes, statistical significance was measured.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	This was a comparison between one year and another. The results indicate there was improvement. It is assumed but not stated that the interventions need to be continued to sustain this improvement.

Totals 5	**4** Met **1** Partially Met **0 Not** Met **0** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

The PIP was successful in increasing the number of grievances and appeals in the DMC-ODS system. It is reasonable to conclude that this result indicates that clients feel more comfortable with this process and may also feel more engaged and empowered in their treatment.

Recommendations:

It is not clear if the PIP results will be maintained without continuing the identified interventions over time. Monitoring grievances and appeals will be continued as part of the quality improvement process; however, in addition, PIP interventions should continue to sustain these results.

Check one:

☒ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time

PIP item scoring

23 Met

2 Partially Met

0 Not Met

3 Not Applicable

PIP overall scoring

((23 x 2) + 2) / (25 x 2) = 96%

Attachment D: County Highlights

None at this time.

Attachment E: Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: **County of San Diego** Review date(s): **May 12-14, 2020**
Person completing form**: Matthew Munski/Erin Shapira**

Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: 100%

County role for access and coordination of care for persons with SUD requiring social work/linkage/peer supports to coordinate care and ancillary services.
Describe county role and functions linked to access processes and coordination of care:

As the County of San Diego DMC-ODS is entirely comprised of 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 with these standards:

In order to engage clients and ensure successful continuity of care, programs should create policies/procedures on care coordination focusing on seamless transitions without disruption to service for the client. Minimum considerations include the following:

• Each SUD client must be assigned a primary counselor at the initiation of services. The primary counselor will guarantee that the client is directed to appropriate resources within the program, including linkage to the program case manager. The primary counselor's contact information must be provided to the client as their designated contact for assistance with in-program needs.

• The program case manager will coordinate with any external resources as indicated by the client's needs, wishes and goals. The client must be provided with the program case manager's contact information for assistance with resources outside the program.

We require that programs have a 42 CFR Part 2 Compliant release of information form for the client's primary care provider (and other treatment providers/collateral contacts) and documentation of attempts to coordinate care in the client chart within 30 days of admission and as needed throughout treatment.

• Programmatic, interdisciplinary team meetings are expected as a means for all staff providing client services to maintain clear communication regarding assessed needs and any indications of change to level of care recommendations.

• Programs shall follow the Missed Scheduled Appointments protocol as defined in the Substance Use Disorder Provider Operations Handbook (SUDPOH) as a means of continued client engagement and care coordination. These standards apply to new referrals (contacting within one business day by a clinical staff when a client does not show for a scheduled first appointment) and current clients (containing within one business day by clinical staff when missing a scheduled appointment without a call to reschedule). Clients with recent elevated risk factors will be contacted by clinical staff on the same day as the missed scheduled appointment.

When a client is transitioning from one level of care to another (or to an ancillary service), care coordination will be based on warm handoff principles: carefully coordinated transfer or linkage of a client to another provider, entity, agency, or organization who will continue, add, or enhance services.

• This warm handoff process will:

- Ensure communication between concurrent providers of service (for example, OTP and IOS providers treating a client at the same time)
- Occur prior to the case closing at the current program
- Ensure the client is clear on the reason for referral or transfer to another level of care
- Include a direct conversation between providers to ensure passing of critical information in a timely fashion
- Include all pertinent documents (including signed release of information when necessary and other relevant clinical information, including ASAM Level of Care Recommendation form) to ensure transfer in a timely manner
- Occur anytime a referral is provided to another service provider

The warm handoff will include:

Ideally, a joint session/meeting with the providers and the client via face-to-face, telephone, or telehealth
Information is shared between providers about client treatment and engagement history
Clients transitioning from non-OTP withdrawal management (WM) and residential services should begin services at the next indicated level of care within 10 business days of discharge from WM or residential services. For coordination up or down the continuum of care, the handoff is considered complete after there is confirmation that the client has engaged, and initial appointment has occurred.
In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. All coordination of care activities must be documented within the client record.

Adequate communication serves a key component in ensuring proper care coordination for clients. Case managers have the responsibility of serving as an advocate for clients in the SUD system of care and shall assist with communication between clients and other service providers. Providers may have to exchange communication through emails, letters, telephone calls, progress notes, or reports to the County, State, or other service providers on behalf of the client. Case managers shall also assist clients in ensuring they are receiving adequate care from other service providers and inform clients of their right to appropriate treatment.

Case Management- Describe if it is done by DMC-ODS via centralized teams or integrated into DMC certified programs or both:

Monthly estimated billed hours of case management: **DMC Billable: 9,949 Units and 2,487 Hours; County Billable*: 1301 Units and 325 Hours**

Comments:
**County Billable units and hours include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.*

The County of San Diego DMC-ODS provides case management as integrated into programs.

Case management services are available to clients in the DMC-ODS based on the frequency documented in the individualized treatment plan. As documented on the treatment plan, case management provides advocacy and care coordination to physical health and mental health, transportation, housing, vocational, educational, and transition services for reintegration into the community. The primary goal of case management services is to ensure clients in the SUD System of Care receive all the necessary support and services available to be successful at meeting their treatment goals.

Case management is effective in keeping individuals engaged in treatment and moving toward recovery and helps an individual address other problem concurrently with substance use. Case management services are especially important among clients with chronic health problems, co-occurring disorders, or those involved with the justice system.

Case management services often start during the intake and assessment process and continue to be provided to the client throughout SUD treatment and in recovery services. As clients move through the system of care, case management assessments and reassessments support different needs from initial service engagement (pre-treatment), treatment, and recovery services. Case management services may be provided face-to-face, by telephone, or by telehealth with the client and may be provided in the community as appropriate.

In order to successfully link clients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate resources, both at the system and the service levels that are needed for the client to optimize care through effective and relevant networks of support. Services provided through case management are thus tailored to facilitate continuity of care across all systems of care and provide extensive assessment and documentation of the client's progress toward self-management and autonomy.

Although an important component of case management in the SUD population is linking clients to outside systems of care, such as physical and mental health systems, case management is equally important in navigating clients through the SUD system of care. Comprehensive SUD treatment often requires that clients move to different levels of care within the SUD continuum, and case managers help to facilitate those transitions.

Recovery Services – Support services for clients in remission from SUD having completed treatment services but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing, relapse prevention, peer support.

Pick 1 or more as applicable and explain below:

1) Included with Access sites for linkage to treatment
2) Included with outpatient sites as step-down
3) Included with residential levels of care as step down
4) Included with NTPs as stepdown for clients in remission

Total Legal entities offering recovery services: **27**
Total number of legal entities billing DMC-ODS: 11*
Choices: **1-3**

Comments:
**Total legal entities billing is 11; total sites billing is 34.*

Recovery services are included with outpatient and residential programs after the client has completed a course of treatment, and assessment indicates that treatment at outpatient or higher level of care on the continuum is not clinically indicated. Recovery services may be received at the program from which a client has completed treatment or at another program of their choosing in the community.

Prior to completing treatment, the current program discusses the option of Recovery Services with the client and requests permission to contact them after treatment ends. If the client has not been linked to Recovery Services at treatment discharge, the Treatment program must make at least 3 attempts to engage the client, on 3 separate days, to demonstrate efforts to engage client in recovery services. These contacts must be documented. If there is no contact from client after 30 days, no additional effort by the treatment program is required.

Level 1 WM and 2 WM: Outpatient Withdrawal Management – Withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).

Number of Sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Estimated billed hours per month: N/A
How are you structuring it? - *Pick 1 or more as applicable and explain below*

1) NTP
2) Hospital-based outpatient
3) Outpatient
4) Primary care sites

Choice(s): N/A

Comments:
Currently, the County of San Diego offers Withdrawal Management for Residential Programs only. The County has participated in community discussions that have expressed interest in having Withdrawal Management in Outpatient Programs and is continuing to evaluate the need of services in the community.

Level 3.2 WM: Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports.

Number of sites: 7
Total number of legal entities billing DMC-ODS: 3*

Number of beds: **127**
Estimated billed hours per month: **WM 3.2 DMC Billable: 976 Units; County Billable**: 256 Units and WM 3.2 Case management DMC Billable: 222 Units; County Billable**: 54 Units**
Pick 1 or more as applicable and explain below:

1) Hospitals
2) Freestanding
3) Within residential treatment center

Choice(s): 3

Comments:
**Total legal entities billing is 3; total sites billing is 4.*
***County Billable units include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.*

This is an organized service delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. Programs providing ASAM 3.2 – WM are encouraged to obtain an Incidental Medical Service (IMS) license through DHCS. Currently there are 3 sites billing ASAM 3.2 WM. This level provides services for client's whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. The clinical components of this level of care include the necessary services for assessment and medication or non-medication withdrawal management, support, services to families and significant others and referrals for ongoing support or transfer planning.

NTP Programs- Narcotic treatment programs for opioid addiction and stabilization including counseling, methadone, other FDA medications, and coordination of care.

Total legal entities in county: 4
In county NTP: Sites 10 Slots: 4,685
Out of county NTP: Sites 0 Slots: n/a
Total estimated billed hours per month: **DMC Billable: 99,001 Units; County Billable*: 151 Units and NTP Case Management DMC Billable: 1,768 Units; County Billable*: 35 Units**

Are all NTPs billing for non-methadone required medications? ☒ Yes ☐ No

Comments:
**County Billable units include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.*

NTP is an organized, ambulatory, addiction treatment service for clients with an opioid use disorder. It is delivered by a team of personnel trained in the treatment of opioid use disorder which includes physicians, nurses, licensed or certified addiction counselors and mental health therapists who provide client centered and recovery oriented individualized treatment, case management, and health education (including education about HIV, tuberculosis, hepatitis C,

and sexually transmitted diseases). NTP services are considered appropriate for clients with an opioid use disorder that require methadone or other medication assisted treatment.

Non-NTP-based MAT programs - Outpatient MAT medical management including a range of FDA SUD medications other than methadone, usually accompanied by counseling and case management for optimal outcomes.

Total legal entities: 1 Number of sites: 1
Total estimated billed hours per month: To be determined – recently executed contract amendment

Comments:

The County of San Diego has executed a contract amendment with HealthRight360, dated March 1, 2020, to begin providing Additional MAT services for women in this program. The program is currently hiring additional staff and, at the time of this writing, has not yet begun to bill for these services. An additional contractor is in negotiations for providing Additional MAT, with a target date of 7/1/2020.

Level 1: Outpatient – Less than 9 hours of outpatient services per week (6 hrs./week for adolescents) providing evidence-based treatment.

Total legal entities: 11 Total sites: 58
Total number of legal entities billing DMC-ODS: 9*
Average estimated billed hours per month: **DMC Billable: 24,871 Units and 13,108 Hours; County Billable**: 6,270 Units and 3,353 Hours**

Comments:

**Total legal entities billing is 9; total sites billing is 44.*
***County Billable units and hours include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.*
***Note:** Units and Hours include 4 dual OTP programs that also provide outpatient services.*

In the ASAM Level 1 level of care (OS), clients receive up to nine hours a week for adults and less than six hours a week for adolescents when determined by a Medical Director or LPHA to be medically necessary and in accordance with an individualized treatment plan. These services include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, discharge services and case management.

The Teen Recovery Centers (TRCs) are specialty population outpatient programs for adolescents that experience many of the complex issues paired with substance use. TRCs provide substance abuse treatment for adolescents age 12-17 and their families. In addition to their main clinics in the regional communities of San Diego, TRCs are also located within school sites to increase access and coordination with school personnel. There are 7 TRCs countywide, and each TRC has at least two additional school-based sites. The 7 sites can provide level 1 and level 2.1. School sites may either provide both 1 and 2.1 or only level 1.

The goals of BHS TRC services are to:
• Provide developmentally and culturally appropriate substance abuse treatment services for adolescents throughout the County
• Increase access to care by reducing access times to entering programs
• Improve capability and functioning for youth and their families
• Decrease the incidence of crime
• Support the youth in becoming self-supporting through education/employment
• Provide Family Counseling
• Provide Co-occurring disorder treatment
• Increase prosocial skills and eliminate illicit substance use

In addition to the TRCs, the County of San Diego offers level 1 Perinatal services in six outpatient programs. The programs provide gender-specific programming and serve women ages 15 and up and can also provide 2.1 level of care.

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.

Estimated billed hours per month: **DMC Billable: 12,644 Units and 7,791 Hours; County Billable**: 2,194 Units and 1,248 Hours**
Total legal entities: 10 Total sites for all legal entities: 53
Total number of legal entities billing DMC-ODS: 10*
Average estimated billed hours per month: **DMC Billable: 12,644 Units and 7,791 Hours; County Billable**: 2,194 Units and 1,248 Hours**

Comments:
**Legal entities billing is 10; 39 sites billing.*
***County Billable units and hours include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.*
***Note:** Units and Hours includes one dual OTP program; however, it is not providing this service at this time.*

In ASAM Level 2.1 (IOS), adult clients receive a minimum of nine hours up to a maximum of 19 hours per week, when determined by a Medical Director or LPHA to be medically necessary, and in accordance with an individualized treatment plan. Adolescents receive a minimum of six hours up to a maximum of nineteen hours a week when determined by a Medical Director or LPHA to be medically necessary, and in accordance with an individualized treatment plan. Intensive outpatient services shall include counseling and education about addiction-related problems with specific components including intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, discharge services and case management services.

Many of our outpatient programs offer both OS and IOS treatment (and Recovery Services), which offers clients in need of these services with more seamless transition opportunities when needs indicate a change up or down in the continuum of care.

As previously stated, the TRCs and Perinatal Programs can also provide level 2.1. The TRCs that have school-based sites provide both 1 and 2.1 outpatient services.

Level 2.5: Partial Hospitalization – 20 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient treatment but not 24-hour care.

Total sites for all legal entities: N/A
Total number of legal entities billing DMC-ODS: N/A
Total number of programs: N/A
Average client capacity per day: N/A
Average estimated billed treatment days per month: Enter treatment days

Comments:

The County of San Diego DMC-ODS does not currently include this level of care.

Level 3.1: Residential – Planned, and structured SUD treatment / recovery services that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.

Total sites for all legal entities: 21
Total number of legal entities billing DMC-ODS: 15*
Number of program sites: 27
Total bed capacity: 686**
Average estimated billed bed days per month: **DMC Billable: 14,192 Units; County Billable***: 1,936 Units**

Comments:
**Legal entities billing is 15; sites billing is 20.*
***Reflects current contracted bed capacity, as of submission date. Bed capacity for Levels 3.1 and 3.5 are based on current utilization patterns as the number for both can be flexible based on client need.*
****County Billable units include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.*

Level 3.1 clinically managed, low-intensity residential services are designed to prepare clients for a successful transfer to outpatient treatment services. Clients meeting criteria for Level 3.1 have an impaired ability to practice recovery skills and sustain change behaviors outside of a 24-hour structured setting. Clients are open to recovery and may have some knowledge of relapse prevention, however their ability to structure daily life in an outside environment requires additional skill building and the development of community supports to prevent relapse. Treatment goals for a client meeting criterion for 3.1 may include learning and practicing coping skills, building community connections, relapse prevention, self-efficacy, and an improved ability to structure and organize tasks of daily living.

In a Level 3.1 program in the County of San Diego DMC-ODS, clients must receive 20 hours a week of structured activities. Of those 20 hours, 5 of them must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

For residential treatment to be reimbursed daily, the service provided must include one of these clinical activities on the date of billing – or one of two other structured activities: client education or transportation (which is defined as provision of or arrangement for transportation to and from medically necessary treatment).

Most AOA residential programs have a provisional ASAM designation of both 3.1 and 3.5. This allows for transition of care within programs to accommodate clients when they are assessed as needing a higher or lower level of residential care.

Level 3.3: Clinically Managed, Population Specific, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.

Total sites for all legal entities: N/A
Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Total bed capacity: N/A
Average estimated billed bed days per month: N/A
(Can be flexed and combined in some settings with 3.5)

Comments:

The County of San Diego is currently developing proposal details for contractors interested in providing this level of care, with a goal of offering these services within the next fiscal year.

Level 3.5: Clinically Managed, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.

Total sites for all legal entities: 20
Number of program sites: 20
Total number of legal entities billing DMC-ODS: 11*
Total bed capacity: 227**
Average estimated billed bed days per month: **DMC Billable: 5,113 Units; County Billable***: 411 Units**
(Can be flexed and combined in some settings with 3.5)

Comments:
**Legal entities billing is 11; sites billing is 15.*
***Reflects current contracted bed capacity, as of submission date. Bed capacity for Levels 3.1 and 3.5 are based on current utilization patterns as the number for both can be flexible based on client need.*
****County Billable units include individual client services that have been delivered and documented within a treatment episode that is not billable to DMC, such as, clients not Medi-Cal*

eligible, justice over-ride clients, or medically necessary and authorized residential treatment days that exceed DMC-ODS benefits.

Level 3.5 clinically managed, high-intensity residential services are designed to prepare clients for a successful transfer to lower intensity treatment services. Clients meeting criteria for Level 3.5 have severe, unstable SUD symptoms, functional impairments, demonstrate a repeated inability to control impulses, and are in imminent danger of substance use outside of a 24-hour structured setting. Level 3.5 services sufficiently address complex needs, including significant emotional, behavioral, or cognitive conditions related to a mental health disorder. Clients receiving level 3.5 services have limited coping skills and an outside living environment that is highly conducive to substance use. Treatment services are comprehensive and address severe instability as a result of a SUD, and contributing issues which may include justice-involvement, a personality disorder, antisocial values, and other maladaptive behaviors. Treatment goals include stabilization, the development of prosocial behaviors, and relapse prevention skills.

Like a Level 3.1 program, clients in a Level 3.5 residential program in the County of San Diego DMC-ODS must receive 20 hours a week of structured activities. However, of those 20 hours, 10 hours must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

Like a level 3.1 program, for residential treatment to be reimbursed on a daily basis, the service provided must include one of these clinical activities on the date of billing – or one of two other structured activities: client education or transportation (which is defined as provision of or arrangement for transportation to and from medically necessary treatment).

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) ☐ Yes ☐ No

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed Capacity: N/A
Average estimated billed bed days per month: N/A

Comments:

Beneficiaries in need of Acute Medical Detoxification (WM 3.7 & 4) can access services in an acute medical facility for a serious medical condition related to substance withdrawal. Additionally, Voluntary Inpatient Detox is an available benefit and covered by the State of California's Fee for Service System. The County has worked to create an information document regarding this benefit for SUD providers and beneficiaries and local hospitals. Additionally, the County of San Diego is currently investigating the possibility of offering Level 3.7/Level 4.0 within the County's Psychiatric Hospital.

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting. (Billing Health Plan/FFS can you access services? ☐ Yes ☐ No

Access)

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed capacity: N/A
Average estimated billed bed days per month: N/A

Comments:

Beneficiaries in need of Acute Medical Detoxification (WM 3.7 & 4) can access services in an acute medical facility for a serious medical condition related to substance withdrawal. Additionally, Voluntary Inpatient Detox is an available benefit and covered by the State of California's Fee for Service System. The County has worked to create an information document regarding this benefit for SUD providers and beneficiaries and local hospitals. Additionally, the County of San Diego is currently investigating the possibility of offering Level 3.7/Level 4.0 within the County's Psychiatric Hospital.

Recovery Residences – 24-hour residential drug free housing for individuals in outpatient or intensive outpatient treatment elsewhere who need drug-free housing to support their sobriety and recovery while in treatment.

Total sites for all legal entities: Varies
Number of program sites: Varies
Total bed capacity: Varies

Comments:

The County of San Diego has allocated realignment funds to contracted treatment providers to establish agreements with recovery residences for clients, so the numbers vary. Legal entities are required to have written procedures guiding the selection of recovery residences utilized as well as procedures outlining coordination of care and payment protocols. Providers are required to track and report spending in alignment with County requirements.

The County has also established a contract with CHIP (Community Health Improvement Partners) to develop a Recovery Residence Association (RRA) to provide oversite and support for local Recovery Residences, their proprietors, owners, and clients to ensure the highest quality of living environment and to address any issues that may arise. CHIP is responsible for identifying and implementing a training curriculum and a set of quality standards and best practices for Recovery Residences that are part of RRA. CHIP continues to recruit residences as part of this Association and BHS contracted treatment providers are encouraged to use Recovery Residences that are part of the RRA.

Are you still trying to get additional services Medi-Cal certified? Please describe:

The County of San Diego is currently developing proposal details for contractors interested in providing other levels of care, with a goal of offering these services within the next fiscal year. These levels of care include: Level 1 WM, 2 WM, Level 3.3. Additionally, the County of San Diego is currently investigating the possibility of offering Level 3.7/Level 4.0 within the County's Psychiatric Hospital.

The County's system of care includes several contractors pending DMC Certification. As of 4/1/2020, there 10 legal entities (13 sites) pending approval.

Attachment F: Acronym List Drug Medi-Cal EQRO Reviews

ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
ART	Aggression Replacement Therapy
ASAM	American Society of Addiction Medicine
ASAM LOC	American Society of Addiction Medicine Level of Care Referral Data
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California's Data Collection and Reporting System
CANS	Child and Adolescent Needs and Strategies
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCL	Community Care Licensing
CDSS	California Department of Social Services
CFM	Client and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CJ	Criminal Justice
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Client Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
DSS	State Department of Social Services
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FY	Fiscal Year
HCB	High-Cost Beneficiary
HHS	Health and Human Services

HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IMAT	Term doing MAT outreach, engagement and treatment for clients with opioid or alcohol disorders
IN	State Information Notice
IOM	Institute of Medicine
IOT	Intensive Outpatient Treatment
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOC	Level of Care
LOS	Length of Stay
LSU	Litigation Support Unit
MAT	Medication Assisted Treatment
MATRIX	Special Program for Methamphetamine Disorders
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MH	Mental Health
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NCF	National Quality Form
NCQF	National Commission of Quality Assurance
NP	Nurse Practitioner
NTP	Narcotic Treatment Program
NSDUH	National Household Survey of Drugs and Alcohol (funded by SAMHSA)
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PED	Provider Enrollment Department
PHI	Protected Health Information

PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PP	Promising Practices
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
RN	Registered Nurse
ROI	Release of Information
SAMHSA	Substance Abuse Mental Health Services Administration
SAPT	Substance Abuse Prevention Treatment – Federal Block Grant
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
Seeking Safety	Clinical program for trauma victims
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STC	Special Terms and Conditions of 1115 Waiver
SUD	Substance Use Disorder
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
TSA	Timeliness Self-Assessment
UCLA	University of California Los Angeles
UR	Utilization Review
VA	Veteran’s Administration
WET	Workforce Education and Training
WITS	Software SUD Treatment developed by SAMHSA
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan
X Waiver	Special Medical Certificate to provide medication for opioid disorders
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version