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2018-19
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 21-23, 2019

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SAN DIEGO DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2018-19
San Diego Threshold Language(s) — Spanish, Vietnamese, Tagalog, Arabic and 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

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 in the east. west, north and south.

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.

San Diego County has a population of 3,095,313 (US Census Bureau 2010) 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 services, retail, aerospace, and electronics. The county is home to multiple military installations and is home to 60 percent of the ships in the US Navy and more than one third of all active U.S. Marines.

San Diego county'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 32 percent are Hispanic and 64 percent are Caucasian. There is an overall median age of 35.8, an average annual income of $76,207 with a poverty rate of 13.3 percent. San Diego County 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. San Diego is a population with a high number of persons speaking Spanish where 22 percent of the county report that Spanish is the primary language spoken in the home. Spanish, Vietnamese, Tagalog Arabic, and Farsi are threshold languages.

San Diego Behavioral Health conducted an array of activities in its DMC-ODS planning process from the fall of 2015 through calendar year (CY) 2016 in order to develop a system of care for substance use disorders (SUD). This included planning meetings, key informant interviews, community stakeholder forums and provider surveys. Forums and focus groups engaged both traditional partners but also engaged targeted populations as San Diego convened dozens of stakeholder meetings across the various regions of the county. In addition to engaging its treatment provider network, San Diego discussed and obtained input from criminal justice, the local health plans, social service agencies, education, clients and its behavioral health advisory board. This interactive process examined existing services levels and identified gaps and encouraged participants to prioritize unmet needs and concerns. Additional planning occurred to ensure service, licensing, billing and monitoring adjustments were operationalized during the initial stages of launch. Input and feedback received through these efforts are incorporated into the waiver implementation plan which serves as the foundation of a client centered and comprehensive delivery system launched in July 2018.

The Population Health Institute ranks San Diego County 10 out of 58 counties for overall health indicators with availability of primary care physicians and mental health providers being a strength while 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.

As with many counties in California, San Diego has not been immune to the impacts of the drug overdose crisis and opioid epidemic. According to the Department of the Medical Examiner Annual Report, in 2017 there were 547 deaths due to drug or drug and alcohol related overdose with more than 50 percent of these involving one or more prescriptive agents. Of those deaths, 84 were from fentanyl or its synthetic analog a dramatic increase of 155 percent from the prior year. According the California Department of Public Health (CDPH) website on opioid surveillance, there has been a 22 percent drop in opioid prescribing though only a slight increase in the use of non-methadone forms of medication assisted treatment (MAT) such as buprenorphine.

San Diego is recognized for its multi-faceted and comprehensive approach in addressing the opioid crisis locally. One facet of this approach includes the Prescription Drug Abuse Task Force (PDATF). This coalition formed in San Diego, partners with San Diego and Imperial counties Medical Societies which includes medical leaders, health department administrators, specialists, pharmacists, hospitals and emergency department medical directors who joined efforts across public and private lines to reduce deaths and addiction due to prescription drugs. PDATF's stated objectives are to decrease prescription drug abuse and access to prescription drugs for non-medical use by promoting safe storage, safe disposal, and safe prescribing practices that

encourages obtaining a dual prescription for naloxone. Efforts have also been made to increase engagement amongst individuals who are in need of treatment. Within the PDATF there are multiple subcommittees including the Medical Task Force committee, working to address prescription drug abuse countywide. San Diego is currently updating the County's Prescription Drug Abuse Plan, initially developed in 2010, to formally include coordination with behavioral health programs.

During this fiscal year (FY) 2018-19 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 first-year implementation of San Diego's DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from CY 2018.

Access

San Diego Medi-Cal beneficiaries have access to a "no wrong door" regionalized screening and assessment system for referral to treatment. San Diego's system of care employs an Administrative Service Organization 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 makes contact with 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.

Implementation of the DMC-ODS waiver enhanced this SUD approach of allowing clients to access information and referral to services by phone through the ACL. Optum operates the ACL 24 hours a day and handles crisis calls, screens 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. As a current pilot program, after doing screening the ACL links to treatment programs using a three-way calling system to allow for warm handoffs to care. 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 treatment program.

San Diego has 87 contract providers who represent more than 100 program sites which are arrayed throughout the county. Walk in or direct requests for services are handled in a way consistent with the screening requirements described above and have Licensed Practitioners of the Healing Arts (LPHAs) and registered or certified SUD counselors who conduct a full assessment. When the assessment is conducted by a SUD counselor, they are required to meet face to face with the program's LPHA to determine appropriate level of care and treatment plan interventions. Clients found to need a different level of service or who would be deemed otherwise not appropriate are given a warm hand off to other providers in the network. While Optum has Avaya telephonic software to track and monitor all the required elements of timely access, the providers utilize a contact log to note the individual's information, request and disposition. Time to service can then be tracked regarding first face to face contact. The collected information is put into San Diego's Web Infrastructure for Treatment Services (SanWITS), that serves as San Diego's SUD computer system) and is available to the county for tracking and reporting on timeliness.

San Diego has taken steps to address the confusing nature of health care and access by providing a simple message to those Medi-Cal beneficiaries looking for treatment. They have pushed out the concept that the department is their health plan for SUD. In other words, that San Diego Behavioral Health is a direct service provider as well as a contractor for substance abuse programs and are part of health care services. This message has been effective as evidenced by the call volume to ACL. Optum reports that in FY 2018-19 they received 5,976 calls for SUD services. The majority of these requests are for residential level 3.1 at 1,676 and for withdrawal management (WM) at 1,263.

Client satisfaction at the Access Center is measured utilizing an electronic survey and monitoring by supervisors along with routine call reviews completed by county staff who oversee this contract. While many calls come from third parties or represent individuals who are unsure or probing for availability, San Diego has been successful in raising awareness allowing the broader community a significant access portal that was not in place for SUD clients prior to the Waiver. The Optum run call center assigns licensed staff 24 hours per day to answer the well publicized 800 telephone number and are knowledgeable on resources across the county.

As clients access treatment services directly at the provider level, each program has designed specific hours and protocols for screening and assessment. The contractors and Optum run access call center attempt to recruit bilingual counselors, case managers and clinicians whenever possible but also have access to translation services as needed. The need to add and recruit qualified clinical staff presented a challenge as providers were at differing levels of readiness to incorporate some of the Waiver mandates. One of the challenges was due to the providers having to ramp up staffing without upfront funds. Residential providers found the adoption of medical necessity, American Society of Addiction Medicine (ASAM) assessment requirement challenging. Due to challenges with hiring LPHAs, there are challenges with completion of timely assessments of incoming clients.

In alignment with State regulation, San Diego requires that each contract program have staff who are trained in the use of ASAM Criteria to do screenings and make provisional determinations on client needs for treatment or other support. Full assessments utilize the ASAM Criteria for matching clients to the appropriate levels of care and treatment. Once a client has been enrolled in a treatment program, they are assigned an individual counselor who provides assistance through the full initial intake and orientation. If an individual is admitted to residential treatment, an authorization is required and requested from Optum who is under contract to make these determinations which are completed within 24 hours. Training is ongoing to support providers' skills in documenting medical necessity for treatment. San Diego shared a very active training schedule and a set of training requirements for its provider organizations and staff.

Training has been provided by San Diego and external subject matter experts on the ASAM, including a session by Dr. David Mee-Lee. Advanced training is available on the associated clinical and documentation standards, but an interview with providers and their staff indicate that sessions are often overbooked and more sessions are needed due to staff turnover. San Diego has taken steps to address this issue by encouraging providers to cancel their registration rather than no-show, in order to free up space for colleagues. Optum is contracted to do additional training for basic SanWITS and reporting to provide needed support. Also, some providers have hired their own trainers to enhance learning or accommodate specific needs. Overall, line staff are enthusiastic about implementing the clinical aspects of the Waiver, but feel there is a steep learning curve since launch. San Diego's quality staff monitor and review clinical and compliance areas pertaining to the assessments, treatment plans, and documentation and most providers find them responsive and helpful.

The ACL has been active for many years as the call center for mental health, which is especially useful for prospective clients who have co-occurring mental health and SUD issues. Additionally, every incoming client whether through ACL or direct referral is assessed for co-occurring disorders. Enrolled clients showed a rate of co-occurring disorders at 34.8 percent across all programs. Due to the integrated nature of San Diego Behavioral Health coordination between mental health and substance abuse is a potential area of strength in the provision of treatment.

While CalEQRO review will typically use ASAM level of care referral data showing the percent of those with an initial assessment admitted into treatment which matches their assessment of needs, San Diego had problems with their ASAM data submission. Reasons for lack of data include batch results forwarded to UCLA which included both DMC beneficiary results along with persons who entered treatment outside the purview of the Waiver. San Diego is working with staff to improve the ASAM submission data and include only Medi-Cal clients in DMC-ODS services.

San Diego reports that it has seen a year over year increase of DMC beneficiaries admitted to their treatment network. Data indicates that client admissions for residential and outpatient services are increasing. Total admissions since implementation are

11,598 which includes movement of 4,585 narcotic treatment program (NTP) clients at the start of FY 2018-19 from their direct contracts with the DHCS system to the contracted reporting unit system with San Diego. Increases in client admissions have persisted with a 39.7 percent increase in Quarter 2 of FY 2018-19 over the same time frame in FY 2017-18. Residential treatment also saw an increase of 4.1 percent in Quarter two of FY 18/19 compared to the same time period in FY 2017-18. San Diego reports that the admission increase also represents an increase in unique unduplicated clients. Between July and December of FY 2017-18 there were 7,065 unique clients. In the same time period of FY 2018-19, excluding the NTP transfers, unduplicated client admissions totaled 7,867 for a net increase of 802 or an 11 percent increase in clients served.

San Diego's overall penetration rate for treating Medi-Cal beneficiaries with SUD is lower than the statewide combined average for all DMC-ODS counties based upon claims data provided to EQRO. However, the data available was incomplete due to billing delays, particularly for San Diego's new services, and is not representative of the total services provided in their first year of implementation. Penetration data will be available in the annual report after a claims data refresh which should capture more services. However, San Diego made a decision to not require its providers to bill DMC for services during the startup year if all documentation requirements were not met, and instead cover their costs with other funding. After provider training and support during this first year, billing is required for all DMC-ODS services provided. Therefore, even the data refresh will not reflect San Diego's full delivery of services, which will have to await the second-year external quality review.

Available claims data for DMC-ODS eligibles indicate that 30.9 percent of the San Diego treatment population is Latino/Hispanic which is very close to 32 percent prevalence of this group in the county. San Diego has taken multiple actions in addressing the specific needs relative to the Hispanic community and looks to prevalence data to plan and address network adequacy, assess program types and unmet needs.

San Diego expanded service capacity and increased the types of services for DMC beneficiaries in its planning and launch of the Waiver. As San Diego is 100 percent contracted for SUD services, many providers had to obtain DMC certification designations in order to meet the mandates of the Waiver. At the time of this review San Diego reports that 78 percent of its network is properly certified to meet the requirements of the DMC-ODS. This included residential WM and residential treatment when these providers also became eligible to bill DMC for new services such as case management, recovery support, and physician consultation.

San Diego transitioned a large network of NTP methadone providers whose previous contracts had been with DHCS to contract with San Diego which included the required expansion to other forms of MAT in addition to methadone. The four NTP legal entities have a total of ten program sites arrayed across the county representing 4,685 treatment slots. While each of the legal entities is making available non-methadone

forms of MAT to persons receiving services at their clinics, the number of persons receiving alternate types of MAT remains small. While most clients in the focus group at the NTP stated they want to be on methadone, all forms of MAT are presented at the time of assessment. NTPs report that they use best practice guidelines to review options for offering non-methadone forms of MAT such as assessing whether the person recurrently tried methadone or had relapses while on it. While the final decision is arrived at in a joint meeting with provider and client, all consent forms list non-methadone options so clients know they can ask to make medication changes while at the NTP. In an interview with executive NTP staff at one legal entity, they estimated that within their four local clinics seven percent of their current caseloads are on buprenorphine rather than methadone.

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 have nine spoke access points. The largest of the NTP providers contracts with five Federally Qualified Health Centers (FQHC) and are seeing clients who come in specifically requesting evaluation for buprenorphine. Induction is now possible at three local emergency departments (ED) who have contracts to assure linkage with SUD treatment providers. San Diego has enhanced access to MAT and treatment through the county's EDs by its development and launch of a tool kit designed for emergency room staff. These materials provide core information on the Waiver, how to identify the need for MAT, and an info-graphic and statement on buprenorphine induction and the merits of its use in the ED. Materials on MAT in the tool kit are approved by the California College of Emergency Physicians (ACEP). In addition, UC San Diego Health was selected as a grant recipient by DHCS CA MAT Expansion Project for the ED-Bridge program which provides funds to help educate medical facility staff on the merits of MAT in order to improve and increase initiation of medication as well as referrals to outpatient clinics.

Housing continues to be a challenge area for San Diego due to low vacancy rates and high cost in most areas of the county. CalOMS admission data from CY 2017 on living status shows that incoming clients are homeless at 30.5 percent which is well over the state average of 24.5 percent. Although the Waiver expanded funding through DMC for residential treatment, the move from a program-centric model to one designed to meet the individualized needs of the client has led to shorter lengths of stay. With increasing movement of clients from residential treatment earlier in their treatment episode and the fact that many present as housing-challenged at admission, options for stepdown care to sober living environments (SLE, Recovery Residence under the Waiver) are in very high demand. Though not billable under DMC, San Diego took initiative to move away from the traditional SLE model which ran as an independent continuum of housing providers. SLE owners were invited to participate in discussions with the county and a Recovery Residence Association (RRA) was formed with San Diego setting quality standards for participation. The RRA adopted a set of facility and quality standards, and San Diego now has a level of oversight not seen prior to the Waiver. Access is through SUD programs with agencies using an independent assisted living model that has long been successful on the mental health side. While 116 beds are now available at 11 sites, the need to increase RRA association participation and recruitment of more

Recovery Residences is indicated in order to secure a more even distribution of residences across the county. RRA facilities have peer monitoring, accept clients on MAT and offer online location and bed capacity information.

San Diego partners with the criminal justice system in order to best identify and serve clients. Criminal Justice is the single largest referral source. In addition to work 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. While discussions assist in individual dispositions, San Diego has been creative in its efforts to inculcate their justice partners on Waiver placement requirements. A “justice override” allowed the ASAM-based assessment to proceed in parallel while giving the judge an ability to step in and make the final determination, with the County paying for those stays that did not align. As education of the bench has been sustained, San Diego reports that use of this override capability has diminished and that a review of such cases actually shows increasing alignment with ASAM determinations. San Diego has also established the Justice Involved Services Training Academy (JISTA) which provides its public safety colleagues with six full days of training over four months with homework between sessions including SUD treatment and system changes. Multiple cohorts of 30 participants have taken part in this effort to ground decision making for shared clients in a foundation of medical necessity, ASAM Criteria and related clinical considerations. JISTA success appears to lie in its interactive nature and the shared desire to enhance recidivism-reduction services and skills.

Timeliness

As a mandate of Waiver implementation, San Diego has required all contract providers to use the county SanWITS Database. Enhancements were made to the database for the purpose of capturing the required Waiver data and providers were trained on the use of this software. Universal utilization of SanWITS allows San Diego to more fully capture and report on timeliness metrics. Development of full electronic health record (EHR) capacity is discussed in more depth in the Information Services chapter of this report.

While contract providers can enter timeliness data directly at their program sites, many are new to the standards and time frames for reporting and are thus challenged to consistently adhere to all tracking standards. Continued orientation and corrective measures are a priority for San Diego going into the second year of the Waiver in order to secure the most complete data possible. San Diego benefits from utilization of its long-term behavioral health vendor, Optum, for coverage of the Access Call Center. 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 a two percent dropped call rate from Waiver launch through March 2019. These data are provided in detailed reports that include not just the Waiver-mandated metrics, but additional clinical and program information making them

highly useful to leadership at San Diego. Since the Optum line is a combined access/crisis line, the incoming calls have the same priority as 911 calls and are given highest priority on the language line when there is a need to access an interpreter.

San Diego tracks the timeliness from initial request to first face-to-face visits and meets their standard of ten days for outpatient, and three days for opioid treatment program (OTP) services. They also track the one day requirement for residential treatment and meet this 86.6 percent of the time. The length of time from initial MAT request to first MAT appointment is also tracked, and San Diego meets the standard of three days 94.4 percent of the time. Follow up encounters post-residential treatment only meet the standard 17.33 percent of the time, with San Diego reporting that of the 3,697 discharges just 640 accessed step-down treatment in seven days. San Diego has developed an urgent request definition that is consumer-focused in that their perceived need is relevant to how the call is triaged. While time to appointment for urgent requests was established when the Waiver launched, an option to capture urgent time frames was just added to SanWITS in late February 2019 with no data available at the time of this review.

San Diego adheres to the DMC-ODS-required response time standards within 24 hours for requests for residential treatment authorizations. While authorizations are expeditious, knowing more about bed availability is important in making the best-informed referrals. Accessible capacity information is available at this time via a cloud-based program while a SanWITS vacancy application is being developed. Concerns regarding the authorization process for residential are linked to the limits that the Waiver has mandated with a cap on the number of times clients can be admitted to residential treatment. San Diego reports that this cap does not consider the large number of early drop outs by clients admitted to residential treatment, however it prioritizes the clients' clinical need by covering costs for needed treatment episodes outside of DMC if clinically indicated. Such a limitation of two allowable treatment episodes for a significant portion of admitted clients can result in lack of access for needed care. With the implementation of the Waiver, San Diego made a policy decision to locally fund additional stays that cannot be claimed to DMC to ensure that appropriate access is not denied.

Quality

Recognizing that a core element of the Waiver is quality treatment determined from a client-centered approach which includes matching treatment to a client's individual situation, San Diego conveyed this impending change to treatment providers in a stakeholder process that spanned more than two years. A strategic planning process resulted in a determination to revise the existing system by incorporating ASAM principles and ASAM Criteria-based treatment recommendations into San Diego's current assessment tool, the Addiction Severity Index (ASI). This in-house ASAM Criteria-based assessment process is currently being built into SanWITS and will be used for all clients after triage by phone call or walk-in screening when a full evaluation

for treatment is indicated. Written policies and procedures were incorporated into provider contracts that supported the need of beneficiaries to meet requirements for service at the recommended level.

While DHCS requires service authorizations for residential treatment, all other San Diego service referrals and placements are decided at the provider level. Capability is being enhanced and developed in SanWITS to more fully track authorizations, residential stays and residential treatment bed availability. Use of ASAM Criteria has fostered a level of communication between contract providers not previously seen. Programs now rely on an ability to discuss and refer incoming clients to other providers when they do not meet ASAM Criteria for their own program.

A San Diego Quality Management (QM) team composed of licensed clinical staff and Administrative Analysts was created specific to DMC-ODS and mirrors one on the mental health side, though there are overlaps for specialty populations such as youth and women. The County also has a team of licensed clinical staff as Contracting Officer Representatives (CORs) responsible for overseeing and monitoring the deliverables of contract providers. The QM team conducts chart reviews to determine overall assurance of quality care and that associated documentation meets the parameters defined by DMC for billing and by the Waiver. The team uses clinically accepted review mechanisms to be more in line with medical standards pertaining to access times, care transitions and related ASAM Criteria.

In addition to ongoing training for providers, San Diego has posted the DMC-ODS policies and procedures online which includes many quality-related requirements. Technical supports are available in person when county monitors are on-site, through the offices of quality management and an email portal that providers can utilize to get an expedient response to any technical needs. While San Diego has messaged information to its provider network early and often on the level of change implied in the Waiver, many of the providers are still challenged with full integration and implementation of changes. EHR and practice management information system capacity is a challenge for many providers in the network.

At present, over 90 percent of providers utilize paper charts and the county has set up specific thresholds that they must meet before they authorize DMC billing. At present, actual billings are lower than expected with only 44 percent of anticipated DMC recoupment being realized. Recognizing providers lacked the capability or infrastructure to move to managed care systems, San Diego continues to work through technical and charting issues in partnership with each provider. This has included an April 2019 Board of Supervisors action authorizing the addition of county general funds to assist struggling providers with fiscal advances in order to overcome unanticipated resource shortfalls and expand staffing needs. San Diego notes that the system is in a state of “start-up” transformation as it establishes new services and business practices.

Most data limitations were linked to contract providers QI/QM functionality. San Diego is planning more expansive QI clinical goals when they launch the SUD EHR online with

their providers. The goal is to launch by January 2020. It is anticipated that the EHR will help providers by streamlining document processes and treatment planning linked to claims processing. Despite these challenges, San Diego county QI has strong analytic capability in house to support quality of care efforts. Data tracking and analysis is enhanced with key partners such as Optum, University of California San Diego (UCSD), and both the County Mental Health Plan and the Medicaid Health Plan (Healthy San Diego). 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 as well as with youth. UCSD also does an additional analysis of the Treatment Perception Survey to assist San Diego with QI efforts.

Congruent with DMC-ODS Waiver principles, San Diego encourages coordination of care with mental health services and screens 100 percent of incoming clients for co-occurring disorders. Providers are not only adherent to trauma-informed principles but are certified as either Dual Diagnosis Capable or Dual Diagnosis Enhanced in alignment with the Comprehensive, Continuous Integrated System of Care model (CCISC). San Diego facilitates a train the trainer model, for which each provider must have a designee that assists in reinforcing CCSIC. Regional Collaborative meetings have sought to enhance the referral and care coordination with mental health. A care integration summit focused on behavioral health and physical health is now in its tenth year. San Diego benefits from a strong collaboration with the local health plans.

The Healthy San Diego Plan Coalition represents seven Medicaid managed care plans, and has MOU agreements with San Diego DMC-ODS. There is a coalition monthly meeting with the County of San Diego to discuss shared concerns. Many quality-related metrics are tracked and structures are in place to facilitate ongoing conversations, including a behavioral health subgroup of 130 individuals who discuss issues specific to both mental health and substance use needs. The health plan 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.

A clinical consultation phone line called Smart Care was established to assist medical providers with questions regarding medication issues and medical education options. Smart Care has expanded to include SUD, ASAM, and MAT consultation. San Diego mandated the utilization of a Coordination of Care form in 2012, and an electronic version is available and shared amongst the provider network. While a fully operational health information exchange (HIE) is being developed it remains several years away from coming online across the health care system. Federal confidentiality laws pertaining to drug treatment remain an ongoing barrier to physical health care coordination with SUD providers.

As with most counties, there is a history of stigma within the community related to the use of methadone and other addiction treatment medications. This has created barriers--actual or perceived for clients on MAT--when they attempt to access most residential and outpatient programs. While much education and resulting movement toward acceptance has occurred, resistance does remain. A provider may not express

bias against MAT, but may claim transporting of clients for dosing or storing medications is a problem. San Diego continues to address this issue with contractors through education and has added contract language requiring programs to allow MAT in an effort to utilize contractual actions if needed.

With a large system that is wholly provided through contracted programs shifting to a client centered model, addressing relapse as part of the recovery process and moving clients across the continuum has presented challenges. In focus groups held by EQRO with both line staff and provider executives, clients with co-occurring disorders were noted as being especially challenging. Training staff through the CADRE integrative training project can assist with clinical capability concerns related to clients with co-occurring disorders. This training is being provided by San Diego. Lack of basic information regarding psychiatric medications indicates the need for better communication down to line staff. While expectations are reinforced in contracts with providers, program employees report need for ongoing and specific training to enhance skills and make appropriate adjustments to programming.

San Diego has encouraged the development of MAT in order to expand their capacity to make available buprenorphine, disulfiram, and other required medications in addition to methadone. All of these medications were available in year one of service implementation at the contracted NTP locations. Care coordination efforts with physical health is an inherently complex endeavor with seven local Medicaid health plans. The Hub and Spoke grant is helping with this effort. For example, one NTP provider has eight spokes which includes five FQHC clinic sites. Behavioral health contractors are working closely with their FQHC sites in each regional area on medication, counseling, and treatments overall.

San Diego has actively participated in prevention efforts in coordination with Public Health which includes distribution of Naloxone and overdose rescue skills. Likewise, the utilization of CURES by prescribers at BHS and contractors is required and monitored. An SUD prevention manager is currently the co-chair of the PDATF which tracks key indicators over time to better understand the local factors contributing to prescription drug and heroin problems in San Diego County. These metrics are provided in the annual Rx Report Card, which was developed to provide data across multiple indicators outlining for the community the local scale of the problem and trends in San Diego over the last five years.

In recognition of the county's cultural and ethnic diversity, San Diego's current Cultural Competence Plan utilizes CLAS standards as its framework. The Plan is due for updating and it was recommended that areas specific to the SUD population be identified and incorporated in a more meaningful way. San Diego recently completed a self-assessment survey of all staff on cultural attitudes and awareness in affiliation with the Georgetown University Cultural Competence program. The survey was in depth, completed by 2672 respondents and separated out SUD and MH program staff. Targeted training will be created based on results from the report.

Also, San Diego mental health and SUD programs recently provided behavioral health support to hundreds of refugees brought in by air to San Diego County. In addition, county leadership in health services has initiated outreach to Native American tribal clinics and is working to address health disparities for the county's inmate population. Due to its unique location, San Diego engaged the City of Tijuana in mutual support efforts on youth SUD prevention specifically regarding alcohol, driving under the influence and binge drinking.

Outcomes

San Diego participated actively in the UCLA Treatment Perception Survey (TPS) and received analyses of their results from UCLA. San Diego took the additional step of compiling the results from the Adult and Youth surveys and had the University of California San Diego do additional analyses and a report on the TPS results. These reports were presented to both the program and management staff and were compiled by the Health Services Research Center (HSRC). In this first year a total of 49 program sites participated and 1591 survey forms were returned. Overall both adult and youth surveys had a high level of participation with 95 percent of the forms turned in being completed. Individual domains and overall results were quite positive, averaging 4.4 out of 5. These scores included the domains of access (4.3), outcomes (4.3), care coordination (4.2), quality of care (4.4) and general satisfaction (4.4). Of the adult clients more than 91 percent agreed or strongly agreed that they felt welcomed. Of the youth, just 71 percent reported general satisfaction though 91 percent of clients agreed or strongly agreed that staff treated them with respect. Convenience of the location of adult and youth treatment services had the highest level of dissatisfaction in the TPS survey results. The outcome domain scores for specific program sites ranged from 3.6 – 4.8, showing that all San Diego contract providers received positive scores. For adults, non-residential treatment levels of care received the most favorable results. TPS scores were consistent with the client feedback in focus groups that CalEQRO conducted, reflecting favorable impressions of treatment and positive communications with program staff.

San Diego has been transparent in the sharing of outcome and performance data specific to the DMC-ODS mandates with its utilization data dashboards. Data metrics are visualized in such a manner to communicate trends to targeted audiences such as program providers, department leadership, advisory board members, and justice partners. This type of outcome data is customized for intended recipients and distributed to key stakeholders on a monthly 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.

While San Diego has 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, some areas of concern remain. In moving to change the initial date of service to July 2018 for all clients who transitioned from state contract to a local contract, San Diego should consider seeking direction on how to reconcile any billing or

other data that could be impacted. San Diego contract monitors continue to analyze CalOMS results for each individual program with reports issued regularly.

Quality input and feedback occurs from monitoring results in a county-generated seven-point report that targets specific program sites and issues unique at that program. These are reviewed with the provider and form the basis of discussion and corrective measures as necessary. Program integrity reports are available for auditing including canned reports that exist in SanWITS to determine adherence to data timeliness, accuracy and completeness. Only services identified as meeting Medi-Cal documentation standards were authorized to submit DMC claims to San Diego's billing unit thereby limiting the ability to systematically collect and report on its DMC-ODS service utilization.

Client/Family Impressions and Feedback

CalEQRO conducted four diverse client focus groups during the onsite review: one at a program site which targets under-served Asian, Pacific Islander, Latino, Middle Eastern, African American and other ethnic populations in outpatient treatment; a second at a women's perinatal residential program, a third at a program that provides youth outpatient treatment and the fourth which was at a woman's recovery center and was primarily monolingual Spanish speaking. The purpose of these focus groups was to obtain perceptions from clients currently receiving treatment services regarding the accessibility, timeliness and quality of those services.

The focus group at the program which targets Asian, Pacific Islander and other ethnic groups reported access to treatment that was mostly expedient ranging from a few days to at most a few weeks. Clients experienced the program admission in varying ways depending on their existing circumstances which included transition from other programs, inmate services, and living out of a car. While in treatment they have appreciated sensitivity to cultural issues, housing assistance, receptivity of staff and involvement in their own treatment plans. They reported after-care planning and work readiness efforts in preparation for discharge, but believed the job services could be improved. A consistently vocalized concern was the daytime hours of operation which made it challenging to secure or retain employment.

The women's perinatal residential focus group described access as "easy" with most clients entering within a few days to a week. One client reported being admitted the day she was assessed while another reported having to wait almost three months due to a number of factors. Contract supervisor will be following up on this three-month case to identify the obstacles. Most participants shared that they felt very comfortable with counselors, that MAT is discussed as an option if needed, and that they felt included in decisions regarding their treatment. However, clients shared concerns related to the abrupt and recent departure of multiple staff. This impacted their access to face to face counseling and led to cancellation of groups. They recommended the program have more structure, a consistent schedule of activities

and help for the remaining counselors who appeared to be under a great deal of stress. EQRO staff discussed these important issues with San Diego staff who immediately dispatched the contract monitor to the site to help resolve these issues.

The youth outpatient focus group described access as “fast” with some clients arriving within hours of a referral to a few days wait. While most of the participants remarked that they were only in the program because of a court mandate, they liked the counselors who they described as respectful and “don’t pretend.” They also stated that they liked the individual sessions and an opportunity to talk with people they can trust and open up to. Clients reported program expectations regarding tardiness, attendance, drug testing and participation to be consistent with programs that are a condition of probation. They did believe that programs could be improved with different hours and more locations as many struggled to arrive on time from school or due to lack of transportation.

The fourth focus group was at a woman’s outpatient program in south county and was conducted in Spanish with a translator. All participants have been in treatment for less than a year and described access as quick with most waiting only a few days to a week. While in treatment they have appreciated sensitivity to cultural and family issues, state the counselors are “always there” for them and seen as caring and supportive. Participants reported that they find staff to be very attentive to their needs when they have a crisis and provide direction on accessing social, medical, housing and legal issues. They uniformly stated that medication was not discussed at this program. Clients stated that the program could be improved by extending into evening hours and by creating more opportunities for them to connect with each other as they sometimes feel alone in their efforts to recover.

Details of all groups were discussed with the San Diego staff to enhance the quality of the services and follow up on concerns.

Recommendations

In the conclusion section, 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 31 of those counties, and EQRO has scheduled each of them for review.

This report presents the FY 2018-19 EQR findings of San Diego's CY 2018 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 twelve PMs include:

- Total beneficiaries served by each county DMC-ODS;
- Number of days to first face-to-face DMC-ODS service after referral;
- Total costs per beneficiary served by each county DMC-ODS;
- Cultural competency of DMC-ODS services to beneficiaries;
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors are validated for access;

[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.

- Coordination of Care with physical health and mental health;
- Timely access to medication for narcotic treatment program (NTP) services;
- Timely access and numbers of beneficiaries accessing non-methadone MAT;
- Timely transitions in levels of care (LOC) after residential treatment in year one of the Waiver;
- 24-hour access call center line availability to link prospective clients to ASAM assessments and treatment;
- Identification and coordination of the special needs of high-cost beneficiaries (HCB);
- Percentage of clients with three or more Withdrawal Management (WM) episodes and no other treatment to improve engagement.

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 first 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.calegro.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,

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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.

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 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.

Examples of the CalEQRO Client Focus Group Forms are included in Attachments to this report.

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.

This means looking at the research-linked programs and special terms and conditions (STCs) of the Waiver as they relate to best practices, enhancing access to MAT, developing and supervising a competent and skilled workforce with ASAM 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.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Past Year's Initiatives and Accomplishments

- San Diego implemented system changes to align with requirements of the DMC-ODS as outlined in the Waiver STCs, Implementation Plan, DHCS-County Intergovernmental Agreement and DHCS Information Notices, as applicable.
- In preparation for the Waiver, San Diego provided training for its providers with topics that ranged from anticipated clinical adjustments to a variety of administrative needs and billing under DMC.
- Contract changes were made in order to address certification, workforce and billing requirements along with establishment of requirements for reporting and for use of the SanWITS data base.
- San Diego established a Quality Management team in order to assure that new program models and required services are monitored to meet parameters of the Waiver and to ensure that any training opportunities are identified.
- Changes in the SanWITS data base were achieved in order to meet the necessary billing, reporting and oversight requirements of DMC-ODS.
- In coordination with the Hub & Spoke program and local health plans, San Diego has continued to work on enhancing access to MAT through linkages with local emergency rooms, and various local FQHCs. SUD prevention efforts assist in the messaging to the local community and there is a partnership with public health to support the distribution of naloxone.
- San Diego's access line operated by Optum assumed responsibility for reviewing and responding to calls for services, linkages to providers and 24-hour authorizations for residential substance use treatment services.
- San Diego administered the TPS and outcomes measures as required. Results of the TPS are in use as a primary data source to evaluate client satisfaction and therapeutic alliance. Their high scores are consistent across the system and within their entire provider continuum and these are shared with their providers and workforce. San Diego has used the results to create attractive reports for quality improvement purposes. The two new measurement systems were launched statewide for use in each county's DMC-ODS services. For more information about CalOMS and about the two new measurement tools, 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

- Continued expansion of MAT services is a priority and San Diego is actively providing technical assistance and guidance to legal entities interested in providing additional MAT services through their established, DMC-certified SUD outpatient programs. The local opioid treatment programs are currently offering additional MAT services through their NTP license.

- San Diego has taken meaningful steps to further enhance collaboration with their criminal justice partners and to overcome any likely communication issues given the level and complexity of change implied by the Waiver. San Diego sough feedback from the District Attorney's Office, the Sheriff, the Public Defender's Office, Probation and the Courts prior to DMC-ODS implementation to ensure that they had the opportunity to address concerns in a proactive way. A special work-group was convened from an already-existing Health and Justice Integration Committee (HJIC) to specifically analyze and address issues that the new DMC-ODS might raise. In addition to creating a single point of contact to assist justice partners with any problems in real time, monthly meetings are underway with the office of the court and Justice Enhanced Treatment (JET) providers to discuss challenges.

- San Diego is continuing the enhancement of their recovery residences in part by fostering and supporting development of the RRA to provide oversight and support for local Recovery Residences and their proprietors, owners, and clients. Through this partnership, San Diego is working to ensure the highest quality of living environment and to address through the RRA any issues that may arise.

- The RRA work team, consisting of Behavioral Health Services, Justice Partners, treatment providers and housing providers developed an application process (including a membership course and Peer Review) and quality standards that were finalized in January 2019. Since January 2019, RRA has successfully enrolled 10 member homes (total of 107 beds) and hopes to continue to add new association members in the coming year.

- San Diego has a plan to continue SanWITS data base development which includes a process to track appointment availability through a Third Next

Available Appointment data field. San Diego's management information systems (MIS) unit has worked with their MIS vendor to develop new data fields in SanWITS to collect the 2nd and 3rd next available appointments for indication in the Intake/Screening/Assessment field and the 2nd and 3rd next available appointments for the Treatment field. These fields are being tested and are expected to be deployed to the production site by May 31, 2019.

- San Diego has developed and seeks to continue expansion of its peer training plan and curricula. SUD Peer Support Services (PSS) is a system of mentorship and advocacy designed to support the beneficiary as they progress through their individualized treatment plan. The Peer Support Specialist uses a person-centered process to engage and empower the beneficiary. This proactive involvement gives the beneficiary someone to connect with, assists with the development of life skills, and encourages successful outcomes. All PSS staff must meet the necessary training requirements to obtain their designation. All Peer Support Specialists operate under direct supervision at the same program site as the client.

- San Diego MIS is actively working with FEI to fully develop an EHR for the DMC-ODS. Assessments are being created in accordance with the County's paper forms that are currently in use. An enhanced electronic Treatment Plan form will be available along with a clinical dashboard list for easy access to clients and documents that need addressed/signed. A Consent and Referral module with updated consent language will be added for referring and releasing client information between providers within SanWITS. MIS is anticipating piloting these new features in October 2019.

- San Diego is planning to launch an online capacity list which will allow programs to see the availability of other SUD programs across the system of care in SanWITS. This will assist with client referrals, eliminating wait time, and allowing the client to enter treatment as soon as possible.

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 will be 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 year two 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.

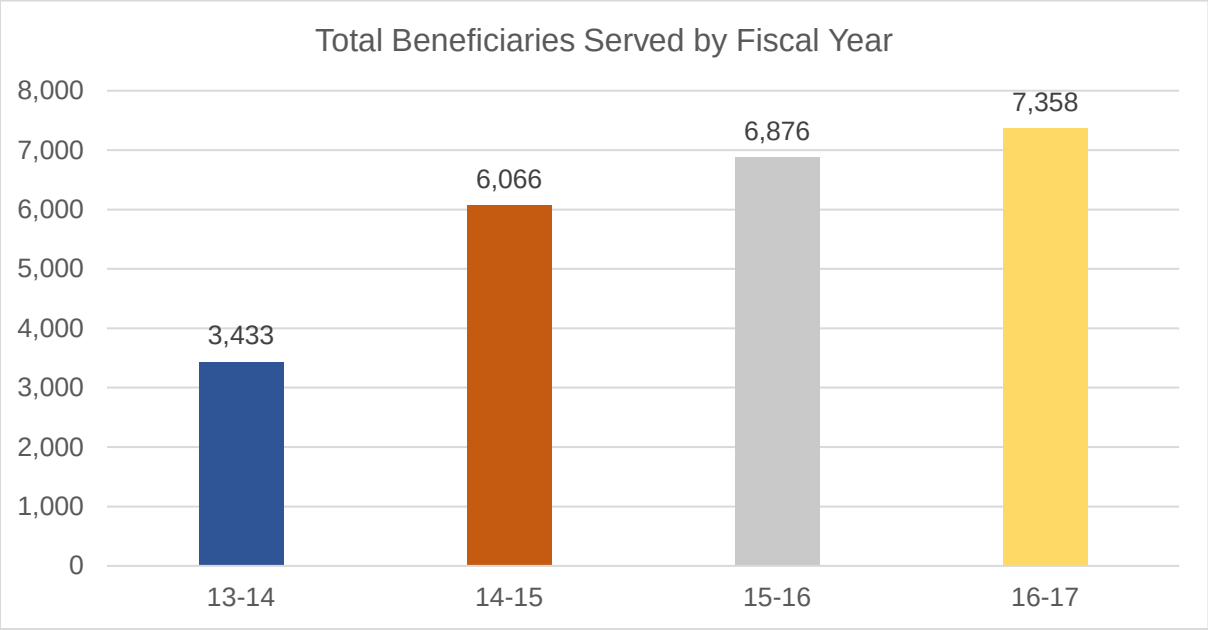
HIPAA Guidelines for Suppression Disclosure:

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 (-).

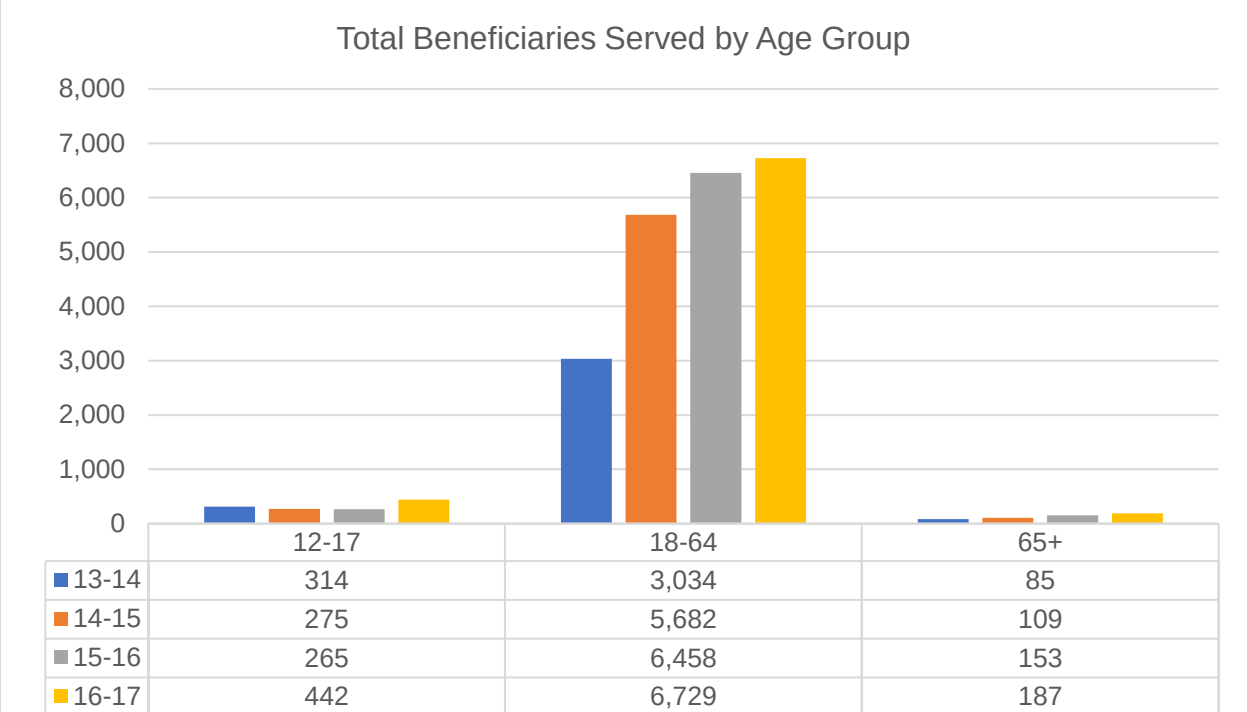
Baseline PM Data for San Diego Prior to the DMC-ODS Waiver

To evaluate the impact of the DMC-ODS Program and Waiver, baseline data for four prior FYs was analyzed both statewide and for each DMC-ODS County. The next seven graphs display several data trends for those years. Table 1 displays the total number of beneficiaries served. Tables 2-6 display number of beneficiaries served by age, by gender, by race/ethnicity, by service category, and by eligibility category. Table 7 displays the average approved claims by eligibility category.

B Table 1-Total Beneficiaries Served



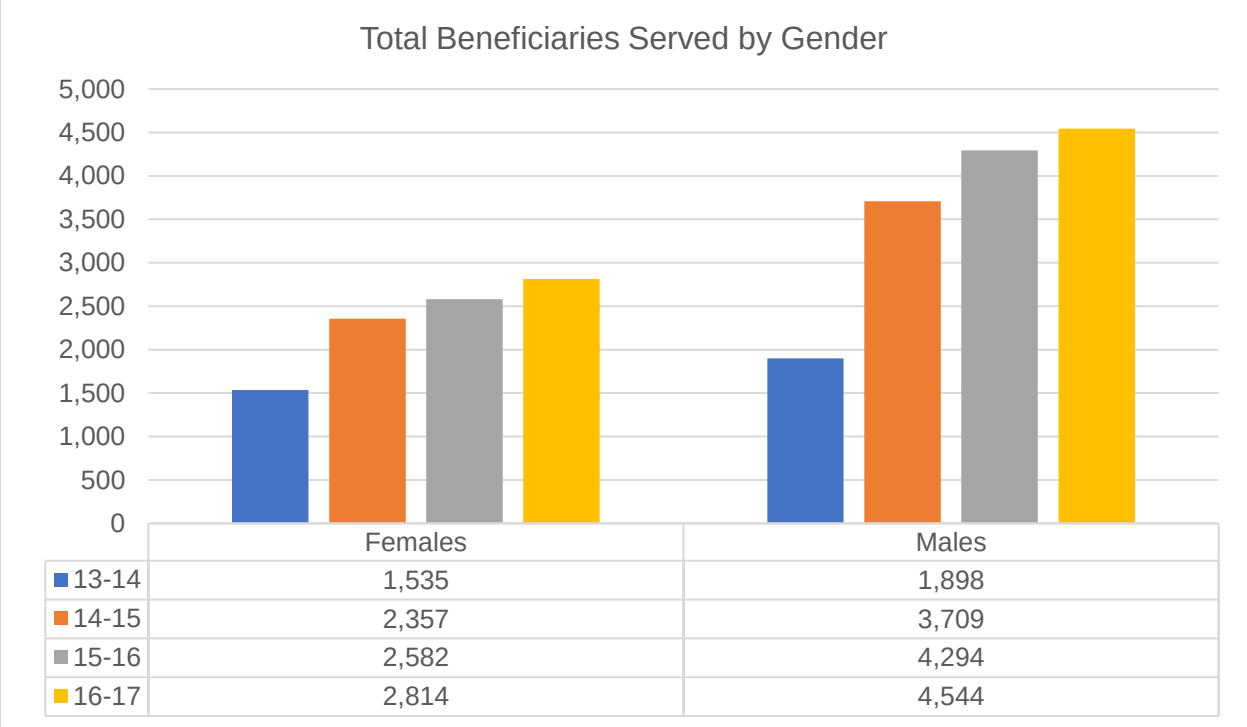
B Table 2 – Total Beneficiaries Served by Age



	12-17	18-64	65+
13-14	314	3,034	85
14-15	275	5,682	109
15-16	265	6,458	153
16-17	442	6,729	187

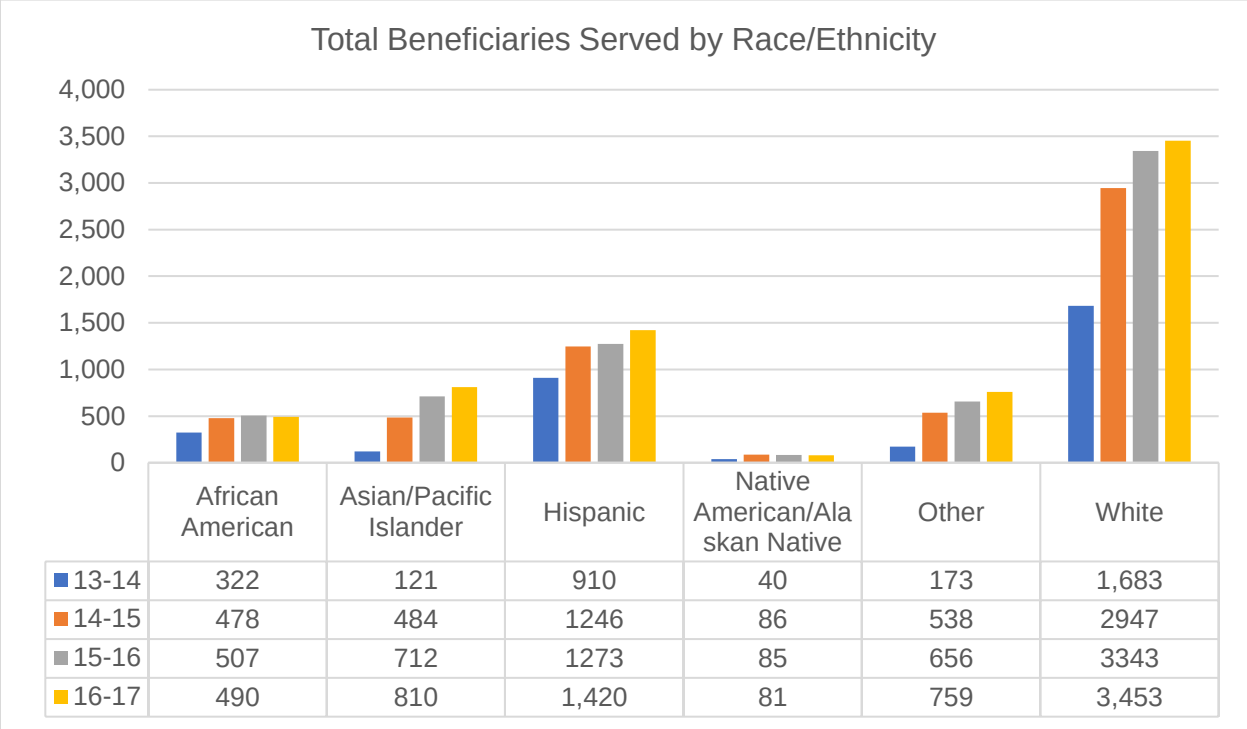
Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

B Table 3 – Total Beneficiaries Served by Gender



	Females	Males
13-14	1,535	1,898
14-15	2,357	3,709
15-16	2,582	4,294
16-17	2,814	4,544

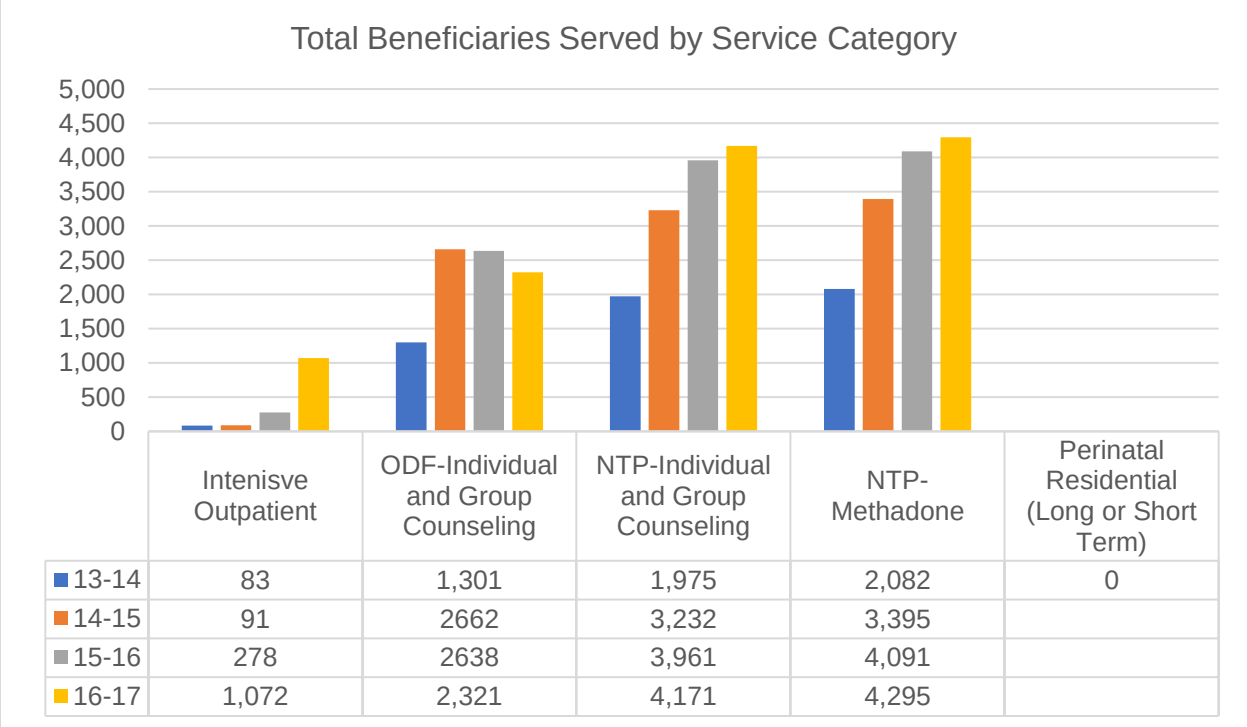
B Table 4 – Total Beneficiaries Served by Race/Ethnicity



	African American	Asian/Pacific Islander	Hispanic	Native American/Alaskan Native	Other	White
13-14	322	121	910	40	173	1,683
14-15	478	484	1246	86	538	2947
15-16	507	712	1273	85	656	3343
16-17	490	810	1,420	81	759	3,453

Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

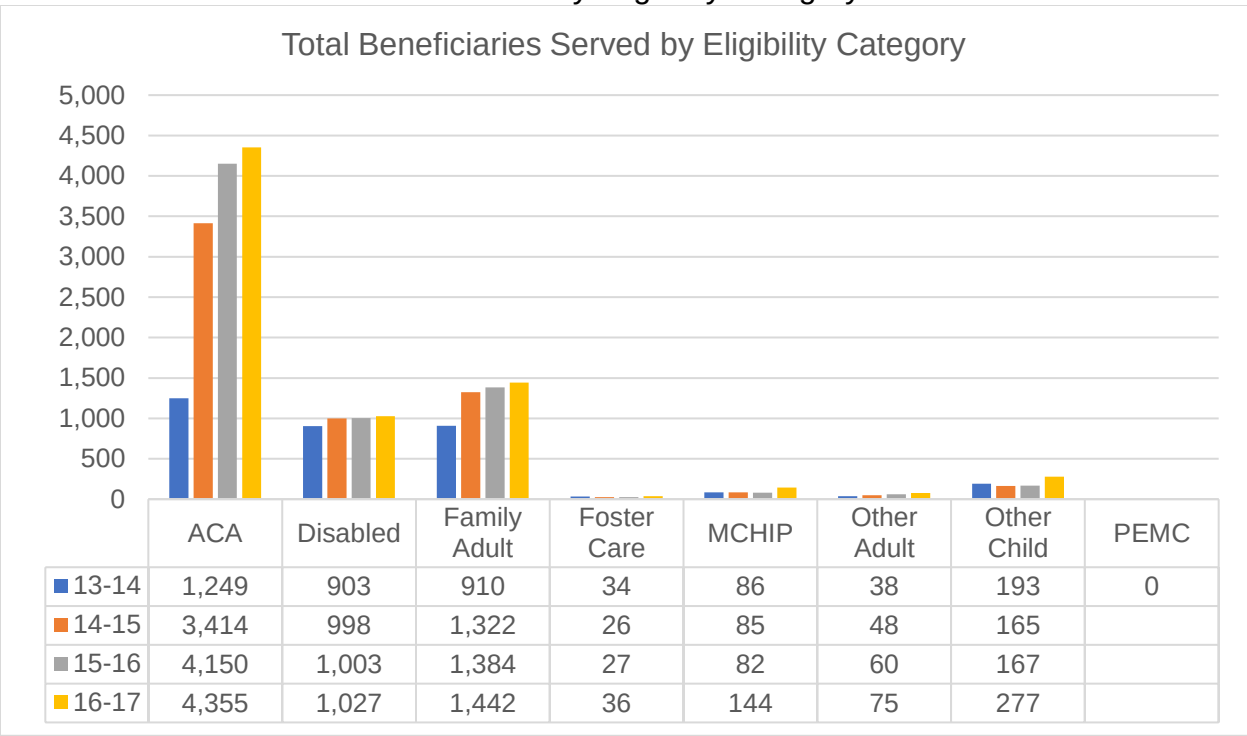
B Table 5 – Total Beneficiaries Served by Service Category



	Intenisve Outpatient	ODF-Individual and Group Counseling	NTP-Individual and Group Counseling	NTP-Methadone	Perinatal Residential (Long or Short Term)
13-14	83	1,301	1,975	2,082	0
14-15	91	2662	3,232	3,395	
15-16	278	2638	3,961	4,091	
16-17	1,072	2,321	4,171	4,295	

Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

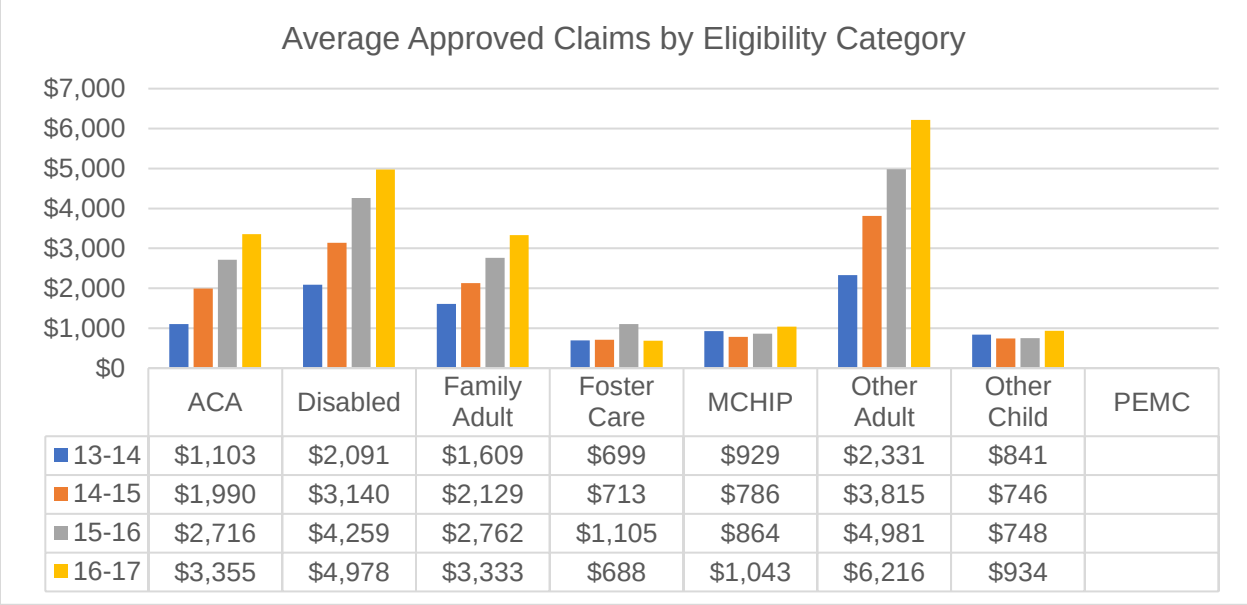
B Table 6 – Total Beneficiaries Served by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	MCHIP	Other Adult	Other Child	PEMC
13-14	1,249	903	910	34	86	38	193	0
14-15	3,414	998	1,322	26	85	48	165	
15-16	4,150	1,003	1,384	27	82	60	167	
16-17	4,355	1,027	1,442	36	144	75	277	

In the above table, ACA is Affordable Care Act; PEMC is pregnancy/emergency/minor consent.

B Table 7 – Average Approved Claims by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	MCHIP	Other Adult	Other Child	PEMC
13-14	$1,103	$2,091	$1,609	$699	$929	$2,331	$841	
14-15	$1,990	$3,140	$2,129	$713	$786	$3,815	$746	
15-16	$2,716	$4,259	$2,762	$1,105	$864	$4,981	$748	
16-17	$3,355	$4,978	$3,333	$688	$1,043	$6,216	$934	

Discussion of Baseline Data Trends and Implications

Overall access increased steadily during the four prior fiscal years due to several key factors. Primary among them was changes in Medi-Cal eligibility through the Affordable Care Act (ACA) that began in January 2014. Prior to the ACA, Medi-Cal eligibility was based upon both poverty-level with children and disability Criteria. Disabilities based upon either physical health or MH conditions would qualify, but not disabilities based upon SUD. Counties had to find other sources of funding for most of their beneficiaries with SUDs.

Prior to the Waiver, SUD treatment services covered by DMC were limited to a narrow range of services including narcotic replacement therapy with counseling, outpatient group counseling, IOT, and perinatal residential treatment. Case management, recovery support, residential treatment, and WM were not covered under the state Medicaid plan.

The Waiver expanded coverage to include several levels of WM, several levels of residential treatment, case management, recovery support services, partial hospitalization, MAT for all addiction medications, and physician consultation.

Year 1 of Waiver Services

DMC–ODS Clients Served in CY 2018

Table 1 represents the number of clients who were provided service and successfully billed under DMC. Due to lag times in claims submissions, the data does not provide complete information on the total number of clients served by San Diego. Also, and more significantly, San Diego's documentation and billing policies during the first year of implementation led to an unintended understatement of their delivery of DMC-ODS services as reflected by claims data. San Diego had decided not to allow treatment programs to submit DMC claims to San Diego's billing unit during the first year of DMC-ODS implementation if they were not able to demonstrate their ability to meet documentation standard thresholds. The data limitations may also influence the indicated percentages served by race/ethnicity.

Table 1 – Clients Served by Race/Ethnicity, CY 2018

DMC-ODS Eligibles and Clients Served by Race/Ethnicity, San Diego				
Race/Ethnicity	**Average Monthly Unduplicated DMC-ODS Eligibles**	**% Eligibles**	**Unduplicated Annual Count of Clients Served**	**% Clients Served**
White	146,854	21.9%	2,013	44.9%
Latino/Hispanic	265,095	39.6%	1,094	24.4%
African-American	40,692	6.1%	270	6.0%
Asian/Pacific Islander	61,369	9.2%	70	1.6%
Native American	3,012	0.4%	57	1.3%
Other	152,967	22.8%	983	21.9%
Total	**669,987**	100.0%	**4,487**	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).

Penetration Rates and Approved Claim Dollars per Beneficiary

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.

Regarding calculation of penetration rates, San Diego uses the same method used by CalEQRO.

CY 2018 Table 2 shows San Diego's penetration rates overall and by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties. The rates are similar to, although slightly higher than the statewide average. Since San Diego's utilization is understated for reasons already discussed, it may be that the actual penetration rate was substantially higher.

Table 2 – Penetration Rates by Age, CY 2018

Penetration Rates by Age CY 2018				
	San Diego			Statewide
Age Groups	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Total	669,987	4,487	0.67%	0.59%
Age Group 12-17	102,176	184	0.18%	0.14%
Age Group 18-64	485,111	3,733	0.77%	0.71%
Age Group 65+	82,701	570	0.69%	0.49%

Table 3 below shows San Diego 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.

Table 3 – Average Approved Claims by Age, CY 2018

Average Approved Claims by Age CY 2018			
	San Diego		Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Total	$5,258,672	$1,172	$3,344
Age Group 12-17	$216,650	$1,177	$1,194
Age Group 18-64	$4,303,110	$1,153	$3,522
Age Group 65+	$738,912	$1,296	$2,640

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.

Table 4 – Clients Served and Penetration Rates by Eligibility Category, CY 2018

Clients Served and Penetration Rates by Eligibility Category CY 2018				
	San Diego			Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	71,280	795	1.12%	1.10%
Foster Care	1,198	19	1.59%	1.18%
Other Child	61,586	120	0.19%	0.15%
Family Adult	134,813	847	0.63%	0.57%
Other Adult	88,838	79	0.09%	0.06%
MCHIP	45,274	53	0.12%	0.10%
ACA	265,097	2,622	0.99%	0.92%

Table 5 below shows San Diego's approved claims by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. 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. Expansion of services to youth is an important focus of San Diego with their expanded residential and outpatient services.

Table 5 – Average Approved Claims by Eligibility Category, CY 2018

Average Approved Claims by Eligibility Category CY 2018				
	San Diego			Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	71,280	795	$1,228	$2,621
Foster Care	1,198	19	$630	$966
Other Child	61,586	120	$1,223	$1,098
Family Adult	134,813	847	$1,054	$2,888
Other Adult	88,838	79	$1,180	$2,513
MCHIP	45,274	53	$1,140	$1,504
ACA	265,097	2,622	$1,174	$3,730

Asterisks in the preceding Table 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.

Average number of days indicated below for San Diego client beneficiaries indicate they are able to access care in a timely manner, on average within one (1) day of diagnosis/assessment.

Table 6 –Days to First Dose of Methadone by Age, CY 2018

Days to First Dose of Methadone by Age CY 2018						
Age Groups	San Diego			Statewide		
	Clients	%	Avg. Days	Clients	%	Avg. Days
Total Count	3,077	100%	<1	24,937	100%	1.2
Age Group 12-17	1	0.0%	<1	5	0.1%	<1
Age Group 18-64	2544	82.7%	<1	19,705	79.0%	1.5
Age Group 65+	532	17.3%	<1	5,227	21.0%	<1

Table 7 – Days to First Dose of Methadone by Race/Ethnicity, CY 2018

Days to First Dose of Methadone by Race/Ethnicity CY 2018						
Race/Ethnicity	San Diego			Statewide		
	Clients	%	Avg. Days	Clients	%	Avg. Days
Total Count	3,077	100%	<1	24,937	100.0%	1.2
White	1531	49.8%	<1	10,731	43.0%	1.5
Hispanic/Latino	693	22.5%	<1	6,807	27.3%	1.2
African-American	132	4.3%	<1	3,010	12.0%	<1
Asian Pacific Islander	36	1.2%	<1	330	0.1%	<1
Native American	38	1.2%	<1	181	0.07%	<1
Other	647	21.0%	<1	3,878	15.6%	1.0

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).

Services for Non-Methadone MAT 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 MAT 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 MAT in other settings additional to their delivery in NTPs. Medical providers are required to receive specialized training before they prescribe some of these medications, and many feel the need for further clinical consultation once they begin prescribing. Consequently, physician uptake throughout most counties throughout the state tends to be slow.

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

Tables 8 and 9 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.

Table 8 – Three or more DMC-ODS Non-Methadone MAT Services by Age, CY 2018

Non-Methadone MAT Services, by Age CY 2018										
Age Groups	San Diego					Statewide				
	# of Clients	At Least 1 Srv	% At Least 1 Srvs	3 or More Srvs	% 3 or More Srvs	# of Clients	At Least 1 Service	% At Least 1 Srvs	3 or More Srvs	% 3 or More Srvs
Total	4,487	75	1.67%	54	1.20%	59,549	1,581	2.7%	676	1.1%
Age Group 12-17	184	1	0.54%	0	0.00%	2,195	2	0.1%	0	0%
Age Group 18-64	3,733	69	1.85%	49	1.31%	50,344	1,472	2.9%	636	1.3%
Age Group 65+	570	5	0.88%	5	0.88%	6,172	93	1.5%	39	0.6%

Table 9 – Three or more DMC-ODS Non-Methadone MAT Services by Race/Ethnicity, CY 2018

Non-Methadone MAT Services CY 2018										
Race/ Ethnicity	San Diego					Statewide				
	# of Clients	At Least 1 Srvs	% At Least 1 Srvs	3 or More Srvs	Srvs	# of Clients	At Least 1 Srvs	% At Least 1 Srvs	3 or More Srvs	% 3 or More Srvs
Total	4,487	75	1.67%	54	1.20%	59,549	1,581	2.7%	676	1.1%
White	2,013	44	2.2%	29	1.44%	22,503	882	3.9%	409	1.8%
Hispanic/Latino	1,094	11	1.0%	7	0.6%	20,284	318	1.6%	112	0.6%
African-American	270	2	0.74%	2	0.7%	6,765	82	1.2%	22	0.3%
Asian Pacific Islander	70	2	2.9%	2	2.9%	1,083	24	2.2%	12	1.1%
Native American	57	0	0.0%	0	0.0%	406	10	2.5%	5	1.2%
Other	4,487	75	1.67%	54	1.20%	59,549	1,581	2.7%	676	1.1%

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).

Transitions in Care Post-Residential Treatment – CY 2018

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 10 and Table 11 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 10 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. Table 11 shows similar information from the perspective of statewide data for DMC-ODS counties. 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, 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.

Table 10 denotes that timely transitions by San Diego are well below those in the statewide data set. However, it should be noted that limitation in San Diego's DMC billing data accounts for an incomplete picture.

Table 10 – Timely Transitions in Care Following Residential Treatment San Diego, CY 2018

	San Diego Transitions in Care Following Residential Treatment CY 2018								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%
Within 7 days	0	0	0.0%	65	1	1.5%	0	0	0.0%
Within 14 days	0	0	0.0%	65	3	4.6%	0	0	0.0%
Within 30 days	0	0	0.0%	65	4	6.2%	0	0	0.0%
Any days	0	0	0.0%	65	4	6.2%	0	0	0.0%
Total Transfer Admits Post-Residential	0	0	0.0%	65	4	6.2%	0	0	0.0%

Table 11 – Timely Transitions in Care Following Residential Treatment Statewide, CY 2018

	Statewide Transitions in Care Following Residential Treatment CY 2018								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%
Within 7 Days	156	4	2.5%	11,999	787	6.6%	328	16	4.9%
Within 14 Days	156	7	4.5%	11,999	1,087	9.1%	328	21	6.4%
Within 30 Days	156	8	5.1%	11,999	1,363	11.4%	328	29	8.8%
Any days	156	15	9.6%	11,999	1,842	15.6%	328	34	10.4%
Total Follow-Up, Post Residential	156	15	9.6%	11,999	1,842	15.6%	328	34	10.4%

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). Youth follow up reflected small numbers in residential.

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUD 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 access 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 perceived 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 12 shows Access Line critical indicators from July 1, 2018 through March 31, 2019. For the Access Line Key Indicator form, please refer to Attachment F.

Table 12 – Access Line Critical Indicators, FY 2018-19

San Diego Access Line Critical Indicators 7/1/2018 through 3/31/2019	
Average Volume	485 calls per month
% Dropped Calls	2%
Time to answer calls	<17 seconds
Monthly authorizations for residential treatment	688
% of calls referred to a treatment program for care, including residential authorizations	82% of callers are linked to treatment through the Access Line
Non-English capacity	32% of FTE Access Line staff are bilingual (English/Spanish) and San Diego ALC vendor has contracts with language line services

High-Cost Beneficiaries

Table 13a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services. 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 $9,931 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.

Table 13a – High Cost Beneficiaries by Age, San Diego, CY 2018

San Diego High Cost Beneficiaries CY 2018						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	4,487	5	0.1%	$40,319	$201,597	100.0%
Age Group 12-17	184	0	0.0%	$0	$0	0.0%
Age Group 18-64	3,733	5	0.1%	$40,319	$201,597	100.0%
Age Group 65+	570	0	0.0%	$0	$0	0.0%

Table 13b – High Cost Beneficiaries by Age, Statewide, CY 2018

Statewide High Cost Beneficiaries CY 2018						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	59,549	3,830	6.4%	$19,250	$73,729,320	100%
Age Group 12-17	2,195	16	0.7%	$19,351	$216,273	0.2%
Age Group 18-64	50,344	3,633	7.2%	$19,351	$70,300,917	96.4%
Age Group 65+	6,172	181	3.0%	$17,747	$3,212,130	3.3%

Table 14a – High Cost Beneficiaries by Race/Ethnicity, San Diego, CY 2018

San Diego High Cost Beneficiaries CY 2018						
Race/ Ethnicity	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	4,487	5	0.1%	$40,319	$201,597	100.0%
White	2,013	2	0.1%	$75,287	$150,573	30.9%
Hispanic/Latino	1,094	3	2.0%	$17,008	$51,024	69.1%
African-American	270	0	0.0%	$0	$0	0.0%
Asian Pacific Islander	70	0	0.0%	$0	$0	0.0%
Native American	57	0	0.0%	$0	$0	0.0%
Other	983	0	0.0%	$0	$0	0.0%

Table 14b – High Cost Beneficiaries by Race/Ethnicity Statewide, CY 2018

Statewide High Cost Beneficiaries CY 2018						
Race/ Ethnicity	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	59,549	3,830	6.4%	$19,250	$73,729,320	100%
White	22,503	1,597	7.1%	$20,667	$33,005,813	44.8%
Hispanic/Latino	20,284	1,383	6.8%	$17,772	$24,578,929	33.3%
African-American	6,765	373	5.5%	$20,172	$7,524,188	10.2%
Asian Pacific Islander	1,083	69	6.4%	$18,109	$1,249,532	1.7%
Native American	406	24	5.9%	$18,699	$448,774	0.6%
Other	4,289	283	6.6%	$14,773	$4,180,790	9.4%

Withdrawal Management with No Other Treatment

This PM intends to measure engagement after WM for beneficiaries with no other DMC-ODS treatment services for their SUD. The goal is to track levels of engagement for a high-risk group of clients who are using only WM. As discussed previously, incomplete Medi-Cal claims data resulted in an understatement of actual services delivered.

Table 15 – Withdrawal Management with No Other Treatment by Age, CY 2018

Withdrawal Management with No Other Treatment by Age CY 2018				
	San Diego		**Statewide**	
Age Groups	**# WM Clients**	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
Total	7	0.0%	3,152	1.7%
Age Group 12-17	0	0.0%	3	0.0%
Age Group 18-64	7	0.0%	3,023	1.62%
Age Group 65+	0	0.0%	126	2.38%

Table 16 – Withdrawal Management with No Other Treatment by Race/Ethnicity, CY 2018

Withdrawal Management with No Other Treatment by Race/Ethnicity CY 2018				
	San Diego		Statewide	
Race/Ethnicity	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	7	0.0%	3152	1.65%
White	2	0.0%	1617	2.0%
Hispanic/Latino	4	0.0%	964	1.2%
African-American	0	0.0%	217	0.9%
Asian Pacific Islander	0	0.0%	39	0.0%
Native American	0	0.0%	18	0.0%
Other	1	0.0%	297	1.7%

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).

Diagnostic Categories

Table 17 summarizes the diagnostic billing codes used statewide by DMC-ODS counties to identify diagnostic groups with SUDs.

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 CY 2018. Opioids, alcohol, and stimulants were the most prominent types of SUDs addressed by San Diego's DMC-ODS treatment providers. However, many types of treatment providers had yet to submit their claims, with the main exception being the NTPs; two-thirds of the approved and pended claims at the time of this review were submitted by them. Since the NTPs almost entirely serve clients whose primary SUD is an opioid use disorder, the results in this table show an inordinately high rate of opioid use disorders among the clients for whom claims were submitted. In contrast, as shown on page 128 of this report, San Diego reports their clients' primary drug of choice to be methamphetamine (33 percent), alcohol (26 percent) and heroin (24 percent). These results are derived from CalOMS admission data based on clients' self-report.

Table 17 – Diagnosis Codes

Diagnosis Category – ICD 10	Diagnosis Codes
Alcohol Use Disorder	F1010, F10120, F10129, F1020, F1021, F10220, F10229, F10230, F10239, F10920, F10929
Cannabis Use	F1210, F12120, F12129, F1220, F1221, F12220, F12229, F1290, F12920, F12929
Cocaine Abuse or Dependence	F1410, F14120, F14129, F1420, F1421, F14220, F14229, F1423, F1490, F14920, F14929
Hallucinogen Dependence or Unspecified	F1610, F16120, F16129, F1620, F1621, F16220, F16229, F1690, F16920, F16929
Inhalant Abuse/Dependence/Unspecified	F1821, F1810, F18120, F18129, F1820, F18220, F18229, F1890, F18920, F18929
Opioid	F1110, F11120, F11129, F1120, F1121, F11220, F11229, F1123, F1190, F11920, F11929, F1193
Other Stimulant Abuse/Dependence	F1510, F15120, F15129, F1520, F1521, F15220, F15229, F1523, F1590, F15920, F15929, F1593
Other Psychoactive Substance	F1910, F19120, F19129, F1920, F1921, F19220, F19229, F19230, F19239, F1990, F19920, F19929
Sedative, Hypnotic Abuse/Dependence	F1310, F13120, F13129, F1320, F1321, F13220, F13229, F13230, F13239, F1390, F13920, F13921, F13929, F13930, F13939

Table 18 – Percentage Served and Average Cost by Diagnosis Code, CY 2018

Diagnosis Codes	San Diego Average Cost		Statewide	
	% Served	Average Cost	% Served	Average Cost
Total	100%	$671	100%	$3,734
Alcohol Use Disorder	4.3%	$3,064	14.4%	$4,989
Cannabis Use	0.9%	$934	7.3%	$2,042
Cocaine Abuse or Dependence	0.6%	$1,628	2.6%	$4,471
Hallucinogen Dependence	0.0%	$0.0	0.5%	$3,731
Inhalant Abuse	0.0%	$0.0	0.0%	$6,031
Opioid	91.0%	$513	49.0%	$3,380
Other Stimulant Abuse	2.5%	$2,101	24.7%	$4,097
Other Psychoactive Substance	0.03%	$125	1.3%	$3,224
Sedative, Hypnotic Abuse	0.03%	$174	0.5%	$5,926

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

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.

Due to reported submission errors from San Diego, no findings were available from UCLA at the time of this report.

Table 19 - Congruence of Level of Care Referrals with ASAM Findings, FY 2017-18

San Diego ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
If assessment-indicated LOC differed from referral, then reason for difference	#	%	#	%	#	%
Not Applicable - No Difference						
Patient Preference						
Level of Care Not Available						
Clinical Judgement						
Geographic Accessibility						
Family Responsibility						
Legal Issues						
Lack of Insurance/Payment Source						
Other						
Total						

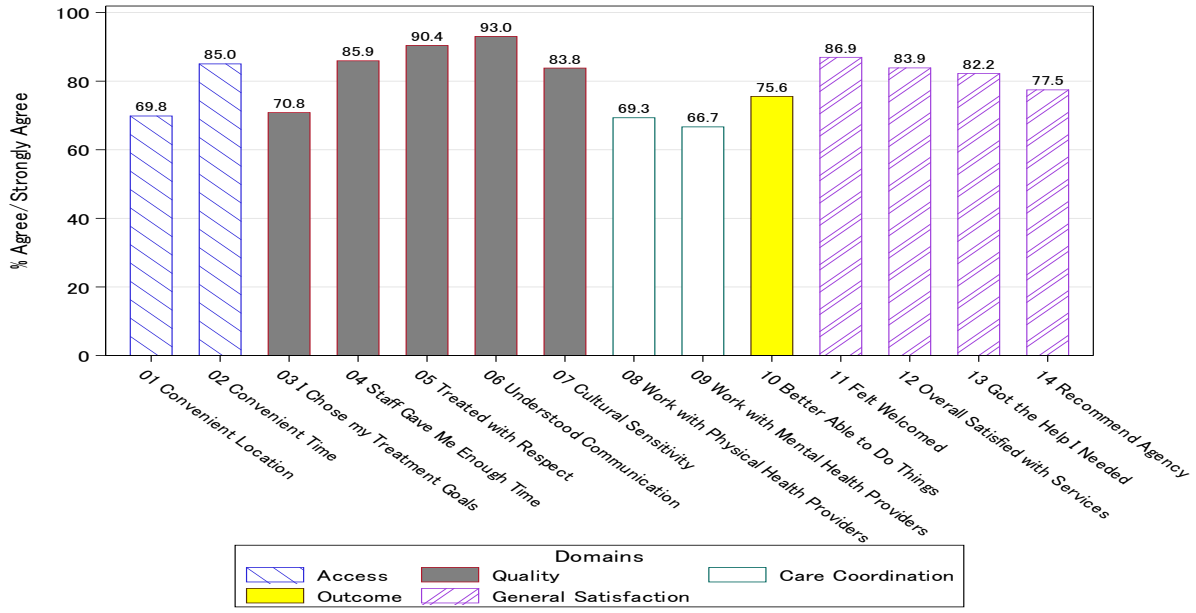
Client Perceptions of Their Treatment Experience

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.

Client ratings for San Diego were high across all domains. The ratings for the Care Coordination domain were somewhat lower than the other four domains, which is consistent with results in other DMC-ODS counties reviewed thus far. San Diego is

actively attempting to improve its care coordination services. There are additional quality improvement opportunities acknowledged by San Diego as it continues to review the program-specific results, which can indicate differences in performance not apparent when reviewing the overall results.

Figure 8 - Percentage of Participants with Positive Perceptions of Care, San Diego, TPS Results from UCLA



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 20-22 are based upon data collected at admission, and indicate that San Diego's clients on average are experiencing greater challenges in key areas of functioning--such as housing and criminal justice involvement—than the average for clients across all DMC-ODS counties statewide.

Table 20 indicates that 30.5 percent of incoming clients are struggling with homelessness compared to 24.5 percent statewide. Similarly, clients assigned to a dependent living situation are more prevalent in San Diego at 36.8 percent as compared to 30.7 percent statewide for all DMC-ODS counties combined.

Table 21 denotes that San Diego clients have more involvement in criminal justice at admission with 42.4 percent of incoming clients assigned to AB 109 compared to 32.5 percent statewide. Likewise, clients with no criminal justice involvement in San Diego is

just 49.7 percent, while other DMC-ODS counties in the state caseload is 57.9 percent with no court involvement.

Table 22 San Diego admission data indicates a large percentage (79 percent) of clients are struggling with unemployment-related issues, much the same as the statewide average for clients in DMC-ODS counties. However, the distribution in San Diego is different, with 34 percent looking for work as compared to 27.3 percent statewide. This suggests that, with treatment for their SUD and assistance with their job searches, many of these clients may find employment that can aid in their recovery journey.

Table 20: CalOMS Admission Living Status, San Diego and Statewide, CY 2017

CalOMS CY 2017				
Admission Living Status	**San Diego**		**Statewide**	
	#	%	#	%
Homeless	2,126	30.5%	18,637	24.5%
Dependent Living	2,561	36.8%	23,355	30.7%
Independent Living	2,278	32.7%	33,971	44.7%
Total	6,965	100.0%	75,963	100.0%

Table 21 – CalOMS Legal Status on Admission, San Diego and Statewide, CY 2017

CalOMS CY 2017				
Admission Legal Status	**San Diego**		**Statewide**	
	#	%	#	%
No Criminal Justice Involvement	3,465	49.7%	43,955	57.9%
Under Parole Supervision by CDCR	214	3.1%	1,966	2.6%
On Parole from any other jurisdiction	58	0.8%	863	1.1%
Post release supervision - AB 109	2,954	42.4%	24,684	32.5%
Court Diversion CA Penal Code 1000	109	1.6%	1,328	1.7%
Incarcerated	4	0.06%	696	0.9%
Awaiting Trial	161	2.3%	2,456	3.2%
Total	6,965	100.0%	75,948	100.0%

Table 22 – CalOMS Employment Status on Admission, San Diego and Statewide, CY 2017

CalOMS CY 2017				
Current Employment Status	**San Diego**		**Statewide**	
	#	%	#	%
Employed Full Time - 35 hours or more	911	13.1%	9,636	12.7%
Employed Part Time - Less than 35 hours	550	7.9%	6,445	8.5%
Unemployed - Looking for work	2,371	34.0%	20,734	27.3%
Unemployed - not in the labor force and not seeking	3,133	45.0%	39,148	51.5%
Total	6,965	100.0%	72,445	100.0%

The information displayed in Tables 23-24 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 23 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.

The data in Table 23 shows diligence by San Diego in engaging clients in treatment and following up with them as part of active discharge planning. The percentage of administrative discharges averages only 26.8 percent which is markedly less than the statewide average of 37.5 percent. San Diego rating demonstrates a concerted effort to collect valid discharge data and utilize the CalOMS data set to make reliable ratings on client progress in treatment.

Table 23 – CalOMS Discharge Types, San Diego and Statewide, CY 2017

CalOMS CY 2017				
Discharge Types	**San Diego**		**Statewide**	
	#	%	#	%
Standard Adult Discharges	7,914	55.4%	65,369	45.8%
Administrative Adult Discharges	3,835	26.8%	53,405	37.5%
Detox Discharges	2,388	16.7%	22,776	15.9%
Youth Discharges	150	1.0%	948	0.7%
Total	14,287	100.0%	142,948	100.0%

Table 24 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 SUD. 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.

San Diego's positive ratings are similar to the statewide average in three of the four categories, and markedly higher in one (Completed Treatment-Not Referred). Overall, 60.2 percent of clients who received either of the four positive ratings as compared to 55.9 percent statewide for all DMC-ODS counties

Table 24 – CalOMS Discharge Status, San Diego and Statewide, CY 2017

CalOMS CY 2017				
Discharge Status	**San Diego**		**Statewide**	
	#	%	#	%
Completed Treatment - Referred	3,362	23.5%	34,415	24.1%
Completed Treatment - Not Referred	2,564	17.9%	13,252	9.3%
Left Before Completion with Satisfactory Progress - Standard Questions	1,590	11.1%	17,001	11.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,096	7.7%	12,224	8.6%
Left Before Completion with Unsatisfactory Progress - Standard Questions	2,936	20.5%	24,425	17.1%
Left Before Completion with Unsatisfactory Progress - Administrative	2,523	17.7%	38,801	27.2%
Death	11	0.08%	226	0.2%
Incarceration	205	1.4%	2,152	1.5%
Total	14,287	100.0%	31,313	100.0%

Performance Measures Findings—Impact and Implications

Overview

Performance Measures data are incomplete and therefore not conducive to drawing conclusions or supporting meaningful analysis. San Diego will be changing its policies in the second year of its DMC-ODS implementation to insure all DMC-ODS certified providers are able to document to full Medi-Cal standards and thus can submit claims to San Diego's billing unit.

Access to Care PM Issues

- Overall, persons who are White accessed DMC-ODS services more readily than others and persons who are Latino/Hispanic or Asian/Pacific Islander were relatively less inclined to access treatment.

Timeliness of Services PM Issues

- None noted.

Quality of Services PM Issues

- San Diego's TPS shows high ratings in the Quality domain (Treated with Respect and Understood Communication). However, the ratings for coordination of substance use care with mental health and physical health providers are relatively lower.

Client Outcomes PM Issues

- San Diego uses CalOMS data to measure treatment success at time of discharge. Its administrative discharges are a lower percentage than the statewide average, suggesting that its discharge status ratings are more likely to be reliable and valid. They rated 60.2 percent of their discharged clients as who have attained satisfactory progress in treatment compared to 53.9 percent for the combined average of DMC-ODS counties statewide.

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 shows the percentage of services provided by type of service provider.

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): 6.9 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

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

Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
16	3	0	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

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**
10	2	0	0

The following should be noted regarding the above information:

- The technology and data analytical staffing numbers include both county and contractor resources.
- UCSD Health Services Research Center supports data analytical and reporting activities.
- Optum supports residential services authorizations and Help Desk support.

Current Operations

- The number of unique clients served in CY 2018 was 4,487. Most claims were processed in the months of July, August and September.
- FEI Systems is the IS vendor and uses application service provider (ASP) model to support San Diego DMC-ODS operations. SanWITS database is maintained outside of California and supported by multi-point network connectivity.
- FEI Systems continues to build-out SanWITS application to support 1115 Demonstration Waiver requirements for DMC-ODS pilot. The project plan includes three phases. Current estimate is to complete phase one work activities by late 2019.

- SanWITS Implementation Team Committees and Workgroups guide the EHR's continued development. Following lists key committees and workgroups supporting development and implementation.
    - Monthly Implementation Committee meetings.
    - Weekly Clinical Needs and End-User Workgroup meetings.
    - Weekly Quality Management Workgroup meetings.
    - Weekly Billing and Claiming Workgroup meetings.
    - Weekly Reports and Data Workgroup meetings.
    - Weekly Training Workgroup meetings.
    - Monthly Future Enhancement and Strategic Planning Workgroup meetings.
    - Weekly Help Desk Review Huddles.
    - Monthly Contractor Workflow meetings.

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

Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
SanWITS	Billing and Reporting	FEI Systems	1	FEI Systems

Priorities for the Coming Year

- Enhance SanWITS for the purpose of capturing DMC-ODS data within a fully functional electronic health record environment, which entails adding:
    - Treatment Plans,
    - Progress Notes,
    - Clinical Dashboards,
    - Medication Module for e-Prescribing and interface with Surescripts,
    - Lab module,
    - Electronic signatures for both staff and clients,
    - Develop additional validation rules for alerts.

- Add assessment functionality for:
    - Adult Initial Level of Care,
    - Adolescent Initial Level of Care,
    - Parent/Guardian Initial Level of Care,
    - Risk and Safety,
    - Diagnostic Determination Note,

  - Recovery Plan,
  - Discharge Summary,

- Build complex reports to monitor outcomes.
- Add Referral Management functionality and Direct Messaging.

Major Changes since Prior Year

- San Diego Behavioral Health Services DMC-ODS went live with SanWITS in July, 2018.
- Phase I supports the DMC-ODS' critical timelines, onboarding and training providers and test/roll out new functionalities to include:
  - Capability to capture timeliness to service, risk categories, first next available appointment for assessment and for treatment.
  - Capacity to calculate ODS groups; and accommodate billing MAT dosing and non ODS groups for OTP providers.
  - Implement authorization module for residential stays.
  - Implement bed management module for tracking beds and creating bulk encounters for residential day services.
  - Implement Capacity module for checking availability.
  - Implement Contract Management module.
  - Implement ASAM screen.
  - Implement document storage and administration of type of document.

- Extensive trainings were provided to providers staff (67 SanWITS basic training; six residential ODS updates; two Bed Management and Encounter training; ten service reporting training and 28 billing trainings for outpatient, OTP and residential programs).

Other Significant Issues

- SanWITS implementation remains a work-in-progress with efforts to complete timely stand-up being impacted by ongoing roll-out of mandates resulting from compliance with CMS Final Rule and DHCS Information Notices; some with date-certain implementation requirements with the risk of sanctions for not meeting the mandate timeline. This condition puts a strain on local subject matter resources and IS vendor to develop or modify system change orders and project plan implementation resources that also impacts SanWITS project timeline.
- It is the San Diego understanding they lack authority to use the Monthly Medi-Cal Eligibility File (MMEF) to determine client/beneficiary eligibility status as DHCS informed them it is not included in their current Intergovernmental Agreement. DHCS provides counties eligibility data monthly, which automates the process to determine client's eligibility status for mental health services.

- Currently SanWITS supports SUD operations, while MHP (mental health) operations is supported by CCBH system. Maintaining two disparate EHR systems, Behavioral Health Services lacks the functionality for two-way exchange of client care data, does not support client care coordination standards nor support collaboration between healthcare providers.
- Contract providers who maintain their own local EHR systems are essentially required to support double-data entry environment - to enter client data into their local system, plus data enter to SanWITS. This process is both time-consuming for staff and prone to data entry errors and requires quality review process to detect errors and correct them.
- San Diego organizational chart places MIS unit within Quality Improvement Unit, who reports to Assistant Director, Departmental Operations, who is the direct report executive member of Behavioral Health Services for San Diego Health and Human Services Agency. While far removed from HHSA decision-making, San Diego's executive team does have authority during this critical time to make determinations as they stand-up SanWITS system. MIS support has an immediate impact on day-to-day operations, more so than finance or quality improvement operations.
- The MIS unit currently supports three disparate systems: ongoing support for CCBH EHR system for MH operations; SanWITS system build-out for SUD operations; and Cerner Millennium system build-out for MH operations. Based on onsite interviews and review of HHSA Organizational Chart dated February 2019. The number of subject matter expert staff members supporting these operations seems inadequate for such large and complex operations though San Diego notes that their efforts are supported by the Millennium build out team of 20 or more individuals as well as Optum team members supporting CCBH.

Plans for Information Systems Change

- San Diego is currently in phase one of SanWITS implementation plan. There are three phases identified for full system implementation; and the tentative completion date currently being June 2020 or thereabouts.

Current Electronic Health Record Status

ISCA Table 5 summarizes the ratings given to the DMC-ODS for EHR functionality.

Table 5: EHR Functionality					
		Rating			
Function	**System/ Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	SanWITS	X			
Assessments	SanWITS	X			
Care Coordination	SanWITS	X			
Document imaging/storage	SanWITS	X			
Electronic signature—client	SanWITS			X	
Laboratory results (eLab)	SanWITS			X	
Level of Care/Level of Service	SanWITS	X			
Outcomes	SanWITS	X			
Prescriptions (eRx)	SanWITS			X	
Progress notes	SanWITS			X	
Referral Management	SanWITS			X	
Treatment plans	SanWITS			X	
Summary Totals for EHR Functionality:		**6**	**0**	**6**	**0**

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

- SDBHS SUD continues to roll-out and deploy EHR functionalities since going live in July 2018 as noted in Table 5 results.

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

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.			26.8
TPS being administered in all Medi-Cal Programs.	X		

Highlights of use of outcome tools above or challenges:

- San Diego is collecting CalOMS data as a Quality Management measure.
- TPSs have been administered to adults and youths and scores are tabulated by domain and level of care. TPSs are available in 14 languages and large print.
- ASAM is administered to all clients to determine their level of care needs.

Drug Medi-Cal Claims Processing

- San Diego's fiscal unit conducts billing reviews monthly. Only programs identified as meeting documentation standard thresholds are allowed to submit claims to the county billing unit. Billing unit checks for errors prior to release to DHCS.
- San Diego has successfully submitted claims during CY 2018. As of May 2019, Billing Unit staff reported the most recent claim files submitted were for November and December 2018.
- SSRS Reports are utilized for claims review and reconciliation.

Special Issues Related to Contract Agencies

- All of San Diego County's DMC-ODS services are provided by contract agencies.
- 90 percent of San Diego County DMC-ODS contract providers operate on paper charts and transitioning to an electronic health record environment is a huge challenge for them.
- OTP providers have their own systems. Interoperability between Methasoft and SanWITS is an important consideration to prevent double data entry for these providers.

Overview and Key Findings

Access to Care

- The Access Call Center operates 24/7 and 34 percent of its FTEs are bilingual in San Diego County's threshold languages.
- A Language Line is also used to ensure the capacity to meet network adequacy standards.
- The Access Line combines both access to services and crisis line responses and has the same priority level as 911 operators. All calls go to the top of the Language Line queue when accessing an interpreter.

Timeliness of Services

- San Diego tracks the following timeliness measures using data in SanWITS:
    - The length of time from initial request to first offered appointment.
    - The length of time from initial request to first face to face visit/appointment.
    - The length of time from initial MAT request to first MAT appointment.
    - The length of time from service request for urgent appointment to actual encounter.
    - Timeliness of follow-up encounters post-residential discharge.
    - Withdrawal management readmission rates within 30 days.
    - MAT provider no show rates.
- Timeliness reports are produced quarterly and data is run by program and regional levels.
- Access Line data is not used to verify timeliness data.

Quality of Care

- Contract providers have full access to SanWITS' assessment, care coordination, level of care, outcomes and document storage functions.
- Some processes such as client eligibility verification are still manual but expects to be automated as the system evolves.
- SDBHS has traditionally used the ASI as its assessment tool. ASAM is used as a level of care determination tool.

Client Outcomes

- San Diego SanWITS to track encounters and outcomes with CalOMS.
- UCSD Health Services Research Center is contracted to administer the TPS to clients. The UCSD team collects and analyzes TPS data and sends it to DHCS.

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. CalEQRO reviewed and validated two PIPs submitted by San Diego, as shown below.

The following lists the number and titles of the PIPs submitted by San Diego, as required by the PIP Protocols: Validation of PIPs.[4]

PIPs Submitted by San Diego		
PIPs for Validation	**# of PIPs**	**PIP Titles**
Clinical PIP	1	Relapse Prevention Evidence Based Practice
Non-clinical PIP	1	Grievances and Appeal Utilization

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, Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[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.

PIP Table 1: PIP Validation Review

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	PM
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	N/A	N/A
		5.2	Valid sampling techniques that protected against bias were employed	N/A	N/A
		5.3	Sample contained sufficient number of enrollees	N/A	N/A
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	M	M
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	UTD	N/A
		8.2	PIP results and findings presented clearly and accurately	UTD	N/A
		8.3	Threats to comparability, internal and external validity	UTD	N/A
		8.4	Interpretation of results indicating the success of the PIP and follow-up	UTD	N/A
9	Validity of Improvement	9.1	Consistent methodology throughout the study	N/A	N/A
		9.2	Documented, quantitative improvement in processes or outcomes of care	N/A	N/A
		9.3	Improvement in performance linked to the PIP	N/A	N/A
		9.4	Statistical evidence of true improvement	N/A	N/A
		9.5	Sustained improvement demonstrated through repeated measures	N/A	N/A

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

PIP Table 2: PIP Validation Review Summary

Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	15	15
Number Partially Met	1	1
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	8	12
Overall PIP Rating Clinical: ((M*2)+(PM))/(AP*2) Non-clinical: ((M*2)+(PM)/(AP*2)	**77.5%**	**96.875%>**

Clinical PIP— Relapse Prevention Evidence Based Practice

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 5%?"

Date PIP Began: 05/01/19

Status of PIP: Active and ongoing

Brief Description:

The goal of this PIP is to decrease the rates of early discharges without satisfactory progress by implementing a Relapse Prevention EBP. It is expected that the implementation of the EBP will encourage consumers to remain engaged in treatment as they learn how to 1) better identify warning signs, triggers, and high-risk situations, 2) avoid triggers and high-risk situations when possible and utilize effective coping strategies when avoidance is not possible, thus decreasing rates of early discharges from treatment without satisfactory progress.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

Technical Assistance Provided: Technical assistance was provided to San Diego via telephone meetings in October 2018 as well as January and early May of 2019. Feedback included assistance with problem statement clarification and with refining the study question and performance indicators.

Non-Clinical PIP— Grievances and Appeal Utilization

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

"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?"

Date PIP Began: 10/12/18

Status of PIP: Active and ongoing

Brief Description:

This PIP aims to improve accessibility of the grievances and appeals processes materials at all programs in the DMC-ODS to increase awareness and usage of and comfort with these processes among clients, which will help identify programmatic and system wide issues. An awareness of this process is expected to increase client satisfaction and retention while simultaneously improving client activation in their own treatment.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

Technical Assistance Provided: The technical assistance provided to San Diego by CalEQRO occurred on the same dates as for the Clinical PIP. CalEQRO recommended that San Diego take steps to obtain consumer input on defining the PIP and that they take steps to identify how the change in administrative processes would be expected to benefit the client and client care.

PIP Findings—Impact and Implications

Overview

San Diego has two active PIPs, which have only recently started. Both PIPs are addressing relevant issues that will San Diego expects will result in improvement for clients through the course of treatment. They expect the clinical PIP to result in increased retention efforts after introducing a set of relapse prevention strategies. They expect the non-clinical PIP to improve awareness and utilization of client grievances and appeals in order to address care issues that may have previously led to client elopement and unsuccessful completions of treatment. A pilot for all residential programs is testing the Clinical PIP concepts. The use of relapse prevention skills by staff is a pilot that can be expanded as intervention results are analyzed and support expansion.

Access to Care Issues related to PIPs

Both PIPs are 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 is 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 seeks to 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 expects 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

Reducing relapse, client dissatisfaction and elopement impacts the whole system. Increasing the number of persons who persist in treatment will improved favorable outcomes and thereby reduce recidivism, making more appointments available in a timely manner for others.

Quality of Care Related to PIPs

San Diego expects that by using an evidence-based practice and framework that prioritizes identification and mitigation of clients' likely relapse triggers, they will improve the quality of their care, limit untoward clinical events and enhance clients' treatment experience.

Studies have shown that an activated client is informed, empowered and engaged in their 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. Positive health behaviors and care decisions are likely to improve the overall satisfaction, retention and quality of client care.

Client Outcomes Related to PIPs

San Diego expects the study indicators for their Clinical PIP that measure discharge status rates to show increased client retention and thereby improved clinical outcomes. They expect the increased assistance in the identification of relapse risk factors to benefit individual clients who will take an active hand in learning necessary disease management skills and be more successful in treatment. San Diego has accumulated only the most limited provisional data and an actual analysis is not available at this time.

San Diego expects 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. They expect that addressing specific client grievance and appeal issues across the treatment program network will assist clients to successfully complete the program and likely improve overall consumer satisfaction. Given that this PIP remains in its early stage of implementation there are no results to report back at this time.

CLIENT FOCUS GROUPS

CalEQRO conducted four 90-minute client and family member focus groups during the San Diego DMC-ODS site review. As part of the pre-site planning process, CalEQRO requested these four focus groups with eight to ten participants each, the details of which can be found in each section below.

The client/family member focus group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the DMC-ODS county being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and client and family member involvement.

Focus Group One: Adult Outpatient Consumers

CalEQRO requested a culturally diverse group of adult beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

The group met on May 21, 2019 at Mental Health System's Assertive Community Treatment Intensive Outreach Needs or ACTION Central which is located at 6244 El Cajon Boulevard, San Diego, CA. ACTION Central is a program that offers treatment for individuals who have both a substance use disorder and mental illness. Nine participants--seven men and two women--showed for the focus group. Participants were generally open in their comments and spoke favorably about the staff and the fact that the program also provides nine months of housing. They reported that program staff rarely discussed MAT options to address their addictions, and some wanted to know more. Eight of the clients had entered treatment in the past 12 months, though they were at varying stages of treatment ranging from a few weeks to several months. Several described having been in treatment multiple times in past years and articulated favorable comparisons to their experiences with programs prior to and after the launch of the DMC-ODS. Seven clients were 25 - 59 years of age and two persons identified as over 60. All spoke English, with no interpreter needed. The group was mostly attended by those who identified as White though it also included two persons of Hispanic descent along with three who were African American.

Number of participants: 9

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected the participating

group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools. Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.8	4-5
2. I got my assessment appointment at a time and date I wanted.	4.8	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.9	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.8	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.2	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.8	4-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.7	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.6	4-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.7	4-5

The following comments were made by some of the participants who entered services within the past year and who described their experiences as follows:

- "Counselors care."
- "She broke through my trust issues. I am loving myself today, which I have never done."
- "This place is awesome. Now I don't have to live in my car."

General comments regarding service delivery that were mentioned included the following:

- Easy process to enter the program.
- Able to get services that they need and to save money for future housing.
- Program provides place to live along with services to help acclimate to mainstream life.
- Case managers help with many areas including showing them how to access food resources and take them to medical appointments

Recommendations for improving care included the following:

- Daytime-only schedule disrupts employment.
- Vocational opportunities including an incentive program to motivate clients.

- Need later program hours so they can seek and maintain employment.
- More assistance with life issues such as future housing, employment, legal or tax problems.

Interpreter used for focus group 1: No

Focus Group Two: Adult Women Perinatal Residential

CalEQRO requested a culturally diverse group of adult female client beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

The group met on May 22, 2019 at North County Serenity House which is operated by HealthRIGHT 360 and located at 1341 N. Escondido Blvd., San Diego, CA. Serenity House is a residential program that provides perinatal substance abuse services to women. The group was affable and open in regards to the questions and consisted of six clients who were ages 25-59 years old along with three whose ages ranged from 18-24. Four of the group were Caucasian, four were Hispanic/Latino and one was African-American; all spoke English and there was no need for a translator. They described positive experiences in regards to accessing and entering the program as well as in their initial communications with assigned counselors. At least two of the women were on differing forms of MAT and most agreed that information on MAT is available and promoted within the program, though one had to access it through the medical director. Similarly, participants described a clinical approach to relapse where individual factors or associated issues are addressed and resulted in stepped up service contact with increased access to staff to help them identify and understand the basis of relapse and better resolve these issues. Some clients shared that they were too new to the program to tell if treatment was of benefit. However, the group became very animated and expressed frustration over recent changes that have impacted their care in a negative fashion. Primarily this appears to be because several employees left the program in the past week in a very abrupt fashion. This caused doubling up of duties with many remaining staff resulting in uncomfortable privacy concerns and cancellation of groups. Participants described that because of the shortage of staff they have trouble accessing them when needed, that there is a lack of structure and a sense of disorganization. One client stated she has been there two weeks but only met with her counselor one time. All clients reported that they now have the same staff as their counselor and their therapist which they find difficult or inappropriate. The clients requested CalEQRO take these issues to San Diego DMC leadership and seek assistance for them.

Number of participants: 9

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that

the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.2	3-5
2. I got my assessment appointment at a time and date I wanted.	4.6	3-5
3. It did not take long to begin treatment soon after my first appointment.	4.9	4-5
4. I feel comfortable calling my program for help with an urgent problem.	3.6	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.6	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.7	3-4
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.1	2.5
8. Because of the services I am receiving, I am better able to do things that I want.	4.1	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.1	2-5

The following comments were made by some of nine participants who entered services within the past year and who described their experiences as follows:

- "Previously the program worked but then it has been bad for about six months."
- "Not sure what is wrong with this organization but it seems very disorganized."
- "Not working" that the counseling and therapy are now being done by the same person whereas in the past these roles were separated by two staff. Chief amongst the concerns is that this attempt to overcome a gap in staffing has resulted in client confidentiality being overridden.
- Two clients on differing forms of MAT say the program is supportive of it.

General comments regarding service delivery that were mentioned included the following:

- Not enough staff or enough groups (a group cancellation was announced over the intercom during this FG activity).
- Previously happy with counseling, now seek help from each other.
- Remaining staff are "stressed out."

Recommendations for improving care included the following:

- Need more staff. Therapist and counselor should be different people.
- Need clearer communication, less leniency and more structure.
- Staff need to be made available especially if they are in crisis.

Interpreter used for focus group two: No

Focus Group Three Adolescent Outpatient

CalEQRO requested a culturally diverse group of youth client beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

The group met on May 22, 2019 at Teen Recovery Center operated by Mental Health Systems and located at 340 Rancheros Drive, San Marcos, CA. The group was reserved and while polite had a tone indicative of adolescents the majority of whom were only in the program due to probation terms. A myriad of program complaints primarily about structure, sanctions for poor attendance and hours of operation were balanced by very positive feedback about the counselors to whom they were assigned. Staff were seen as respectful and as people with whom they could open up and speak. The group consisted of eight participants who were primarily male, with two being female and all of whom were under 18 years of age. All clients identified as Hispanic/Latino except for one participant who was White. All spoke English and no translator was needed. Seven of the eight reported initiating treatment within the past 12 months.

Number of participants: 8

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	3.9	3-4
2. I got my assessment appointment at a time and date I wanted.	3.4	2-4
3. It did not take long to begin treatment soon after my first appointment.	3.5	2-4
4. I feel comfortable calling my program for help with an urgent problem.	3.6	3-4
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.4	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.4	1-4
7. I found it helpful to work with my counselor(s) on solving problems in my life.	3.5	3-4
8. Because of the services I am receiving, I am better able to do things that I want.	3.9	3-4
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	3.9	3-4

The following comments were made by some of the seven participants who entered services within the past year and who described their experiences as follows:

- Felt very welcomed when they came into the program
- “Staff has a very positive attitude; some have shared that they are in recovery.”
- “Counselors relate to real life and understand how our life is. They don’t pretend.”
- All prefer individual sessions with counselors so they can “open up.”

General comments regarding service delivery that were mentioned included the following:

- Have to “start over” if they “pop a dirty” drug test.
- Program “is the same if you have to start over”, which they do not see the value of.

Recommendations for improving care included the following:

- Expand hours of groups. Have to rush to attend and not be late from school.
- Make the program shorter.
- Family involvement would be good if it involved education from the counselors.

Interpreter used for focus group three: No

Focus Group Four: Adult Women's Outpatient

CalEQRO requested a culturally diverse group of adult client beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

The group met on May 22, 2019 at South Bay Women's Recovery outpatient program as operated by McAlister Institute for Treatment and Education (MITE) which is located at 1180 3rd Avenue, Chula Vista, CA. Five female SUD clients attended who identified as Hispanic/Latina and ranged in age from 18-24 years old. All the participants spoke Spanish as a primary language, and an interpreter was needed and provided. The group was active and clients spoke favorably regarding counseling staff, various forms of social assistance and the program provides a sense of safety and support. Most of the clients had substance use disorders involving alcohol, marijuana and methamphetamines so they reported a general unawareness of MAT used mostly for opiate addictions, and reported that it had not come up in treatment discussions with staff.

Number of Participants: 5

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.8	4-5
2. I got my assessment appointment at a time and date I wanted.	4.0	3-5
3. It did not take long to begin treatment soon after my first appointment.	4.8	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.8	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.2	3-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.0	4-4
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.8	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.0	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.8	4-5

The following comments were made by some of five participants who entered services within the past year and who described their experiences as follows:

- “Counselors have my back.”
- All were appreciative of the counselors who are “caring and supportive.”
- Feel “respected” by staff. “Society sees us as bad people, but we are people going through pain.”

General comments regarding service delivery that were mentioned included the following:

- Concern expressed about federal immigration efforts and the Immigration and Customs Enforcement agency (ICE).

Recommendations for improving care included the following:

- The program should provide more opportunities for them to connect individually with each other so as to help re-enforce their efforts and realize that they are not alone.
- Provide more support for employment.
- Help with getting more family support.

Interpreter used for focus group four: Yes

Client Focus Group Findings and Experience of Care

Overview

A total of four focus groups were conducted with youth and adult clients with who had experiences from a variety of programs. One of the focus groups was conducted with clients who were primarily Spanish speaking.

Access Feedback from Client Focus Groups

- The participants at one program were positive about temporary housing they could utilize for nine months conditional on their participation in treatment that met a few core standards. Other clients suggested that more post-treatment housing placement options are needed.
- One program appeared to have an acute staff shortage which had resulted in negative impact on access to treatment services typically available or offered.
- Access for youth to outpatient programs could benefit from expanded hours as the current schedule makes it difficult to arrive on time and maintain employment.

Timeliness of Services Feedback from Client Focus Groups

- Participants in the adult focus groups generally agreed that for most substance use treatment services, obtaining timely access to treatment is easy and involves shorter wait times for service compared to prior years.
- Youth and those adult clients involved with the courts were generally required to be in treatment as a condition of probation. They said they found the referral processes to be expedient after being assessed, even if the assessments were done while they were in custody.

Quality of Care Issues from Client Focus Groups

- The adult outpatient client participants were generally satisfied with the quality of their services as contracted by the county. Case managers and assigned counselors stood out as almost universally of assistance and helpful in establishing a connection with clients who reported a history of difficulty sustaining recovery in the past.
- Clients vocalized their appreciation for ancillary services such as vocational and housing support services. Clients on MAT also expressed appreciation for the supportive nature of the SUD programs with regards to their continuing their MAT.

Client Outcomes Feedback from Client Focus Groups

- The adult client participants agreed that while services are helpful in recovery, they would be more able to sustain participation if expanded or evening hours were available. A common theme amongst the youth focus group is that limited hours made access and ongoing participation a challenge.
- The participants in the focus group for residential female clients expressed several concerns due to five employees leaving in the past week. In addition to the disruption of scheduled activities many had little or no ongoing access to their assigned counselor. Counselors were “stressed out” and there was a general sense of frustration and confusion as to what course this program was taking to rectify matters. Most reported that they had resorted to helping each other but as a consequence progressed very little in their own recovery. Participants remarked that the program appeared disorganized and their needs were not being met.

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

Table 1: Access to Care Components		
	Component	**Quality Rating**
1A	Service accessibility and availability are reflective of cultural competence principles and practices	M
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. San Diego addresses various CLAS standards for training and operates from its well-established department Cultural Competency Plan which is due for a revision in July 2019.		
1B	Manages and adapts its capacity 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. San Diego utilizes a single electronic system at the provider and call center to track requests, referrals and intakes as well as reporting and analysis to respond to system challenges. They are professionalizing and expanding related services such as Recovery Residences by way of fostering a provider led association in hopes of increasing capacity. They have identified both rural and east county areas as areas in which to continue to develop capacity to assure it is adequate.		

Table 1: Access to Care Components		
Component		**Quality Rating**
1C	Integration and/or collaboration with community-based services to improve access & care	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. Designated emergency departments in the county are conducting buprenorphine inductions with support from San Diego's MAT tool kit. San Diego's work with its contracted DMC service providers during the first year of DMC-ODS implementation focused primarily on meeting basic Waiver requirements, especially documentation, billing and full implementation of the ASAM principles. The coming year is expected to see more emphasis on quality of care.		

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

Table 2: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first face to face appointment	M
Timely access was evidenced by San Diego tracking reports in the Timeliness Self-Assessment form, and with detailed supporting reports provided by Optum, the call center vendor for this DMC-ODS. Processes are in place that efficiently connect clients to the provider network and both secure and track scheduled first appointments. Clients in all the focus groups reported experiencing easy access to services.		
2B	Tracks and trends access data from initial contact to first MAT/NTP appointment	M
As indicated in Performance Measure data tables in this report based upon claims data, San Diego enters the data necessary to track timeliness from first contact to first dosing. It is apparent that the local NTPs usually begin dosing within two to three days of first contact, which is timely. San Diego has increased availability for		

Table 2: Timeliness of Services Components		
Component		**Quality Rating**
non-methadone MAT as delivered through their NTPs and various local FQHC clinics though the data on prescribing practices were not readily available. In the MAT session facilitated by CalEQRO anecdotal data from NTP providers indicated that up to ten percent of some OTP clinics were on alternate forms of MAT. San Diego NTP providers shared clinical practices and information documents which are given to incoming clients in order to educate them on options and thereby increase adoption of alternate forms of MAT.		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
San Diego has initiated an urgent request protocol and recently formatted the data collection elements in their SanWITS software. No data was available at the time of this review and once available will only reflect back to late February 2019, well after launch of the Waiver.		
2D	Tracks and trends timely access to follow-up appointments after residential	PM
San Diego tracks and reports the timely access to follow up measure. They set a timeliness standard of 7 days from discharge to follow up appointment, but met it with only a small percentage of their clients. Increasing timely transitions post discharge from residential is an area of focus that San Diego set for its upcoming second year of its Waiver implementation.		
2E	Tracks and trends data on re-admissions to residential treatment and WM	M
San Diego tracks all WM client re-admissions to ascertain the total number within 30 days of discharge. Utilizing these entries in the San WITS database a low level of readmissions were found to be occurring. Out of 1,663 WM discharges, only 95 clients were subsequently readmitted within a month representing just 5.4 percent.		
2F	Tracks and trends no shows	M
San Diego has the capability to systematically collect this data and works on reporting results within the SanWITS software. Reported no shows for NTP and other MAT providers is 11.8 percent. At present a standard for no shows is not established by these providers in San Diego.		

Quality of Care

CalEQRO identifies the components of an organization that are 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

Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
San Diego's QI Plan for the DMC-ODS is separate from the one established for the MHP. The Plan utilizes a framework which borrows from the MHP plan and is well-written, with meaningful and clearly stated goals and objectives. 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 status, 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.		
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 in formulating data analyses. San Diego provides monthly graphic displays of these data to assist management, providers, and policy makers in visualizing and understanding the reports, and aiding them in decision making regarding multiple defined areas of quality improvement (see Attachment C – County Highlights).		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	PM
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. San Diego has taken a unique approach in engaging criminal justice, a primary referral source. Due the level of change required of providers and their staff, San Diego initiated an enhanced two-way communication effort with providers specific to their modality and needs to better assist them in overcoming the complexity of tasks involved in launching a managed care system. Line staff need ongoing support to effectively transition their treatment practices to meet the new requirements. CalEQRO suggests a measured and limited set of expectations given evidence of change fatigue and burn out.		
3D	Evidence of an ASAM 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 which San Diego monitors judiciously. As San Diego fully designs and implements it's EHR, they expect is will afford them		

Table 3: Quality of Care Components		
Component		**Quality Rating**
with an increased understanding of the ASAM continuum of care. Full EHR implementation for all treatment providers is expected in 2020.		
3E	MAT services both outpatient and NTP exist to enhance wellness and recovery:	M
San Diego beneficiaries have access to MAT services through their NTP network of opioid treatment programs who provide full spectrum outpatient treatment along with methadone. NTPs also offers all other required forms of MAT and have been expanding their assessment and prescribing practices as evidenced by clients walking into a methadone clinic asking to be placed on buprenorphine. San Diego receives grant funding for a Hub and Spoke program that contracts with local NTPs and are providing services at several FQHC sites. These efforts are clearly supported by DMC-ODS with line staff and clients reporting reduced stigma as compared to pre-Waiver times for clients accessing both NTPs and MAT services. While pockets of resistance persist, San Diego has made inroads in carrying the message of reducing MAT related stigma in the larger health care system and the community. As one NTP provider stated in a CalEQRO session, “I was never invited to sit at the table before, we were not considered treatment. The Waiver has helped push through those biases.”		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
San Diego has utilized a variety of tools and provided training opportunities to implement the ASAM Criteria. This was further reinforced by a training that featured Dr. David Mei-Lee. San Diego and its contracted providers continue to make a priority of achieving fidelity to the ASAM Criteria and to assure that clients are routinely reassessed to address individual needs. Line clinical staff continue to experience some difficulties in adhering to the client-centered principles as programs make the needed adjustments. Due to the complexity of a systemic cultural change represented under the Waiver, some providers feel it has been a struggle to ensure clients continue to be engaged in treatment or avoid relapse. As stated to CalEQRO, staff felt the Waiver would lead to more services and therefore more time for client contact along with reduced caseloads. What they report has occurred is that they now have higher caseloads and less face to face time with clients due to more time spent meeting new documentation standards. Providers also report that accessing training is a challenge as sessions are often located at some distance or found to be at capacity. Line staff also expressed frustration with the seemingly constant pace of change. They requested clearer direction and either a prioritization of work or a reduction to just essential training. San Diego has thus far established a small network of Recovery Residences (RRs) that are part of an association which they are working to expand so as to be accessible for more DMC-ODS beneficiaries who		

Table 3: Quality of Care Components		
Component		**Quality Rating**
need it. San Diego set a priority of expanding it RRs for women with children as only one facility is currently available for that population.		
3G	Measures clinical and/or functional outcomes of clients served	M
Client level outcomes are collected, and the system uses the ASAM level of care data as well as the CalOMS data. While San Diego had to undergo the challenges inherent in moving thousands of CalOMS data elements from its NTP providers into SanWITS, they continue to review data at multiple levels of care to identify and address program level needs or issues. San Diego also uses client self-report ratings on the TPS outcome-related items to determine treatment effectiveness. San Diego provided CalEQRO with reports based upon the TPS rating results which had been used to discuss findings with its providers, leadership and advisory board.		
3H	Utilizes information from client perception of care surveys to improve care	M
San Diego administers the TPS to clients as required, and the results measure several important domains in clients' experience of care: Access, Quality, Outcomes, Care Coordination, and Satisfaction. Clients report high satisfaction in all areas. A review of provider level responses found variations that were somewhat below or above the aggregate but no outliers. San Diego has shared results with its provider network utilizing its partnership with UCSD which produced a clear and informative document.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- San Diego provided local admission rate data which indicates that overall enrollment numbers are up since the launch of the DMC-ODS. Comparing FY 2017/18 July through December and the same time frame in FY 2018/19, unduplicated client admissions rose by 11 percent. Although DMC-specific claims data were available for those months, they have yet to be fully submitted to and approved by DHCS, and so a similar comparison specific to just DMC beneficiaries was not possible.

- San Diego chose to expand use of the existing mental health access line in order to develop an integrated centralized call center called the Access and Crisis Line (ACL). This service is operated by Optum, a well-regarded contract provider, whose clinical staff screen and refer callers using ASAM Criteria-based tools. Systems were in place to capture calls, log dispositions, make warm handoffs, facilitate three-way calls with providers, data enter requests for treatment placement, and generate weekly and monthly reporting. Screening for associated mental health or urgent situations were built in, which functions as a designated crisis line. The statistics indicate good accessibility (17 seconds average call wait time, and two percent average monthly caller abandonment rate).

- A no wrong door philosophy and the use of existing providers has allowed for direct community access should clients walk into a program site. San Diego requires that each provider designate clinically qualified staff to perform the necessary assessment and placement of incoming clients, even if this means referring to another level of care. A strength of this model is that providers are better acquainted with each other and often rely on former competitors for mutual aide in the proper placement of clients across the county. With systems in place to capture calls and walk-in requests for services at the contractor level, timely access to care is monitored in compliance with state standards.

- San Diego has a large and robust NTP presence with more than 4,600 treatment slots for MAT. Methadone providers have expanded their use of other forms of MAT and are often called upon by BHS to provide information and guidance in the use of all forms. Assessment and induction protocols along with printed information provided by NTP programs indicate a willingness to offer and utilize non-methadone forms of MAT if clinically indicated or preferred. Three local hospitals have secured funding and are supported by BHS expertise and tool kits

to secure buprenorphine starts in emergency rooms with referrals to drug treatment upon discharge. Finally, hub and spoke grants have expanded use of MAT to those in need with five FQHC clinics participating.

- San Diego benefits from strong data analytics capacity which it skillfully utilizes to impact tracking and performance issues that pertain to access and timeliness to service. Reports are generated specific to a target audience and reviewed each month in a variety of decision-making settings.

Opportunities:

- San Diego has worked to address disparities in access for the various ethnic and linguistic groups that are found in this large and wide-ranging county. While the Cultural Competency Plan did address several essential standards and utilize CLAS as a framework, it was not clearly focused on the specific needs found in the substance use disorder population. An update to the plan is envisioned and it is recommended that meaningful efforts and initiatives be integrated into the broader department plan going forward.

- San Diego contract executives and program line staff expressed a sense of overwhelm and challenges with the level and rapidity of change they have to facilitate in order to meet the requirements of a managed care environment under DMC-ODS. There is ongoing concern about workforce development, staff retention and turnover due to change fatigue. Leadership may not be able to solve the root causes of these problems but can perhaps find ways to address with staff some of their stress levels.

- Given the prevalence of MAT treatment opportunities both in and out of the immediate DMC-ODS network, obtaining data from the Health Plans and FQHCs to track utilization and timeliness measures should be pursued.

Timeliness of DMC-ODS Services

Strengths:

- San Diego established timeliness standards for all the services in the Waiver implementation and has clear tracking for outpatient and residential treatment programs. Contractors are required to utilize SanWITS, the county EHR which was enhanced at the launch of the Waiver to capture and report on timeliness metrics and tracking. Universal utilization of the same software assures complete and timely recording of these standards.

- The ACL tracks and reports on all the required data for time to service and its operator, Optum, provides training to treatment and program staff assuring

consistent application of standards and protocols for data entry. Detailed reporting on combined timeliness performance measures are provided to San Diego clinical and operations leadership for regular analysis.

- San Diego reports the average length of time from the first request for outpatient or residential service to the first offered appointment is 3.1 days for all services. While adult services met the established standard 86.6 percent of the time, this increased to 90.9 percent for adolescents. The average length of time from initial request to first MAT appointment including methadone was 2.3 days meeting the established standard 94.4 percent of the time.

- San Diego has developed a definition for urgent requests that is consumer focused and well defined. If the clients relate that their need is urgent it is deemed as such. If upon discussion it is actually found to be emergent it is bumped up accordingly. San Diego set its timeliness standard for urgent service requests at the same times as for its MHP—48 hours except when authorizations are necessary, in which case the standard is 72 hours. Limited data was available as a new field in their EHR for Urgent requests was added in February 2019.

Opportunities:

- San Diego remains challenged in facilitating timely post-residential discharge appointments for continuation of care. San Diego reports that of the 3,697 clients who left residential care only 17.33 percent or 640 of those discharged obtained an appointment within the seven-day time frame they set as a standard. CalEQRO's analysis of San Diego's claims data indicates a much lower percentage, although it is with incomplete claims data. San Diego will continue to work with its providers on identifying and addressing areas that are impacting this measure, and try to increase the rate.

- Urgent appointment standards were established in the EHR in late February of 2019 and no data was available at the time of this review. San Diego is on target to have this data available in the next few months.

- San Diego has a robust ability for systematic tracking of the required timeliness measures. Up to date capacity information has been identified as a challenge, given the numerous and varied types of programs in the San Diego network. While cloud-based capacity information is currently available, San Diego should continue its work to develop a vacancy data field in SanWITS. This enhancement will provide more reliable real-time capability for moving clients into proper level of care placements.

Quality of Care in DMC-ODS

Strengths:

- San Diego has successfully implemented a well-developed ASAM continuum of care which meets the state requirements for specific ASAM levels of care. Additional service needs were identified and expansion is being developed in the more rural and eastern ends of the county. Formal treatment efforts are supported by temporary housing through recovery residences (RR) which require residents to concurrently participate in DMC-ODS treatment. San Diego helped establish a local RR association to enhance the quality of its RRs by establishing quality standards and a certification process amongst San Diego's small but growing network of facilities.

- ASAM training and establishment of the placement Criteria has helped solidify these standards across the system. San Diego has provided initial and ongoing training opportunities and while challenges continue in related issues such as documentation, programs remain intent on raising overall competencies use of ASAM Criteria. San Diego has also educated partners and key referral sources so they understand that treatment levels of care will be determined by the clinical needs identified through the assessment process.

- San Diego has assigned licensed clinical staff as Contracting Officer Representatives (COR) to oversee quality areas at the contract program sites. The activities of the CORs along with chart reviews provide assurance that quality care is being delivered in the manner defined by DMC for billing and by the Waiver for client-centered ASAM-based care. Along with ongoing technical assistance, the CORs provide each program with a monthly priority list of corrective areas identified while on site.

- San Diego provides integrated MH and SUD treatment to persons with co-occurring disorders in an effort to improve outcomes. All incoming clients are screened for co-occurring disorders. Contract providers are designated to be either Dual Diagnosis Capable or Dual Diagnosed Enhanced. This approach also includes strong collaboration with physical health.

- San Diego coordinates care with Health Plans for both MH and SUD clients. The umbrella organization Healthy San Diego coordinates planning with the behavioral health department for its Medi-Cal Health Plan, the County's Mental Health Plan, and the County's DMC-ODS. They have a dedicated work group of leaders from physical health and providers as well as over 100 people who work specifically on the interface between BHS and the health plans. The special collaborative projects they work on include the DMC-ODS, the Health

Homes grant and the Whole Person Care grant, each of which strengthens care for persons with MH or SUD needs.

- In 2018 San Diego required all of its program providers to participate in a Cultural Diversity Self-Assessment facilitated by its QI performance improvement team project. The survey acquired 2,672 respondents including 477 from SUD program staff. San Diego has utilized this data to inform and guide initiatives of its Cultural Competency Plan and workforce.

- San Diego has been long recognized for its efforts in addressing both the opioid epidemic and prevalence of methamphetamine. San Diego took a leadership role in the opioid crisis response and SUD issues in general, as was evident in the San Diego Rx Abuse Task Force and in the work being done by the Criminal Justice Coordinating Council specific to Methamphetamine, a long-standing local crisis given the county's proximity to drug trafficking realities across the border in Mexico. For both the opioid crisis and SUD issues, San Diego, collaborated with other agencies to raise community awareness, secure coordinated efforts 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.

- San Diego has benefitted from a long-standing partnership with the University of California, San Diego (UCSD) to assist with both research and evaluation. Its strong capacity for obtaining and reporting data results has assisted San Diego to respond to issues and problems pertaining to performance and quality in a meaningful and targeted fashion.

Opportunities:

- San Diego is working intensively to develop an EHR to support clinical services at the contract provider level. At present more than 80 percent of the contractors are utilizing a paper chart which have limited ability to capture key information for operations, services and key content that pertains to quality of care such as treatment plans. San Diego is working to launch a system wide EHR by 2020.

- Exchange of information to facilitate coordination of care is very important in a county this size with such a large number of providers and health plans. San Diego has been working toward more information sharing which will help with many of their quality efforts as part of San Diego Connect. One of the ongoing challenges has been with federal confidentiality regulations such as 42 CFR, part B and an inability to secure a good system of unified releases and consents.

- While quality management raised the level of provider documentation to more closely approximate required standards, many were not submitting claims due to fear of documentation disallowances. This provider practice limited San Diego's ability to draw down federal funding and to produce complete claims data useful for tracking full service utilization. During the second year it will be important to take the next steps in provider claiming of DMC-ODS services.

- While San Diego continues to provide training as the system evolves and needs are identified, logistical issues such as short notice for training sessions described as being 'overbooked' or not convenient were noted in focus groups with providers. Some contractors report that training has been ill suited to current or specific needs and have taken to arranging their own.

- San Diego contract providers have undergone a level of change that has required adjustments to workflow and business practices down to the line-staff level. While mandatory training lists expand to meet the clinical and new managed care processes, contract managers expressed desire to have BHS reduce and prioritize the curricula to those deemed essential, thus allowing staff to have more time for program work.

- San Diego needs to catch up on DMC billing submissions and fix issues with ASAM data submission. This was reported as a top priority and their goal was to have data from this fiscal year completed by the end of the summer.

Client Outcomes for DMC-ODS

Strengths:

- San Diego utilizes the TPS data to evaluate client satisfaction and therapeutic alliance. Their high scores are consistent across the system and within their entire provider continuum. Their average score was 4.4 with a range of 3.6 to 4.8. The results of the TPS were reformatted in an attractive and informative report that was shared at the Quality Improvement Committee and with its contract providers and other community stakeholders.

- San Diego has provided contractor training on how to retrieve and utilize the CalOMS data available in SanWITS. This is part of a larger effort by San Diego to orient providers on the necessity and value of accessing data that is available to gauge program performance and clinical outcomes.

Opportunities:

San Diego's contract providers remain mostly (80%) in a paper chart environment. While it has made the development and implementation of an

EHR a priority for the coming year, lack of an EHR impedes its ability to fully realize its analytic and reporting potential.

Recommendations for DMC-ODS for FY 2019-20

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.

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

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

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.

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

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.

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.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment D: County Highlights

- **D.1 Access Line Summary Statistics Report**
- **D.2 Behavioral Health / SUD Service Indicators**
- **D.3 Annual Report San Diego Prescription Drug Abuse Task Force (PDATF)**
- **D.4 Emergency Department Tool kit**
- **D-5 Interactive web page addressing opioid use**

Attachment E: Client Family Focus Group Forms

Attachment F: Access Call Center Key Indicators

Attachment G: Continuum of Care Form

Attachment H: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A—On-site Review Agenda

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

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

Attachment B—Review Participants

CalEQRO Reviewers

Patrick Zarate, Lead Reviewer
Rama Khalsa, Second Quality Reviewer
Maureen Bauman, Quality Reviewer
Ewurama Taylor-Shaw, Quality Reviewer
Bill Ullom, Lead Information Systems Reviewer
Caroline Yip, Information Systems Reviewer
Diane Mintz, Client and Family Member Reviewer

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 Services
3255 Camino Del Rio South
San Diego, CA 92108

Contract Provider Sites

Action Central, Mental Health Systems, Inc
6244 El Cajon Blvd, Suite 17
San Diego, CA 92115

Access Call Center, Optum San Diego
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

Acadia Fashion Valley Comprehensive Treatment Center
7545 Metropolitan Drive
San Diego, CA 92108

North County Serenity House, HealthRIGHT 360
1341 North Escondido Blvd
San Diego, CA 92123

Teen Recovery Center, Mental Health Systems, Inc
340 Rancheros Drive, Suite 166
San Marcos, CA 92069

South Bay Women's Recovery Center, McAlister Institute for Treatment and Education
2414 Hoover Avenue, Suite A-C
National City, CA 91950

Kiva Women and Children Learning Center, McAlister Institute for Treatment and Education
2049 Skyline Drive
Lemon Grove, CA 91945

Table B1 - Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Aguilar	Lidia	Clinical Line/Program Staff	Kiva Women and Children's Learning Center
Alexander	Michelle	Clinical Line/Program Staff	Kiva Women and Children's Learning Center
Arguelles	Brenda	Office Assistant	BHS - QI - PIT
Aston	Heather	Program Manager	Optum
Atkins	Gary	QM Specialist	BHS - QI - QM
Bailey	Patty	Director of Healthy Homes and Health Services	MAAC
Bauers	Brian	SUD Counselor	The Way Back Inc.
Baumen	Maureen	Quality Reviewer	BHC - CalEQRO
Benintende	Tara	Utilization Rev Quality Improvement Specialist	BHS - QI - QM
Bersabe	Junida	Principal Administrative Analyst	BHS - Fiscal
Binam	Carrie	Utilization Rev Quality Improvement Specialist	BHS - QI - QM
Bridgeman Smith	Linda	COR, DUI Programs and Prevention Services	BHS
Bridgeman-Smith	Linda	COR, DUI Programs and Prevention Services	BHS
Bunyi	Nolan	Administrative Analyst I	BHS - QI - QM
Cacho	Janet	Quality Management Supervisor	BHS - QI - QM
Castillon	Cinthia	Lead Counselor	MHS Serial Inebriate Program
Chowdhury	Tasnuva	Research Analyst	BHS - QI - PIT
Conlow	AnnLouise	MIS Manager	BHS - QI - MIS
Cook	Robert	Executive Director	Heartland House
Daitch	Diana	Utilization Rev Quality Improvement Specialist	BHS - QI - QM
DeForrest	Michelle	Clinical Line/Program Staff	Kiva Women and Children's Learning Center
Delaney-Terrones	Monica	SUD Counselor	ECS Central East Regional Recovery Center
Donovan	Kristen	Executive Director	CCR Consulting
Eftekhari	Alisha	BH Program Coordinator	BHS - AOA

Table B1 - Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Elkind	Jessica	Administrative Analyst III	BHS - CYF
Emerson	Cynthia	Administrative Analyst III	BHS - QI - MIS
Enos	Christy	Regional Director	Acadia Healthcare
Escamilla	Adrian	Information Technology Specialist	BHS - QI
Esposito	Nicole	Assistant Clinical Director	BHS - CDO
Esposito	Nicole	Assistant Clinical Director	BHS - CDO
Evans Murray	Cara	BH Program Coordinator	BHS - AOA
Fulan	John	Utilization Review Quality Improvement Specialist	BHS - QI - QM
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	BHS - AOA
Gonzaga	Alfie	Program Coordinator	BHS - CDO
Gonzalo	Marc	Clinic Director	SOAP MAT, LLC
Good	Stephanie	Program Manager	MITE - North Central Women and Adolescent Center Perinatal Outpatient Program
Guevara	Christopher	Administrative Analyst III	BHS - QI - PIT
Guingab	Amelia	Principal Administrative Analyst	BHS - Fiscal
Hagmann	Terri	Divisional Director	HealthRIIGHT 360
Hamilton	Deborah	Grant Director	Acadia Healthcare
Henley	Richard	Alcohol and Drug Program Specialist	BHS
Higgins	Mysty	LPHA	Stepping Stone of San Diego
Hillery	Naomi	Project Manager	UCSD
Jackson	Shannon	BH Program Coordinator	BHS - CYF
Johnson	Nicole	QI Manager	Stepping Stone of San Diego
Jolly	Beck	Counselor	Heartland House
Keller	Lesslie	CEO	Episcopal Community Services
Kemble	Derek	Administrative Analyst II	BHS - QI
Khalsa	Rama	Quality Reviewer	BHC - CalEQRO

Table B1 - Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Kiviat	Aurora	Assistant Director, Departmental Operations (COO)	BHS
Kneeshaw	Stacey	BH Program Coordinator	BHS - AOA
Knight	Betsy	BH Program Coordinator	BHS - AOA
Kobold	Helen	Quality Management Specialist	BHS - QI - QM
Koenig	Yael	Deputy Director, Children, Youth & Families System of Care	BHS - CYF
Lang	Tabatha	Quality Improvement Unit Administrator	BHS - QI
Lansang	Cheryl	Administrative Analyst II	BHS - QI - MIS
Lau	Karna	Division Chief	Probation
Loyo-Rodriguez	Raul	Departmental Budget Manager	BHS - Fiscal
Marsters	Ana	Clinical Line/Program Staff	Kiva Women and Children's Learning Center
Martinez	Edina	Managing Director	HealthRIGHT 360
Miles	Liz	Principal Administrative Analyst	BHS - QI - PIT
Millan	Mireya	Counselor	MHS North Inland TRC
Miller	Karen	LPHA	ECS Central East Regional Recovery Center
Mintz	Diane	Client/Family Member Consultant	BHC - CalEQRO
Mockus-Valenzuela	Danyte	Prevention and Planning Manager	BHS - PPU
Morgan	Maria	BH Program Coordinator	BHS - AOA
Morgan	Maria	BH Program Coordinator	BHS - AOA
Mullen	David	BH Program Coordinator	BHS - AOA
Munski	Matt	Administrative Analyst II	BHS - QI - QM
Nguyen	Aily	Program Coordinator	Solutions for Recovery
Nickelberry	Melinda	Deputy Director, Administrative Services	BHS - Admin Services
Nuñez	Janeth	Administrative Analyst II	BHS - QI - QM
O'Reilly	Kristyn	Senior Account Manager	FEI Systems
Panczakiewicz	Amy	Project Manager	UCSD
Pauly	Kimberly	BH Program Coordinator	BHS - CYF

Table B1 - Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Pauly	Kimberly	BH Program Coordinator	BHS - CYF
Penalba	Chona	Principal Accountant	Fiscal Services
Preston	Kristie	Director of Clinical Operations	Optum
Quach	Phuong	BH Program Coordinator	BHS - AOA
Ramirez	Ezra	Administrative Analyst I	BHS - QI - PIT
Ramos	Nilanie	Chief, CDO	BHS - CDO
Rodriguez	Lourdes	Administrative Analyst II	BHS - QI - MIS
Rossi	Laura	CEO/Executive Director	SOAP MAT, LLC
Salazar	Lisa	Program Manager	Vista Hill
Saline	Maria Carmen	Administrative Analyst II	Fiscal Services
Scolari	George	Behavioral Health Program Manager	Community Health Group San Diego
Shapira	Erin	Administrative Analyst III	BHS - QI - QM
Shaw-Taylor	Ewurama	Quality Reviewer	BHC - CalEQRO
Sheaves	David	Implementation Manager	FEI Systems
Shephard	Karissa	Program Director	Acadia Healthcare
Spickard	Ashleigh	Administrative Analyst I	BHS - QI - MIS
Stump	Don	Executive Director	NC Lifeline
Summers	Heather	Associate Director	Solutions for Recovery
Surget Mondragon	Nancy	Administrative Analyst I	BHS - QI - PIT
Talaro	Oscar	Administrative Analyst III	BHS - QI
Tally	Steve	Senior Project Manager	UCSD
Terrell	Justin	Training Manager	Optum
Tormey	Timothy	BH Program Coordinator	BHS - QI - QM
Tran	Phuong	Administrative Analyst I	BHS - QI - PIT
Turner	Sharon	Program Manager	Casa de Milagros Nosotros
Ullom	Bill	Lead Information Systems Reviewer	BHC - CalEQRO
Umanzor	Krystle	Administrative Analyst III	BHS - QI - PIT
Weeks	Anthony	Clinical Line/Program Staff	Kiva Women and Children's Learning Center
White-Voth	Charity	BH Program Coordinator	BHS - AOA
Winchell	Elisabeth	Program Manager	MHS North Inland TRC
Wood	Katie	Program Manager	Solutions for Recovery

Table B1 - Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Yip	Caroline	Information Systems Reviewer	BHC - CalEQRO
Zambrano	Lidia	Clinical Line/Program Staff	Kiva Women and Children's Learning Center

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 (MM/DD/YY): 05/01/19

Completion Date (MM/DD/YY): 04/30/20

Projected Study Period (#of Months): 12

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 05/22/19

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):

The goal of this PIP is to decrease the rates of early discharges without satisfactory progress by implementing a Relapse Prevention EBP. It is expected that the implementation of the EBP will encourage consumers to remain engaged in treatment as they learn how to 1) better identify warning signs, triggers, and high-risk situations, 2) avoid triggers and high-risk situations when possible and utilize effective coping strategies when avoidance is not possible, thus decreasing rates of early discharges from treatment 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-disciplinary team was assembled to help guide development and implementation of the PIP. This has included subject matter experts and staff from San Diego County Behavioral Health Services (SDCBHS), the Health Services Research Center (HSRC) at UCSD. Contract treatment providers interested in participating in a workgroup to provide guidance on the PIP development and implementation were given opportunities to do so.
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	Yes, FY 2017/18 data involved the discharge status of more than 5,000 treatment episodes across all the treatment providers in SD DMC network.
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	This project is exploring a new approach to its discharge planning in order to address relapse and recidivistic episodes. While its foundation is based on an evidence-based practices, individual needs and factors are anticipates to be addressed and assist in any required enhancements.

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 curriculum will be tested at six programs for four months (May – August 2019). Depending on feedback received by the pilot programs, the curriculum will be offered system-wide by the end of 2019.
Totals		**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	Acknowledging that relapse is a normal event in the course of treatment, the PIP correctly set its goal. The process by which they will measure the expected impact is clearly stated in the PIP.
Totals		**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	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	See 1.3 and 1.4
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	The DMC clearly demonstrated data collection approach and capability in the baseline data provided within the PIP tool.
Totals		**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 clients Discharged with unsatisfactory status 2. Percent of clients Discharged with standard or completed treatment status	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Measures a reliable, appropriate and valid this project

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	Efforts to increase persistence in treatment will likely result in an outcome that favorably improves health and functional status along with other improved areas favorable to the client.
Totals		**2** Met **0** Partially Met **0** Not Met **0** 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	

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	
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	
	Totals	**0** Met **0** Partially Met **0** Not Met3 N/A 0 UTD

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	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☒ Provider ☒ Other: SanWITS is operated by County DMC	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Discharge data recorded at the provider level but accessible through the county run EHR.
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	See 6.2

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: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The research team at HSRC/UCSD will receive monthly SanWITS extracts from SDCBHS via a secure file share. Additional staff level and consumer feedback mechanisms will be utilized to generate related data.
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 data analysis plan is specific and speaks to contingency options should there be untoward results.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Liz Miles, PhD, MSW, MPH Title: Principle Administrative Analyst Role: PIP Lead *Other team members:* Names: HRSC/UCSD	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**6** Met **0** 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:* 1. Introduction to staff of the Relapse Prevention EBP 2. Pilot of a Relapse Prevention curriculum 3. Roll-out of Relapse Prevention curriculum to DMC-ODS	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Reasonable interventions were described though the DMC recognizes training of staff on the relapse prevention material doesn't constitute an actual intervention. Full implementation of the EBP is just underway this month. There is cross checking of reported exposure to the EBP with a questionnaire for clients which will test exposure and check fidelity on key components by staff.
Totals		**0** Met **1** 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? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Only the most limited of data available which was verbally provided at the PIP session to CalEQRO; reports and analysis are not available at this time.
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	See 8.1

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:_____ Indicate the statistical analysis used:_____ Indicate the statistical significance level or confidence level if available/known:_____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	See 8.1
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:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Will be ongoing, see 8.1
Totals		**0** Met **0** Partially Met 0 Not Met 0 NA **3** 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	See 8.1

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	
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	
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	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **5** 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: Very early in this PIP launch. With just a couple of weeks of data available unable to draw any conclusions, therefore no measurable results. Project plan, methods and goal are well stated and appropriate to this PIP.	
Recommendations: Continue with the PIP through completion. Consider expansion to all DMC-ODS network if promising results are achieved.	
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

15 Met

1 Partially Met

8 Not Applicable

PIP overall scoring

((15x2) + 1) / (20 x 2) = 77.5%

GENERAL INFORMATION

DMC-ODS: San Diego ☐ Clinical PIP ☒ Non-Clinical PIP

PIP Title: Grievances and Appeal Utilization

Start Date (MM/DD/YY): 10/12/18

Completion Date (MM/DD/YY): 04/30/20

Projected Study Period (#of Months): 18 months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 05/22/19

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 awareness and usage of and comfort with these processes among clients, which will help identify programmatic and system wide issues. An awareness of this process is expected to increase client satisfaction and retention while simultaneously improving client activation in their own treatment.

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-disciplinary team was assembled by San Diego to develop and guide the implementation of this PIP. Membership included representation from SDCBHS, treatment providers, peer run recovery services, UCSD research and evaluation partners along with contract agencies who handle patient advocacy.
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	Grievance logs provided necessary indication that the grievance and appeal process was under-utilized. Stakeholder interviews, provider discussions and client surveys provided additional context and data that supports a hypothesis on poor messaging or support to make this process more available to those in treatment.
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 is surmised that raising awareness and increasing the use of the grievance and appeal process will lead to increased client satisfaction and retention empowering clients in regards to their own care and thereby improve clinical outcomes. San Diego has enhanced this language as the initial PIP submissions emphasized process improvement and was not clear.

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 project will include all clients receiving SUD treatment services as part of the SDCBHS DMC-ODS
Totals		**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:* **1.** Will improving accessibility of materials and educating clients on the processes increase awareness and comfort with the grievance and appeals 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 should include additional text pointing to how this improvement will lead to a consumer-based benefit.
Totals		**0** Met **1** 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This project will include all clients receiving SUD treatment services as part of the SDCBHS DMC-ODS.

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: SDCBHS access to SanWITS provider data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data collected at the provider level along with access points in the EHR are capable of providing the necessary data elements.
	Totals	**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. The % of TPS respondents who do not know how to file a grievance. 2. The % of TPS respondents who do not know how to file an appeal. 3. The % of TPS respondents that were not informed of the grievances and appeals process by their provider. 4. The # of grievances received.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	These indicators appear clear, reliable 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	Modified TPS survey and utilization of client solicited grievance or appeal will insure client focus. Client satisfaction linked to sense of empowerment and having a voice in their own treatment. San Diego has enhanced language in this revised PIP submission to emphasize benefit for the client which was not clear in past iterations.
Totals		**2** Met **0** Partially Met **0** Not Met **0** 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	
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	

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	
	Totals	**0** Met **0** Partially Met **0** Not Met 3 N/A 0 UTD

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	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☒ Provider ☒ Other: TPS supplemental survey questions	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Activity logs for grievances and appeals along with supplemental TPS 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	Rigorous quality assurance standards are evident and will be applied by UCSD.

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: grievances and appeals	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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 PIP submission is specific in its design and speaks to process should untoward results unfold.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Liz Miles, PhD, MSW, MPH Title: Principle Administrative Analyst Role: Project Lead *Other team members:* Names: UCSD/HSRC	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**6** Met **0** 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:* 1.Presentations to consumers at the programs. 2.Providers trained on beneficiary rights by SDBHS, 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	Given the wide-spread lack of knowledge or utilization of this important client-based feedback mechanism, the described interventions are reasonable and provide a variety of formats by which to make them. San Diego will need to continue to monitor for consistent application due to training needs for new employees or the emphasis placed on this process by providers.
Totals		**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? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Project cycle has yet to reach the point where data reporting and analysis can be completed. Preliminary findings after the scheduled summit intervention were provided by San Diego. This data confirmed that a significant number of clients did not know how to file a grievance or an appeal, 39 percent, though after the intervention now felt they did. Data also indicated that of the clients surveyed 26 percent had wanted to file a grievance or an appeal but did not.

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	See 8.1

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:_____ Indicate the statistical analysis used:_____ Indicate the statistical significance level or confidence level if available/known:_____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	See 8.1
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:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	See 8.1
	Totals	-0 Met **0** Partially Met **0** Not Met 4 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	Repeat measurements not scheduled to occur at this time.
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	See 9.1
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	See 9.1
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	See 9.1

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	See 9.1
	Totals	**0** Met **0** Partially Met **0** Not Met **05**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:

PIP has benefitted from rewrite focused on client benefit. Continued realization of client involvement in their own care via the grievance and appeal mechanism may well result in improved clinical outcomes and client retention. While preliminary findings are encouraging definitive conclusions are not possible at this stage of the project.

Recommendations:

Continue with the PIP through completion.

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

15 Met

12 Not Applicable

PIP overall scoring

((15x2) + 1) / (16 x 2) = 96.875%1 Partially Met

Attachment D—County Highlights

The following section includes a series of presentation slides that graphically display important DMC-ODS data trends, performance measure dashboards, and other results used by San Diego for reporting and for quality improvement. They include:

- **D.1 Access Line Summary Statistics Report:** telephonic software call center analysis provided to leadership for review each month; excerpted pages include report content index, answered call volume and trends, average call response time, SUD call volume by referral disposition.

- **D.2 Behavioral Health / SUD Service Indicators:** one of several monthly reports that are created specifically with a target audience in mind. Utilized by San Diego to inform key stakeholders, providers and partner agencies on service and performance indicators of interest to that group.

- **D.3 Annual Report San Diego Prescription Drug Abuse Task Force (PDATF):** established over a decade ago, the task force which is co-chaired by the SUD Prevention Manager, has an established history of collaboration and partnership in order to address the overdose and opioid epidemic as found locally. The attached cover page is from a full 2018 report that illustrates the use of data to understand the scope of the problem and better inform local solutions. The full report can be found at: *www.SanDiegoRxAbuseTaskForce.org*

- **D.4 Emergency Department Tool kit:** Further illustrates San Diego's targeted messaging this time for medical practitioners who may be looking for tools, information and an understanding of how to access substance abuse treatment or when to recommend MAT.

- **D.5 Interactive web page addressing opioid use:** the attached link provides an array of data, graphs and trends in San Diego County pertaining to opioid prescribing, use and overdoses.

  https://discovery.cdph.ca.gov/CDIC/ODdash/

D.1 Access Line Summary Statistics Report

County of San Diego Behavioral Health Services
Optum Access & Crisis Line Summary Statistics Report
April 2019

Report Content

Crisis Lines - 901 & 907 (Bridge Line & Crisis Queue)
Access Lines - 904, 908, 903 (English, Spanish, Provider Line)
SUD Lines - 938 & 939 (SUD Referral & SUD Auth-afterhours and weekends)

Data Source for Fig. 1 - 3: Call Management System (CMS)

Fig. 1a & 1b: Call Volume-Calls Answered – Data includes Crisis, Access & SUDS Line; excludes abandoned calls

Fig. 2a - 2d: Average Call Response Time – Duration in seconds once call enters the queue until it's answered by a counselor. Data includes Crisis, Access & SUDS Line; excludes abandoned calls

Fig. 3a & 3b: Abandonment Rate - Occurences in which a call enters queue but exits before connected to a counselor. Data includes Crisis, Access & SUDS Line; excludes abandoned calls

Data Source for Fig 4-13: Call Logging

Fig. 4 Call Volume-Hearing Impaired Calls - Data includes calls identified as TTY / TDD or Relay

Fig. 5 Non English Calls – Data includes all non-English calls answered by bilingual staff or interpreter

Fig. 6a - 6d: Non-English Calls by Language - Data includes all non-English, calls answered by bilingual staff or interpreter identified by language

Fig. 7a - 7d: Non-English SUDS Calls by Language – Data includes non-English calls answered by bilingual staff or interpreter identified by language

Fig. 8 Crisis Calls by Age Group – Data includes calls identified as Urgent or Emergent

Fig. 9 Non-Crisis Calls by Age Group – Data includes MH calls identified as Routine

Fig. 10 SUDS Calls by Age Group – Dataincludes calls identified as SUDS

Fig. 11 SUDS Call Volume by Referral Type – Data includes calls identified as SUD: Auth, Case Management, Intensive Outpatient, MAT, Opiod Treatment, Physician Consultation, Recovery Residences, Recovery Services, Residential Services (3.1, 3.3, 3.5) and Withdrawal Management

Fig. 12 Warm Transfer for SUDS Referral Calls – Data includes calls identified as SUDS

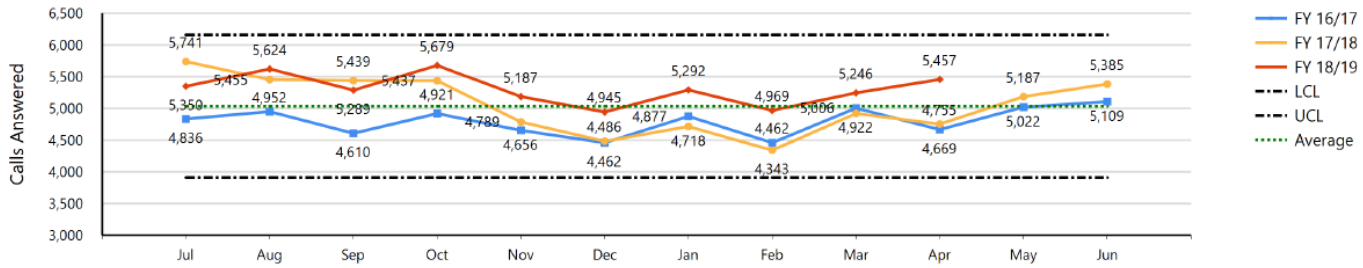
Fig. 13 Top 5 Reasons for Call - Data includes the top 5 reasons for calls to the ACL by highest call volume

San Diego
Access and Crisis Line

Free assistance 7 days a week / 24 hours a day
We are here for you!
888-724-7240
711 TTY

County of San Diego Behavioral Health Services
Optum Access & Crisis Line Summary Statistics Report
April 2019

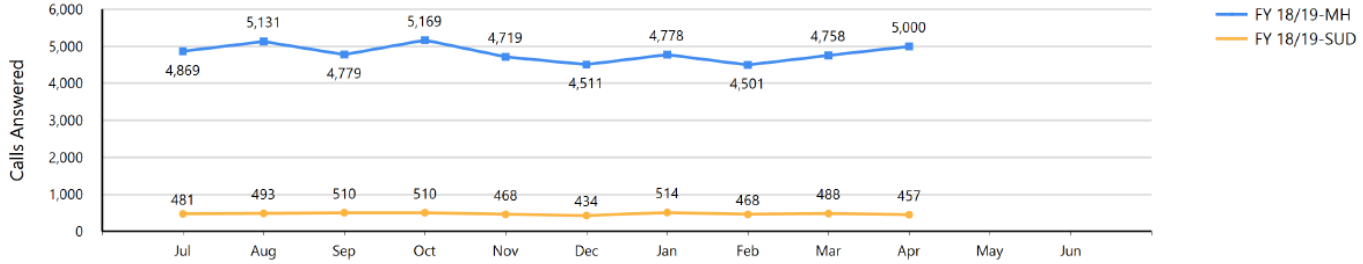
Figure 1a. Access & Crisis Line Call Volume - Answered Calls



Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Totals
FY 16/17	4,836	4,952	4,610	4,921	4,656	4,462	4,877	4,462	5,006	4,669	5,022	5,109	57,582
FY 17/18	5,741	5,455	5,439	5,437	4,789	4,486	4,718	4,343	4,922	4,755	5,187	5,385	60,657
FY 18/19	5,350	5,624	5,289	5,679	5,187	4,945	5,292	4,969	5,246	5,457			53,038

Note: After hours and weekend psychiatric hospital authorization calls to the Access and Crisis Line (ACL) were added to this graph September 15, 2017 with data reported retroactively beginning July 2016. As a result, a higher number of calls will be reported monthly on this graph when compared to past deliveries of this report.

Figure 1b. Access & Crisis Line Call Volume - Mental Health (Access+Crisis) vs SUD Answered Calls



FY 18/19	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Totals
MH	4,869	5,131	4,779	5,169	4,719	4,511	4,778	4,501	4,758	5,000			48,215
SUD	481	493	510	510	468	434	514	468	488	457			4,823

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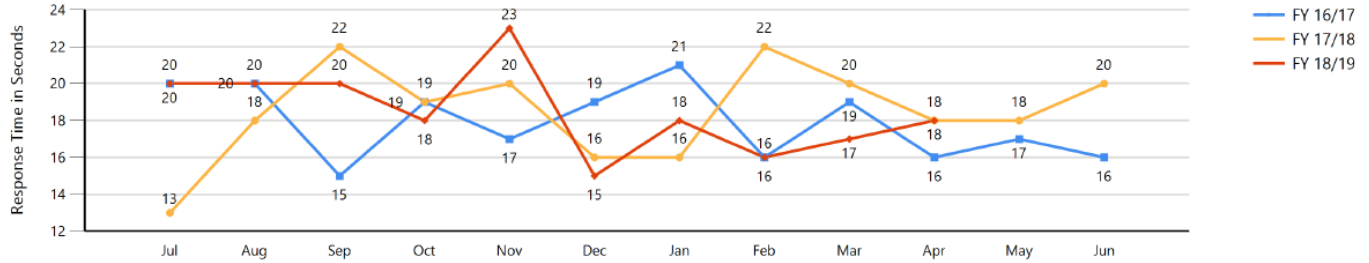
County of San Diego Behavioral Health Services
Optum Access & Crisis Line Summary Statistics Report
April 2019

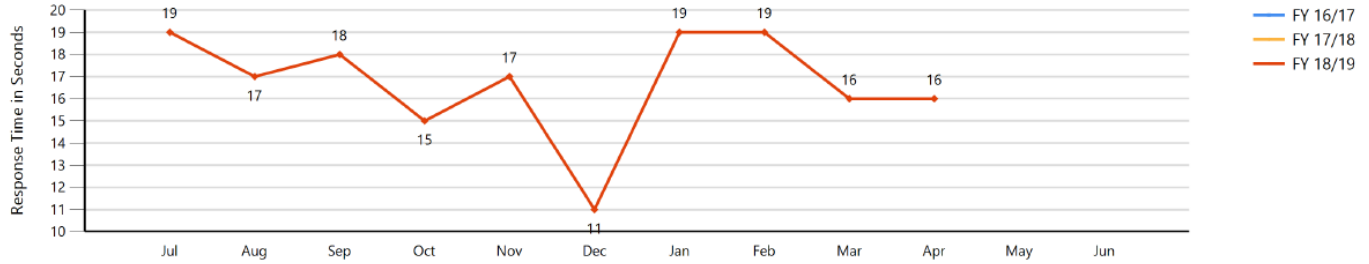
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Figure 2c. MH Access Line - Average Call Response Time



Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 16/17	20	20	15	19	17	19	21	16	19	16	17	16
FY 17/18	13	18	22	19	20	16	16	22	20	18	18	20
FY 18/19	20	20	20	18	23	15	18	16	17	18		

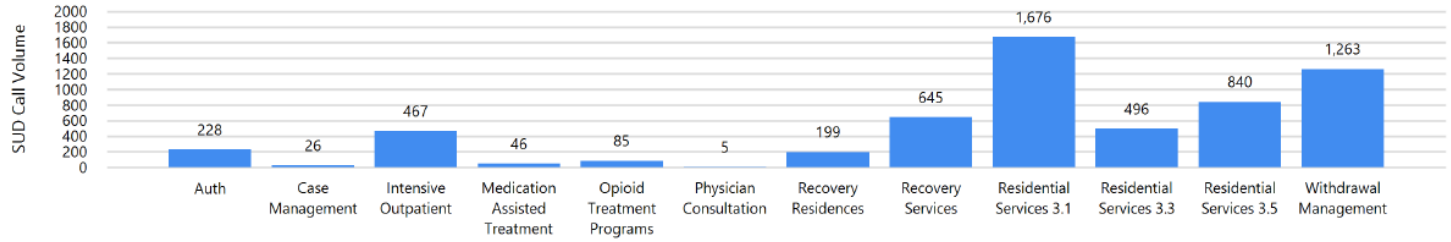
Figure 2d. SUD - Average Call Response Time



Fiscal Year	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 16/17	0	0	0	0	0	0	0	0	0	0	0	0
FY 17/18	0	0	0	0	0	0	0	0	0	0	0	0
FY 18/19	19	17	18	15	17	11	19	19	16	16		

County of San Diego Behavioral Health Services
Optum Access & Crisis Line Summary Statistics Report
April 2019

Figure 11. Access & Crisis Line by Referrals to Substance Use Disorder Services



FY 18/19	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Auth	36	28	20	15	25	23	17	21	20	23			228
Case Management	9	1	1	4	1	0	3	3	2	2			26
Intensive Outpatient	46	49	52	38	41	28	47	52	51	63			467
Medication Assisted Treatment	8	6	3	7	2	3	5	7	2	3			46
Opioid Treatment Programs	15	9	14	10	8	4	6	4	7	8			85
Physician Consultation	2	0	0	0	0	2	0	0	0	1			5
Recovery Residences	17	24	26	22	19	23	29	10	16	13			199
Recovery Services	36	53	64	50	55	49	62	81	106	89			645
Residential Services 3.1	173	176	161	131	137	133	170	210	204	181			1,676
Residential Services 3.3	62	41	53	69	59	38	36	56	37	45			496
Residential Services 3.5	67	68	60	72	100	76	80	95	99	123			840
Withdrawal Management	137	131	145	127	129	150	106	104	117	117			1,263
Total:	608	586	599	545	576	529	561	643	661	668			5,976

D.2 Behavioral Health / SUD Service Indicators

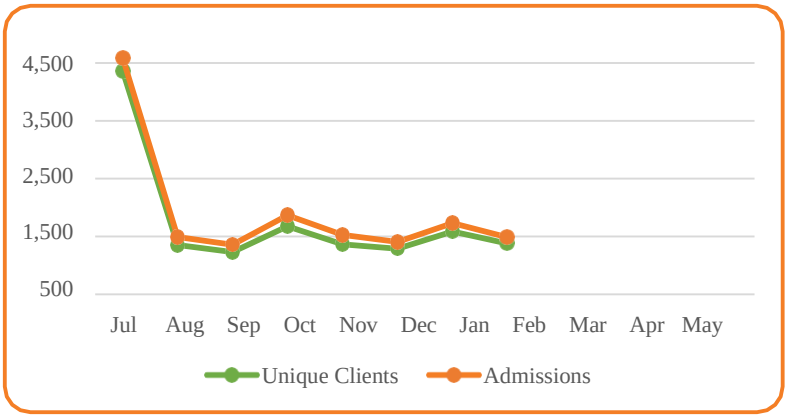
BEHAVIORAL HEALTH DASHBOARD INDICATORS

County of San Diego Behavioral Health Services

SUBSTANCE USE DISORDER SERVICES INDICATORS

Report Month: February 2019

TOTAL ADMISSIONS



Current Trends	
Feb '19 vs Feb '18	58.3% (1,483 vs. 937)
Feb '19 vs Jan '19	-14.1% (1,483 vs. 1,727)

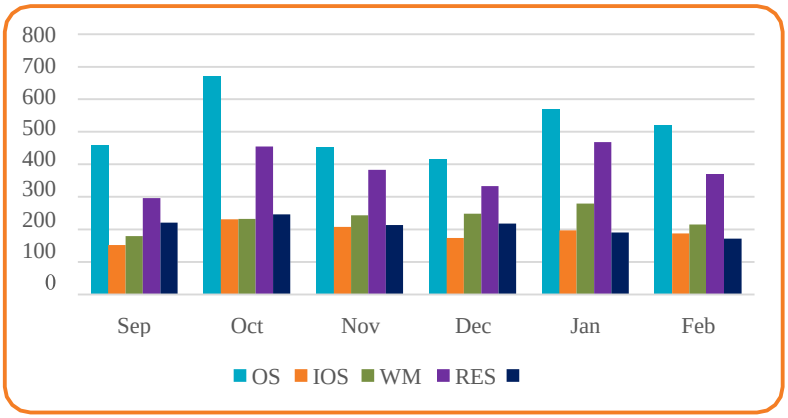
February '19 Admissions:

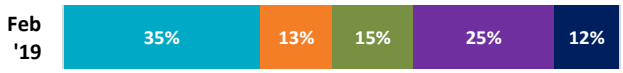
Adolescent: 118 Adult: 1,365

Annual Trends

Year	Admissions	Average Per
FYTD 18-19	15,446	1,931
FY 17-18	11,862	989

ADMISSIONS BY LEVEL OF CARE





February '19 Admissions

Adolescent	LOC	Adult
96	OS	424
10	IOS	178
1	WM	214
9	RES	361
0	OTP	172

Recovery Services Feb 2019 = 18 FYTD = 251

CLIENTS WHO TRANSFERRED BY LOC

Discharging \ Receiving LOC	REC	OS	IOS	WM	RES	OTP
REC	100%	0%	0%	0%	0%	0%
OS	33%	0%	33%	0%	33%	0%
IOS	0%	100%	0%	0%	0%	0%
WM	0%	9%	4%	6%	81%	0%
RES	2%	76%	15%	5%	2%	0%
OTP	0%	0%	0%	0%	0%	100%

Note: Clients must be discharged with a referral and transition to a program within 10 days of discharge to be considered connected.

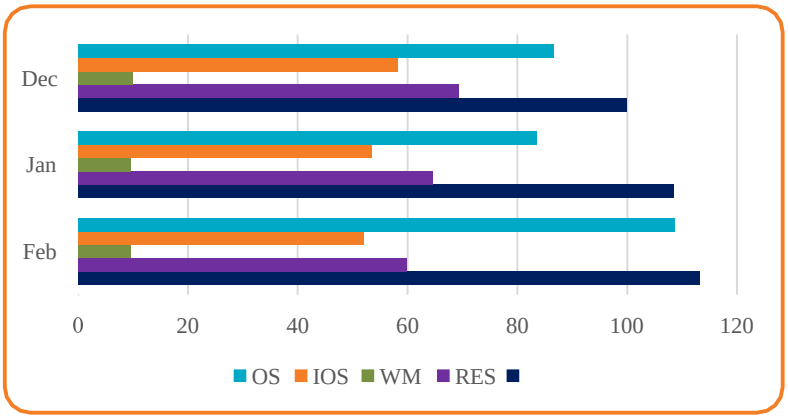
Discharging LOC	Not Connected Within 0 to 10 days		Not Connected Within 0 to 30 days	
Rec	19	95%	19	95%
OS	31	91%	31	91%
IOS	3	18%	2	12%
WM	59	52%	52	46%
RES	106	72%	93	63%
OTP	0	0%	0	0%

All Discharges: 1,321
Discharges with Referral: 25% (332/1,321)
Referred Discharges with 10 Day Connection: 34% (114/332)
Referred Discharges without 10 Day Connection: 66% (218/332)

BHS QI PIT: TC, CLG 4/18/19 | Data: SanWITS

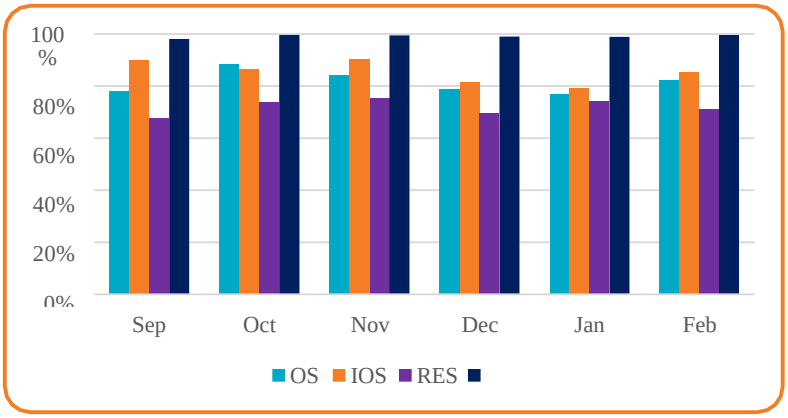
REC = Recovery Services | OS = Outpatient Services | IOS = Intensive Outpatient Services | WM = Withdrawal Management | RES = Residential Services | OTP = Opioid Treatment Program

CLIENTS AVERAGE LENGTH OF STAY BY LOC



LOC	Feb '19	FYTD
OS	109 Days	90 Days
IOS	52 Days	52 Days
WM	9 Days	11 Days
RES	60 Days	77 Days
OTP	113 Days	74 Days

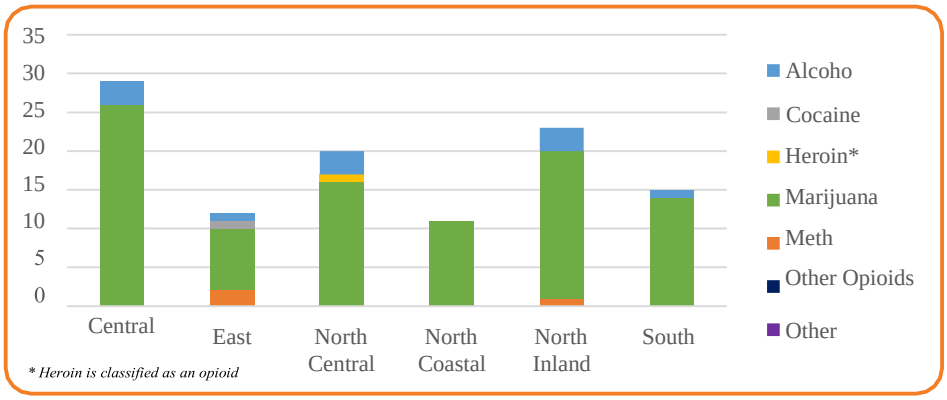
PERCENT OF CLIENT CONTACTS THAT MET ACCESS TIME STANDARDS BY LOC

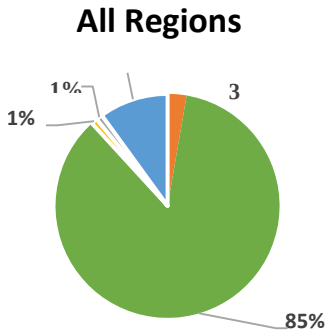


LOC	Feb '19	FYTD
OS	82%	83%
IOS	85%	86%
RES	71%	75%
OTP	99%	97%

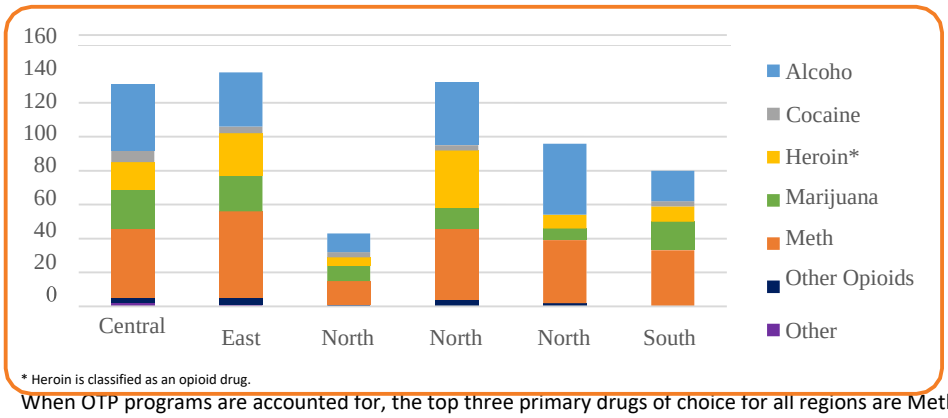
OS Access Compliance Time is 10 Business Days IOS Access Compliance Time is 10 Business Days Residential Access Compliance Time is 24 hours OTP Access Compliance Time is 3 Business Days

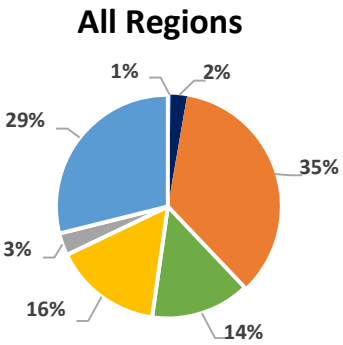
DRUG OF CHOICE BY REGION - ADOLESCENTS





DRUG OF CHOICE BY REGION - ADULTS (EXCLUDING OTP PROGRAMS)





When OTP programs are accounted for, the top three primary drugs of choice for all regions are Meth (33%), Alcohol (26%), and Heroin (24%).

Note: Region is determined by the zip code of client residence. "Other Opioids (2.26 %)" includes Other Opiates or Synthetics (1.29%), Other Sedatives or Hypnotic (0.32%), OxyCodone / OxyContin (0.48%), and Tranquilizers (e.g. Benzodiazepine 0.16%). "Other" includes Barbiturates, Ecstasy, PCP, Other Amphetamines, Other Club Drugs, Other Simulants, and Unknown.

D.3 Annual Report San Diego Prescription Drug Abuse Task Force (PDATF)

The Status of Prescription Drug and Heroin Abuse in San Diego County

The Rx Report Card provides concrete data on the scale of the prescription drug abuse problem by looking at multiple factors and data points over the last five years in San Diego County. Readers are cautioned not to consider a single data point alone, but rather are encouraged to look at all of the information, as well as the direction of trends over time.

Misuse and abuse of these drugs have serious consequences for health and safety of San Diego County residents, as well as our public health and safety community systems. Additional detailed data, including an alert about Fentanyl, is available in the 2017 Rx Addendum. Please see page 3 for a list of data sources.

Visit www.SanDiegoRxAbuseTaskForce.org for more information

Table 1. **Key Measures of Prescription Drug and Heroin Problems in San Diego County: 2013-2017**

	Indicator	2013	2014	2015	2016	2017
1	Unintentional Rx-Related Deaths					
	• Number	259	244	248	253	273
	• (Rate per 100,000 residents)	(8.2)	(7.6)	(7.7)	(7.7)	(8.3)
2	Emergency Department (ED) Opioid Activity					
	• Number of Discharges	5,723	6,866	7,501	7,005	Not Available until 2019
	• (Rate per 100,000 residents)	(182)	(215)	(228)	(213)	
3	11th Graders Self Report of Lifetime Rx Misuse	13%		14%		10%
4	Adult Drug Treatment Admissions					
	• Number of Admissions	16,629	16,104	15,177	15,790	15,952
	• Percentage of Prescription Pain Medication	4.5%	4.5%	4.3%	4.1%	3.2%
5	Arrestees Self Report of Rx Misuse					
	• Adult	43%	39%	42%	49%	47%
	• Juvenile	37%	37%	43%	40%	46%
6	Rx Prosecutions[1]					
	• Rx-specific Fraud Charge	431	308	117	140	95
	• Other Charges with Rx-involved	1,064	1,237	1,353	1,422	1,172
7	Pharmacy Robberies/Burglaries[2]					
	• Night Break-Ins/Burglaries	5	8	6	14	25
	• Armed Robberies	n/a	n/a	n/a	17	27
8	Pounds of Safely Disposed Medications					
	• Take Back Events	18,732	17,676	14,595	17,772	21,824
	• Sheriff's Department Collection Boxes	13,872	13,079	14,725	15,901	16,199
9	Annual Number of Dispensed Pills Per County Resident					
	• Pain Medication[3]	36	40	39	37	33
	• Anti-anxiety	14	13	13	13	12
	• Stimulants	4.9	4.7	5.2	5.2	5.8

D.4 Emergency Department Toolkit:

ED Toolkit

A Reference Tool for San Diego Emergency Department Providers

County of San Diego

Behavioral Health Services

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

LIVEWELLSD.ORG

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
3255 CAMINO DEL RIO SOUTH, MAIL STOP P-531
SAN DIEGO, CA 92108-3806
(619) 563-2700 . FAX (619) 563-2705

ALFREDO AGUIRRE
DIRECTOR, BEHAVIORAL HEALTH SERVICES

February 5, 2019

Dear Valued Emergency Department Providers,

The County of San Diego recognizes that substance use is a major public health and safety problem adversely impacting all of our communities. In July of 2018, The County of San Diego implemented the Drug Medi-Cal Organized Delivery System (DMC-ODS) to enhance our treatment systems to be person centered, recovery focused and improve outcomes.

The Drug Medi-Cal implementation brought the Opioid Treatment Providers, also known as "OTPs", into the County network of care. This local oversight will allow for better connections between OTPs and the rest of our substance use disorder programs and local health system partners to ensure clients have access to medicines, if appropriate. In addition, quality of care will improve by establishing a standardized practice of individual assessments to ensure clients are matched at the appropriate level of care, based on their individual needs.

We greatly appreciate your interest in working with us to pilot improvements in access to Medically Assisted Treatment (MAT) for people with Opioid Use Disorders.

The use of evidenced based practices, such as relapse prevention and motivational interviewing, will be standard throughout programs improving quality. Programs that serve individuals involved in the justice system will receive specific training to improve our treatment effectiveness for these individuals.

The core of value of our system transformation is to ensure that an individual gets the right services, at the right time.

Sincerely,

NICOLE ESPOSITO, M.D.
Assistant Clinical Director
Behavioral Health Services
County of San Diego, Health & Human Services Agency

Drug Medi-Cal (DMC) Organized Delivery System (ODS)

Services starting July 1, 2018

What is DMC-ODS?

The DMC-ODS provides California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with substance use disorders (SUD). Counties participating in the DMC-ODS are required to provide access to a continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. Through the DMC-ODS, eligible enrollees will have timely access to the care and services they need for a sustainable and successful recovery.

What is ASAM?

The ASAM Criteria is a proven model in the SUD field, and is the most widely used and comprehensive set of guidelines for assessing patient needs and optimizing placement into SUD treatment. The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels. Counties implementing the DMC-ODS are required to use the ASAM Criteria to ensure that eligible beneficiaries have access to the SUD services that best align with their treatment needs.

What is OTP (aka Methadone clinic)?

The Opioid Treatment Program (OTP), or more commonly known as methadone clinics, provides opioid medication assisted treatment (MAT) to those persons addicted to opiates. OTPs also provide detoxification and/or maintenance treatment services which include medical evaluations and rehabilitative services to help the patient become and/or remain productive members of society.

What is MAT?

Medication Assisted Treatment (MAT) is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUD. Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD.

What are the changes to OTP under DMC-ODS?

With DMC-ODS implementation, OTPs will be required to contract with the County effective July 1, 2018. This change will include direct local oversight and improve care coordination of MAT services throughout the San Diego County health care systems. Under DMC-ODS, OTPs are required to offer and prescribe methadone, buprenorphine, naloxone and disulfiram. A client's length of stay in an OTP will be driven by medical necessity that will be determined by using ASAM.

How will the County engage with OTPs to ensure they are connecting responsibly with clients and with the community?

County Behavioral Health Services (BHS) will closely monitor OTP providers by meeting with them regularly, and as needed, to continue to develop county-contractor relationship, and to discuss any community or clients issues that arise.

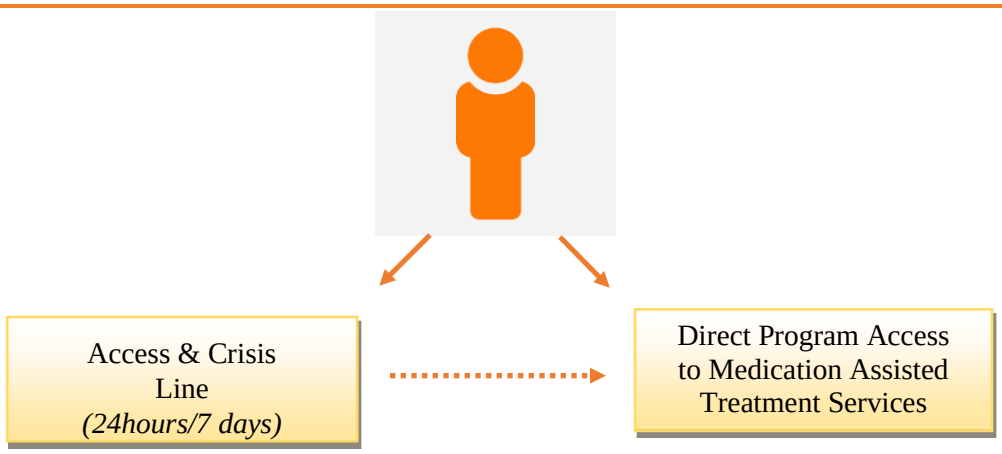
Who do I call with a complaint?

For issues or concerns with OTPs after July 1, 2018, you may call the Consumer Center for Health Education and Advocacy (CCHEA) at their toll free number:

(877) 734-3258

Drug **M**edi-**C**al (**DMC**)
Organized **D**elivery **S**ystem (**ODS**)
Services starting July 1, 2018

How do Clients Access Opioid Treatment Program (OTP) Services?



Location of OTPs

HHSA Region	OTP Provider / Site	Program Phone #	Original License Date
Central	Eldorado Community Service Center 1733 Euclid Avenue, San Diego 92105	(619) 263-0433	09/23/2010
Central	Progressive Medical Specialists, Inc. 4974 El Cajon Boulevard, Suites A & H, San Diego 92115	(619) 286-4600	03/15/2006
North Central	Mission Treatment Services, Inc. 8898 Clairemont Mesa Blvd., Suite H, San Diego 92123	(858) 715-1211	04/22/2005
North Central	San Diego Health Alliance, Inc., Fashion Valley Clinic* 7545 Metropolitan Drive, San Diego 92108	(619) 718-9890 afterhours: (855) 232-5796	01/01/1983
North Coastal	Mission Treatment Services, Inc. 1905 Apple Street, Suite 3, Oceanside 92054	(760) 547-1280	09/24/2014
North Coastal	SOAP MAT, LLC* 3230 Waring Court, Suite A, Oceanside 92056	(760) 305-7528	03/12/2012
North Inland	Mission Treatment Services, Inc. 161 N. Date Street, Escondido 92025	(760) 745-7786	07/07/2004
North Inland	San Diego Health Alliance, Inc., Capalina Clinic* 1560 Capalina Road, San Marcos 92069	(760) 744-2104 afterhours: (855) 232-5796	01/01/1983
East	San Diego Health Alliance, Inc., El Cajon Treatment Center* 234 North Magnolia Avenue, El Cajon 92020	(619) 579-8373 afterhours: (855)232-5796	01/01/1983
South	San Diego Treatment Services, LLC, Third Avenue Clinic* 1155 Third Avenue, Chula Vista 91911	(619) 498-8260 afterhours: (855)232-5796	01/01/1983

* Clinics providing Suboxone induction services

Questions?
Info-DMC-ODS.HHSA@sdcounty.ca.gov

Patients

What patient group will have the greatest benefit from buprenorphine treatment?

Patients at risk for death from opioid overdose should be prioritized; risk factors include:

- Injection heroin and non-medical pain reliever abuse
- History of overdose and/or substance abuse
- History of mental illness
- > Morphine 100 mg equivalents/day
- Medicaid/low income patients
- Frequent emergency department visits
  - > 3 in the last year;
  - ED visits with disposition of leaving without treatment or against medical advice
- Multiple opioid prescriptions in last year and multiple prescribers. However, any patient who meets DSM 5 criteria for opioid use disorder should be strongly considered for starting buprenorphine.

What does the buprenorphine patient look like?

There are multiple kinds of patients that can benefit from a buprenorphine treatment.

Starting a patient on buprenorphine lowers mortality from opioid addiction 7-fold. It is strongly recommend to start BUP in ED after overdose (OD), due to 10% risk of fatal OD within 12 months in these patients. Patients in opioid withdrawal or who desire to stop using opioid pills or heroin can work well for this program.

Another type of patient that can be more tricky is an individual with chronic pain. If they have a prescribing doctor, encourage them to go talk with that clinician.

With these patients, we encourage starting a conversation about potential transition to buprenorphine, to reduce overdose risk and possibly improve pain control. However, patients should generally be directed to discuss this option with their opioid prescriber prior to starting buprenorphine.

Addiction Treatment Comes to the Emergency Department

By **Dr. Andrew Herring**

While doctors require a special federal license — an X waiver — to prescribe buprenorphine, emergency department physicians without a waiver can administer it to patients with opioid addiction. Those patients are more likely to be in treatment at 30 days than those simply referred to treatment. Photo: Al Lopez

California is seeing progress in addressing the opioid epidemic. Overall prescribing is down, access to addiction treatment is up, and the state's opioid-related death rate is stable. And while everyone wants to see the number of deaths decline, rates in California are not climbing, as is the case in other states.

But across the state in emergency departments like the one where I work, visits due to opioid overdose rose more than 15% between 2015 and 2016.

People with opioid addiction often come to the emergency department (ED), some because they have overdosed, and others because they are suffering in withdrawal. Teams work to revive the patient who has overdosed or to treat others suffering the symptoms of withdrawal. After that, the typical next step for emergency physicians is to refer patients to addiction treatment services. Then the patient is discharged.

Imagine if, instead, the emergency department team used these encounters to offer patients treatment on the spot for the underlying disease of addiction?

In 2016, this is what we started doing at Highland Hospital in Oakland, where I'm an emergency physician. At Highland, when patients present in withdrawal, we can offer them buprenorphine, an FDA approved medication that treats withdrawal and cravings. We then connect them to outpatient addiction treatment. (There are two other medications approved for opioid addiction, methadone and naltrexone, but buprenorphine is the most appropriate in an ED setting. People with opioid addiction who have access to buprenorphine are more likely to recover, less likely to overdose, and less likely to turn to street drugs, thereby reducing their risk of contracting hepatitis C and HIV.)

New Model of Care

Physicians need special training for the US Drug Enforcement Administration to issue them an "X" waiver to prescribe buprenorphine to patients with opioid addiction. But emergency physicians can administer buprenorphine to patients in the emergency department for up to three days without the waiver.

This medication makes a big difference. A 2015 JAMA study found that patients who were given screening, brief intervention, and referral to treatment — combined with buprenorphine — had nearly 80% retention in treatment at 30 days, more than double those who only were screened and referred to treatment. From an addiction standpoint, that is a spectacular success.

A later study found initiating buprenorphine to be the most cost-effective option as well.

When we started this approach at Highland two years ago, we saw only a few patients, maybe two a week. Now we're seeing one to two patients a day and are able to connect them to outpatient services.

Spreading the Approach Throughout California

I recently cared for a young woman who had become dependent on the combination medication hydrocodone-acetaminophen after a difficult pregnancy and labor. (Brand names for this drug include Vicodin; hydrocodone is a synthetic opioid.) After her doctor stopped prescribing the medication, the woman experienced severe withdrawal symptoms and cravings but was afraid to tell her doctor. Instead, she turned to buying pills from drug dealers. She came into the ED in withdrawal, and we started her on buprenorphine. She is doing well now. Not everyone has to hit "rock bottom." There are many people who have a susceptibility to addiction and inadvertently get caught up in this disease. They want help but don't know where to go.

Shortly after we launched our program at Highland, the California Health Care Foundation supported me in an effort to spread this model to eight hospitalsacross both California's rural and urban areas.

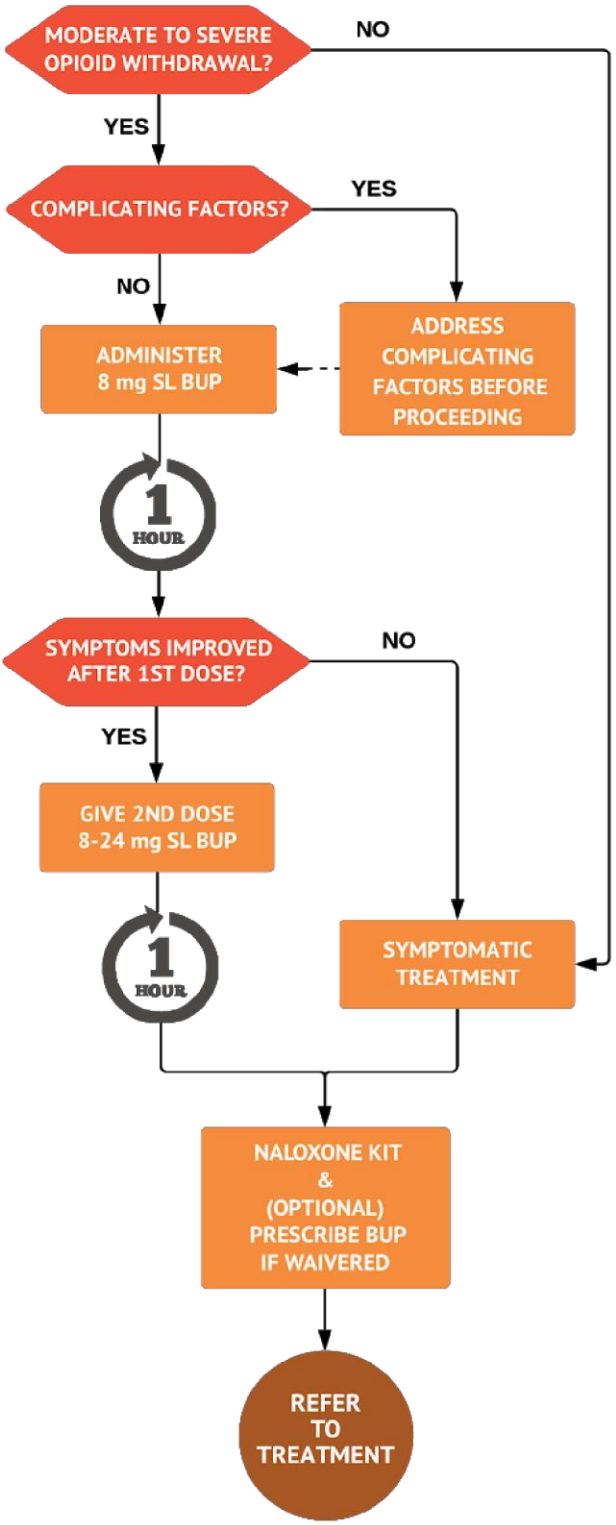
This was one of the first attempts to take the idea from an academic urban teaching hospital and see if it was feasible in a rural community hospital. Very soon after getting started, we found that treating withdrawal with buprenorphine became an everyday practice in these EDs. It's a pretty simple process of starting patients on treatment with buprenorphine and then giving them information to receive ongoing care with a partnered community health center. Generally, patients who come to the emergency department are highly motivated, and they want to change. We help them get started.

In part because of the success of this pilot program, the California Department of Health Care Services this year began supporting the spread of medication-assisted treatment in the ED more broadly with a $690,000 grant through the statewide Medication Assisted Treatment Expansion Project. We are calling this effort ED-Bridge because we start treatment in the ED and connect people to outpatient care.

Our goal is for every emergency department in California to be equipped and skilled in offering addiction treatment.

BUPRENORPHINE (BUP) ALGORITHM

AUGUST 2018



MODERATE TO SEVERE OPIOID WITHDRAWAL

- Use clinical judgement to determine moderate to severe withdrawal.
- If uncertain, use the Clinical Opioid Withdrawal Scale (COWS)
- If using COWS, the score should be ≥ 8 or ≥ 6 with at least one objective sign of withdrawal
- Document: which opioid used, time of last use

COMPLICATING FACTORS

Identify and manage complicating factors prior to proceeding.
The only absolute contraindication is allergy to buprenorphine.

Refer to Buprenorphine Guide before dosing buprenorphine for:

- Clinical suspicion of acute liver failure
- ≥ 20 weeks pregnant
- Intoxicated or altered
- Withdrawal precipitated by naloxone
- Taking methadone or long acting opioid
- Chronic pain patients taking prescribed opioids
- Withdrawal symptoms are inconsistent or borderline (COWS of 6-8), or opioid use within 12 hours; consider beginning with a low dose (2-4 mg SL) and titrating every 1-2 hours

PARENTERAL DOSING

- Use if unable to take sublingual (SL)
- Start with 0.3 mg IV/IM buprenorphine; may repeat as needed; switch to SL when tolerated

PRECIPITATED WITHDRAWAL

- Buprenorphine can cause precipitated withdrawal if too large a dose is given too soon after the last opioid use
- The longer the time since last opioid use (> 24 hours) and the more severe the withdrawal symptoms (COWS ≥ 13) the better the response to initial dosing
- Only patients with objective improvement in withdrawal after the 1st dose should receive subsequent dosing
- Worsening after buprenorphine is likely precipitated withdrawal; no further buprenorphine should be administered in the ED; switch to symptomatic treatment

SYMPTOMATIC TREATMENT

- Supportive medications such as clonidine, gabapentin, metoclopramide, low-dose ketamine, acetaminophen, NSAIDs

LOWER TOTAL DOSE OPTION (16 mg)

- Possible lower risk of sedation or precipitated withdrawal
- Some patients will go back into withdrawal in less than 12 hours increasing risk of early dropout.
- Buprenorphine prescription or next day follow-up should be available

HIGHER TOTAL DOSE OPTION (24-32 mg)

- Increased magnitude and duration of opioid blockade
- More complete treatment of withdrawal in heavy users
- May suppress craving and protect against overdose (opioid blockade) for 2 days or more
- Use with caution in medically complex patients, older patients, and patients using other sedatives such as alcohol or benzodiazepines

RE-EVALUATION TIME INTERVALS

- The time to SL buprenorphine onset is typically 15 minutes and peak clinical effect is typically within 1 hour
- Re-evaluate patient 1 hour after buprenorphine doses
- Observe for 1 hour after the final dose before discharge

DEA 72 HOUR RULE

- Patients may return to the ED for up to 3 days in a row for repeat doses
- At each visit administer 16 mg SL buprenorphine

FOLLOW-UP

- Goal: follow-up treatment available within 3 days

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

ED BRIDGE
Emergency Buprenorphine Treatment

Buprenorphine Requirements Across Medi-Cal Systems of Care

May 2017

Question	Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties	Drug Medi-Cal (DMC) Non-Waivered Counties / State Plan Only Services	DHCS Fee-For-Service (FFS)
Is buprenorphine a covered benefit?	Yes. Buprenorphine is a covered benefit and access to buprenorphine is required in NTP facilities. Access to buprenorphine is optional in non-NTP facilities.	No. Buprenorphine is not a covered benefit under DMC State Plan Services. A Data 2000 waivered professional may become a FFS provider and provide this service in a SUD setting.	Yes. Any DATA 2000 waivered Medi-Cal professional can order, stock, and administer buprenorphine for treatment of opioid addiction. The patient can also fill the prescription under the FFS Pharmacy Benefit.
Where can buprenorphine services be provided?	Services can be provided at DMC-certified facilities and in the community.	Buprenorphine is not a covered benefit under DMC State Plan Services.	Services can be provided at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of NTPs.
What are the provider contract requirements?	The DMC provider must be selected by the county to provide services.	Buprenorphine is not a covered benefit under DMC State Plan Services.	The qualified practitioner contracts directly with DHCS (not the county) as a FFS provider.
Is telehealth covered?	Yes, but only if the county chooses to provide this service.	Buprenorphine is not a covered benefit under DMC State Plan Services.	No.[1]

1 Telehealth services are available, but telehealth for SUD services are not covered. See http://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx.

Resources

Below are some helpful resources.

California Department of Health Care Services

California Department of Health Care Services (DHCS)—
https://www.dhcs.ca.gov/Pages/default.aspx

Emergency Buprenorphine Treatment

Emergency Buprenorphine Treatment ED-Bridge—https://ed-bridge.org/

JAMA

JAMA Network—https://jamanetwork.com/

Rx Drug Abuse Task Force—San Diego County

Rx Drug Abuse Trask Force (PDATF)—https://www.sandiegorxabusetaskforce.org/

Attachment E—Client Focus Group Forms

Client focus group forms
Parents/ Guardians of Adolescent Clients Focus Group Feedback

Program/Clinic Name: _____ Date: _____

1. What is your age?
   - 0-17
   - 18-24
   - 25-59
   - 60 +

2. What is your gender?
   - Male
   - Female
   - Transgender
   - Other
   - Decline to state

3. What is your Race/Ethnicity?
   - African American/Black
   - Asian American/Pacific Islander
   - Caucasian/White
   - Hispanic/Latino
   - Native American
   - Other _____

4. What is your preferred Language?
   - English
   - Spanish
   - Other _____

My child/ person I am caring for started therapy in the last year with this counselor/program: Yes_____ No_____

My child/ person I am caring for have seen their counselor for more than a year: Yes____ No_____

Please read the sentences below about working with your counselor/program. After reading each sentence decide how much the sentence is correct based on what you feel. There are no right or wrong answers for this questionnaire, just how you feel.

---

1. I easily found the treatment services that my child/person I am caring for needed.


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

2. The child/ person I am caring for got an assessment appointment at a time and date we wanted.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3. It did not take long for my child/person for whom I am caring for to begin treatment after their assessment appointment.

Strongly Disagree Disagree Undecided Agree Strongly Agree

4. I feel comfortable calling the program for help with an urgent problem concerning my child/person I am caring for.

Strongly Disagree Disagree Undecided Agree Strongly Agree

5. Has anyone discussed with you and your family the benefits of new medications for addiction and cravings?

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.) of my child/person I am caring for.

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. The child/person I am caring for responds in the following way to learning it is time to go to see their counselor again:

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. Because of the services my child/ person I am caring for is receiving, he/she is better able to do things he/she wants.





Strongly Disagree Disagree Undecided Agree Strongly Agree

9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.





Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

10. What do you think would make the program or counselor more helpful to your recovery?

11. What would you change if you could to make the services better?

Client focus group forms
Transitioning Age Youth (TAY) Focus Group Feedback

Program/Clinic Name: _____ Date: _____

1. What is your age?
- 0-17
- 18-24
- 25-59
- 60 +

2. What is your gender?
- Male
- Female
- Transgender
- Other
- Decline to state

3. What is your Race/Ethnicity?
- African American/Black
- Asian American/Pacific Islander
- Caucasian/White
- Hispanic/Latino
- Native American
- Other _____

4. What is your preferred Language?
- English
- Spanish
- Other _____

I started therapy in the last year with this counselor/program: Yes_____ No_____

I have seen my counselor for more than a year: Yes____ No_____

Please read the sentences below about working with your counselor/program. After reading each sentence decide how much the sentence is correct based on what you feel. There are no right or wrong answers for this questionnaire, just how you feel.

---

1. I easily found the treatment services I needed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

2. I got an assessment appointment at a time and date I wanted.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3. It did not take long to begin treatment after my first appointment.

Strongly Disagree Disagree Undecided Agree Strongly Agree

4. I feel comfortable calling my program for help with an urgent problem.

Strongly Disagree Disagree Undecided Agree Strongly Agree

5. Has anyone discussed with you or your family the benefits of new medications for addiction and cravings?

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.).

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. I found it helpful to work with my counselor(s) on solving my problems in life.

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. Because of the services I am receiving, I am better able to do things I want.

Strongly Disagree Disagree Undecided Agree Strongly Agree

9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

10. What do you think would make the program or counselor more helpful to your recovery?

11. What would you change if you could to make the services better?

Client focus group forms
Adult Client Focus Group Feedback

Program/Clinic Name: _____ Date: _____

1. What is your age?
   - ☐ 0-17
   - ☐ 18-24
   - ☐ 25-59
   - ☐ 60 +

2. What is your gender?
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Other
   - ☐ Decline to state

3. What is your Race/Ethnicity?
   - ☐ African American/Black
   - ☐ Asian American/Pacific Islander
   - ☐ Caucasian/White
   - ☐ Hispanic/Latino
   - ☐ Native American
   - ☐ Other _____

4. What is your preferred Language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other _

I started therapy in the last year with this counselor/program: Yes_____ No_____

I have seen my counselor for more than a year: Yes____ No_____

Please read the sentences below about working with your counselor/program. After reading each sentence decide how much the sentence is correct based on what you feel. There are no right or wrong answers for this questionnaire, just how you feel.

---

1. I easily found the treatment services I needed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

2. I got an assessment appointment at a time and date I wanted.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3. It did not take long to begin treatment after my assessment was completed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

4. I feel comfortable calling my program for help with an urgent problem.

Strongly Disagree Disagree Undecided Agree Strongly Agree

5. Has anyone discussed with you the benefits of new medications for addiction and cravings?

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.).

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. I found it helpful to work with my counselor(s) on solving my problems in life.

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. Because of the services I am receiving, I am better able to do things I want.

Strongly Disagree Disagree Undecided Agree Strongly Agree

9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

10. What do you think would make the program or counselor more helpful to your recovery?

11. What would you change if you could to make the services better?

Attachment F—Summary of Access Call Center Key Indicators

Access Line Performance Measure

Overview/ Analysis

Average Monthly Call Volume in Last 12 months: 485
Average Monthly Calls: Enter Average Calls. **from** 7/1/2018 **to** 3/31/2019

Average Dropped Calls Per Month: 2% (10 abandoned calls/485 incoming calls)

Average Wait Time on the Phone until Answered: 17 Seconds

Dedicated Full Time Equivalent (FTE) Staff Assigned to Call Center: 2 for DMC

Software/Vendor for Tracking Call Metrics:
Software Name: Avaya
Software Version: Call Management System
Or ☐ *DMC-ODS Data Not Available*

County Has No Wrong Door Policy	☒ Yes	☐ No
If yes, does the county track walk-ins and calls at other sites requesting service?	☒ Yes ☐ N/A	☐ Not currently
Call Center Linkage to EHR for county services	☒ Yes	☐ No
Call Center Does ASAM Based Screening	☒ Yes	☐ No
Call Center Does Full ASAM Based Assessments	☐ Yes	☒ No
Call Center Authorizes Admissions to Residential Treatment	☒ Yes	☐ No
Call Center Tracks Disposition of Calls	☒ Yes	☐ No
Call Center Allows Callers to Leave a Message	☒ Yes	☐ No

Attachment G—Continuum of Care Form

Continuum of Care DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Capacity:

County: **County of San DiegoCounty of San Diego**
Review Date(s): **May 21 – 23, 2019May 21 – 23, 2019**
Person Completing Form**: Matt MunskiMatt Munski**

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 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.

• The "Coordination and/or Referral of Physical and Behavioral Health Form" must be completed at intake/no later than 30 days from admission to connect a client to a primary care provider (PCP) within that timeframe, if the client does not have a current PCP.

• 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's centralized or integrated into programs or both:

Monthly Estimated Billable hours of Case Management: **4,332 Units**

Comments:
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.

How are you structuring Recovery Services?

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 peer support.

Pick 1 or more as applicable and explain below:

1) Included with Outpatient sites as step-down
2) Included with Residential levels of care as step down
3) Included with NTPs as stepdown for clients in remission

Total Legal Entities: **25** Choices: **1 and 2**

Explanation:

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.

What is your estimated monthly estimated billable hours of recovery support services? 745 Units

Withdrawal Management Outpatient – withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).

Number of Sites: N/AN/A Estimated Billable house per month: N/AN/A

How are you structuring it? - *Pick 1 or more as applicable and explain below*

1) NTP?
2) Hospital
3) Outpatient
4) Primary Care Sites

Choice(s): N/A

Explanation:

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 will evaluate the need of services in the community.

How are you doing this?

Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports for the withdrawal.

Number of Sites: 7 Estimated Billable hours per month: 2,080 Units

Pick 1 or more as applicable and explain below:

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

Choice(s): 3

Explanation:

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.

How are they organized?

NTP Programs- Narcotic Treatment Programs for opioid addiction and stabilization including counseling, methadone, and coordination of care.

Total Slots: 4,685 Number of Sites: 10
Total Legal Entities: 4
Out of County NTP: Slots 0 Sites: 0
In County NTP: Slots 4,685 Sites: 10

Comments:

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.

MAT

MAT Outpatient (providing other drugs besides methadone)- Outpatient services providing MAT medical management including a range of medications other than methadone, usually accompanied by counseling for optimal outcomes.

Total Legal Entities: N/A Number of Sites: N/A

Comments:

Currently, the County of San Diego is in discussions with Outpatient providers who are interested in expanding services to include additional MAT.

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

Average estimated Billable hours per month: 22,324 Units
Total Legal Entities: 11 Total Sites for all Legal Entities: 58

Comments:

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 Billable hours per month: 8,059 Units
Total Legal Entities: 11 Total Sites for all Legal Entities: 58

Comments:
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 Number of Programs: N/A
Total Sites for all Legal Entities: N/A
Average Client Capacity per day: N/A

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 that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.

Number of Program Sites: 26
Total Sites for all Legal Entities: 26
Total Beds: 1,043

Comments:
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 criteria 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.

Number of Program Sites: N/A
Number of Legal Entities: N/A

Total Bed Capacity: N/A
(Can be flexed and combined in some settings with 3.5)

Comments:

Currently the County of San Diego has three programs with a provisional 3.3 designation.

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.

Number of Program Sites: 16
Number of Legal Entities: 14
Total Bed Capacity: 1,031
(Can be flexed and combined in some settings with 3.5)

Comments:

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?)

Number of Program Sites: N/A
Number of Legal Entities: N/A
Total Bed Capacity: 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.

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?)

Number of Program Sites: N/A
Number of Legal Entities: N/A
Total Bed Capacity: 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.

Other comments on Continuum of Care:

None

Attachment H—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