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2020-21
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

SAN DIEGO DMC-ODS REPORT

Prepared for:
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SAN DIEGO DMC-ODS REPORT

Beneficiaries Served in Fiscal Year (FY) 2019-20: 11,362.
San Diego Threshold Language(s): Spanish, Tagalog, Arabic, Vietnamese, Farsi
California External Quality Review Organization (CalEQRO) obtained the Drug Medi-Cal Organized Delivery System (DMC-ODS) threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070
San Diego Size: Large
San Diego Region: Southern
San Diego Location: San Diego
San Diego Seat: San Diego
San Diego Review Process Barriers: None.

Review Special Characteristics

This review took place during the coronavirus disease 2019 (COVID-19) pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, CalEQRO worked with San Diego to design an alternative to the usual in-person onsite review format. San Diego requested a desk audit with some video sessions and exchange of information due to the impact of COVID-19 on staffing re-deployment to emergency assignments and illness. San Diego was not able to support consumer or family focus groups; however, was able to have contract providers ask clients to respond to the online survey and the results are included in this report. San Diego responded in writing to a set of questions designed to clarify the documents reviewed by CalEQRO. A second set of questions was then developed for further clarification with additional questions. There was a video session, with the San Diego team, at the conclusion of the review for wrap up questions and exit interview questions and discussion.

Introduction

San Diego is a large county in the southern region with an integrated behavioral health system that includes the DMC-ODS. San Diego provides the DMC-ODS services exclusively through their provider network. All services are provided within the county. San Diego has a focus of high-quality services to persons with co-occurring disorders.

San Diego officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in July 2018 for Medi-Cal recipients as part of California's 1115 DMC Waiver. In this report, "San Diego" shall be used to identify the San Diego DMC-ODS program unless otherwise indicated.

During this FY 2020-21 San Diego review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to DMC access, timeliness, quality, and outcomes

related to the second-year implementation of San Diego's DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2019-20.

How Beneficiaries Access Care

There are some best practices important to DMC-ODS programs in how they organize their access to care. To understand whether a county is doing these, it is important to know how they have organized their access systems. In addition, the special terms and conditions (STCs) of the 1115 Waiver have specific requirements for the 24-hour beneficiary access line (BAL) or as many describe it their "Access Call Center". The Access Call Centers play different roles in different counties in the linkage of clients to treatment depending on the size of the county and the design of the access points. To evaluate this element of quality, it is important first to know how this DMC-ODS has chosen to organize its access system to bring beneficiaries into the treatment system via screenings, assessment, and engagement.

San Diego DMC-ODS has developed their access system with the following elements:

San Diego, an integrated system, has a "No Wrong Door" hybrid model that allows Behavioral Health Services (BHS) clients to access DMC-ODS services by directly contacting contract providers or through the BAL, in San Diego called Access and Crisis line (ACL), to assist clients during or after business hours. 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 (LOC). The integrated ACL includes 27 clinicians who are trained to screen and make referrals to both mental health and DMC-ODS services. The bulk of the work goes to mental health but Optum carefully tracks data on callers to both systems. The two full-time equivalents (FTE) identified as supporting DMC-ODS are based on the distribution of the calls between the two systems. There are nine bilingual staff among the Optum's ACL personnel and Optum makes every attempt to hire qualified bilingual clinicians. Once that determination has occurred, the individual will be directed to a service provider who can complete a comprehensive assessment.

The ACL operates 24 hours a day. They handle crisis calls, screening for mental health issues along with substance abuse requests for service. Official designation as a crisis line allows the ACL to address more acute needs in a way that avoids call transfer to another service. Third party or family calls regarding someone with a substance abuse problem are handled as a first-person screening and referrals are offered. For those calls which come in outside normal business hours or on weekends the ACL will provide the caller with three referrals. This gives callers alternative provider options if staff are unable to make immediate contact with a provider program that is closed. When beneficiaries contact any substance use disorder (SUD) treatment program in the community to be screened for services, the same screening function will occur along with facilitation of any indicated need for referral, even if it is to another LOC of care or provider. If it is determined that the LOC of care offered at that site is not appropriate, staff are required to link the client via a warm hand-off to appropriate referrals. The majority of beneficiaries

go directly to San Diego contract providers, as they have always done, to request services. In the second quarter of the review year only two percent of SUD clients requested services through the ACL.

The San Diego ACL provides good consumer experience of quick response to calls (15 seconds) and a low dropped call rate (2.14 percent), yet data shows, despite having the capacity for a warm hand off, there is a low rate of clients linking from this contract to treatment services. In response to this data, and a CalEQRO recommendation, the ACL has looked at messaging around the warm transfer process and its value to callers, updating their language when offering this resource. They also worked to expedite the screening to reduce call time prior to offering a warm transfer to determine if that improves the transfer rate. San Diego has added language so callers can respond to "why" they are declining the warm transfer and this data will now be collected. San Diego also noted that over 40% of the callers included in the unsuccessful warm transfer category were third party callers collecting referrals on behalf of someone else. San Diego plans to keep this detail in the report but exclude these callers from the overall percentages highlighted to show a more accurate representation; however, in the last year the percentage of persons linked to treatment reduced from 12 percent to 9 percent. San Diego attributes this in part to the high number of calls received that are crisis calls relating to mental health. The SUD calls equate to 8.13 percent of total call volume. The clinicians were then able to successfully identify and refer and additional one percent through screening for individuals who did not initially identify themselves as needing substance use treatment.

In addition, the ACL team has a Utilization Management team dedicated to managing the residential authorization process, it currently consists of 3.5 clinician positions with the ACL clinicians providing coverage afterhours and on weekends. The ACL authorized on average 740 clients monthly for residential treatment; of this number, 311 were initial (first request) authorizations, 294 continued (second request) authorizations and 133 extensions (third request).

Optum has developed a "secret shopper" program, specifically reviewing the actual call language, and rating the ACL clinician in a variety of areas including completeness of information documented, screening proficiency with American Society of Addiction Medicine (ASAM) LOC tools, medication follow up, appropriateness of the screening and overall impressions. This feedback is about specific staff and Optum utilizes the data to provide staff with learning opportunities and improved responses to clients. In the last year there were five calls reviewed each quarter.

Continuum of Care Overview

The STCs require an implementation plan with phased levels of care based on the ASAM continuum, expanding over time treatment options for clients to access based on their individual needs. Each year the CalEQRO reviews in depth the current services and capacity and plans for changes in the services by levels of care or capacity including consideration of locations, special needs, age groups, etc.

San Diego has a solid continuum of care, allowing good usage of appropriate services and levels of care using ASAM criteria. San Diego services are distributed to clients based on ASAM criteria, and their utilization indicates services are available to those needing specific LOC. Of note their intensive outpatient treatment (IOT) served 11.6 percent and non-methadone medication assisted treatment (MAT) served 6.2 percent of clients, slightly higher in comparison to the statewide average. Narcotic Treatment Programs (NTP), residential and outpatient are evenly accessed by the client population.

San Diego has one site, through a contract with Mental Health Systems ACTION East that provides integrated serious mental illness (SMI) and SUD treatment services. The SUD outpatient and IOT services include individual and group counseling, patient education, MAT, CM, and recovery services. Specialty mental health services are provided through other funding sources. The target population is individuals 18 years and older with a SUD diagnosis who meet medical necessity using ASAM criteria and are homeless or at risk of homelessness in this region. A second contract with HealthRight360, will provide non-methadone MAT in an outpatient setting to women at the Serenity House outpatient program. Unfortunately, due to COVID-19, Serenity House was not able to hire additional staff and so there has been a delay in implementation.

San Diego NTP/OTP contract providers all provide non-methadone MAT services to clients assessed to benefit from these new medications. Three hospitals have established grant funded Bridge programs for persons with opioid addiction seeking help in emergency departments (ED). These programs offer buprenorphine induction and then assist patients in linking to ongoing follow up care. In addition, there are federally qualified health clinics (FQHCs) in San Diego who have been trained to treat opiate addicted clients with MAT through a collaborative project between Center for Care Innovation and the California Health Care Foundation. San Diego also contracts with an FQHC that provides DMC services in two regions (Central and South county).

San Diego has two levels of residential 3.1 and 3.5 and was moving forward last year to expand the 3.3 level; unfortunately, COVID-19 delayed the procurement process that was planned. San Diego is discussing the timing for moving forward this procurement but there is no date at this time.

San Diego currently has only residential withdrawal management (WM) services; however, they are participating in community discussions where there was interest expressed in having WM outpatient programs. San Diego is continuing to evaluate procurement of these services. San Diego is also exploring ways to establish a WM 3.7 program as they work with a new epidemiology team to understand the true need for WM in the community. The San Diego goal is to expand both quantity and type of WM.

As San Diego does not have Acute Medical Detox levels 3.7 and 4.0 in place at this time, they help beneficiaries to access those services from acute medical facilities. San Diego confirms the Medi-Cal Managed Care Health Plans cover the acute medical detox benefit and that local acute medical hospitals are providing these services to beneficiaries.

San Diego has provided funding to contract providers with outpatient and IOT services to fund Recovery Residences (RR), as needed for their clients. There are 42 RR in their directory that meet the outlined standards and are available, each RR has a varying number of beds.

DMC-ODS providers are contractually expected to have the capacity to provide recovery services within 90 days of a client's treatment conclusion, including "graduates" from other treatment providers' programs. Programs complete LOC forms to align or match treatment which may include outpatient individual or group counseling, recovery monitoring, substance abuse assistance, education and job skills, family support, support groups, and ancillary services such as housing linkages, transportation, CM, and service coordination that supports clients in their recovery.

San Diego does have a Peer Support Plan that was approved by DHCS, but implementation was delayed due to the pandemic. San Diego's plan is to develop this capacity and have contracted programs hire peer positions. In addition, San Diego contracts and funds peer-run organization RI International to train future peer staff as defined in the DHCS-approved DMC-ODS Peer Support Plan. RI International also supports peers working in the system and guides them in advancement opportunities. Although the County's Peer Support Plan, including training has not officially launched, there is currently SUD peer training available through RI International.

The San Diego continuum collaborates through the contract providers with a variety of non-profit community groups especially as a referral for clients including Alcoholics Anonymous/Narcotics Anonymous (AA/NA), SMART Recovery, and other community-based self-help groups.

Case Management/Care Coordination Model

Case Management (CM) and coordination of care in a managed care model based on the ASAM continuum of care is a critical service. DMC-ODS programs have approached this element of the care system in vastly different ways. Because it has such a major impact on the clients and their outcomes, it is important to understand how the DMC-ODS has chosen to organize this service as part of the continuum of care. In many ways, it is the glue that makes the system work as a whole for the client versus siloed program elements. CM services include advocacy, linkage, support, and practical assistance based on a foundation of a therapeutic alliance with the client with SUD. Given the levels of impairment and stages of change experienced, many clients need these CM supports especially in early stages of treatment to be successful in initiation and engagement, and ultimately in progress and positive outcomes.

San Diego, a system entirely comprised of contract providers, defines the county role in care coordination to set forth standards, train contracted providers on those standards and monitor to program compliance with the standards. San Diego expects contract providers, in order to engage clients and ensure successful continuity of care, to set policies and procedures on care coordination, focusing on seamless transitions without

disruption to service for the client. San Diego expects contract providers at minimum to assign each client with a primary counselor at the initiation of services with the responsibilities to 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 with assistance with in-program needs. The program case manager is expected to 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.

San Diego requires that programs obtain a compliant release of information form for the client's primary care provider and other treatment providers or collateral contacts. It is expected that there will be documentation of attempts to coordinate care in the client chart within 30 days of admission and as needed throughout treatment. San Diego expects that interdisciplinary team meetings are used as means for all staff providing client services, to maintain clear communication with each other regarding assessed needs and indications of change to level of care (LOC).

San Diego has included in the Substance Use Disorder Provider Operations Handbook (SUDPOH) a missed schedule appointment protocol with timeliness expectations of following up after a missed appointment by a new referral or a current client who did not call to reschedule (within one business day by a clinical staff) and a client with recent elevated risk factors (on the same day as the missed scheduled appointment).

San Diego also defines a warm hand off which is expected when a client transitions from one level of care to another or to an ancillary service. San Diego is clear that assisting clients to successfully transition to another entity, to continue care smoothly, is critical for long-term success. The warm hand off process includes communication between concurrent providers of service that occurs prior to the case closing at the current program. It also includes ensuring the client is clear on the reason for referral or transfer, a direct conversation between providers to ensure timely passing of critical information, and timely transfer of pertinent documents.

San Diego believes the ideal is a joint session or meeting with the providers and the client face to face, telephonically or virtually so information can be shared between providers about the client treatment and engagement history. A successful transition is defined as confirmation that the client has engaged, and an initial appointment has occurred. In all cases San Diego expects the last treatment SUD provider be responsible for and coordinate transitions in care. All coordination of care activities must be documented in the client record.

San Diego uses tools such as a SUD Admission checklist and monitoring tools to assure that through a medical records review process the expectations for CM are monitored for individual clients and programs as a whole providing feedback and requests for plans of correction to achieve improvement. San Diego has assessed their client transitions from residential and WM to the next LOC as not meeting timely state standards. San Diego

has established a Performance Improvement Project (PIP) to specifically address this issue with a pilot that will utilize a client engagement intervention that has the potential, if successful, to be implemented system wide.

CM 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, CM 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 CM 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.

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 contracted with 30 separate counties and seven Partnership 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.

This report presents the FY 2020-21 EQR findings of San Diego's FY 2019-20 implementation of their DMC-ODS by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

Both a statewide annual report and this DMC-ODS-specific report present the results of CalEQRO's validation of 16 performance measures (PMs) for ongoing implementation of the DMC-ODS Waiver as defined by DHCS. The 16 PMs are listed at the beginning of the PM chapter, followed by tables that highlight the results.

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

[1] Department of Health and Human Services. CMS (2019). Protocol 1. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. CMS (2019). Protocol 2. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

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.

The CalEQRO staff provide trainings and technical assistance to the County DMC-ODS staff for PIP development. Materials and videos are available on the website in a PIP library at http://www.caleqro.com/pip-library. PIPs usually focus on access to care, timeliness, client satisfaction/experience of care, and expansion of evidence-based practices and programs known to benefit certain conditions.

DMC-ODS Information System Capabilities[3]

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

Validation of State and County Client Satisfaction Surveys

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

[3] Department of Health and Human Services. CMS (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

include both structured questions and open questions linked to access, timeliness, quality, and outcomes.

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

CalEQRO reviews also include meetings during in-person or virtual sessions with line staff, supervisors, contractors, stakeholders, agency partners, local Medi-Cal Health Plans, primary care, and hospital providers. Additionally, CalEQRO conducts on-site or video 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. In the case of a desk review, site visits and virtual sessions are not conducted; instead, written documentation submitted by the county is used to assess the KC and make recommendations.

CalEQRO assesses the research-linked programs and STCs of the Waiver as they relate to best practices, enhancing access to MAT, and developing and supervising a competent and skilled workforce with the ASAM criteria-based training and skills. The DMC-ODS should 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 from the last year and since the launch of the DMC-ODS Program that were identified as having a significant effect on service provision or management of those services. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including any changes that provide context to areas discussed later in this report. This information comes from a special session with senior management and leadership from each of the key SUD and administrative programs.

PRIOR YEAR REVIEW FINDINGS

In this section, the status of last year's (FY 2019-20) EQRO review recommendations are presented, as well as changes within the DMC-ODS's environment since its last review.

Status of Prior Year Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made a number of recommendations for improvements in the DMC-ODS's programmatic and/or operational areas. During this current FY 2020-21 desk review, CalEQRO and DMC-ODS staff discussed the status of those prior year recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the DMC-ODS has either:

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

Not Met is assigned when the DMC-ODS performed no meaningful activities to address the recommendation or associated issues.

Prior Year Key Recommendations

Recommendation #1: San Diego should review trends and data from its call center to identify unsuccessful call interactions where callers decline service, screening has stopped or there was no hand off referral made. These are critical lost opportunities for client engagement in critical lifesaving care.

Status: Met

- During the past year, the ACL has looked at messaging around the warm transfer process and its value to callers, updating their language when offering this resource. They have also been working to expedite the screening to reduce call time prior to offering a warm transfer to determine if that improves the transfer rate. It is important to note, however, that callers who do not accept a warm transfer may be following up with program referrals on their own and not refusing services.
- The report was updated to include the wording, "caller declined warm transfer" to make this distinction. It was determined, however, that it would also be

helpful to have additional specifics, so the ACL will be asking callers "why" they are declining the warm transfer and the report will be updated once this data is being collected in a way reporting can be maximized.

- Lastly, in examining the data over time, it was noted that over 40 percent of the callers included in the unsuccessful warm transfer category were third party callers collecting referrals on behalf of someone. The County of San Diego Behavioral Health Services (SDCBHS) is looking to keep this detail in the report but exclude these callers from the overall percentages highlighted to show a more accurate representation.

Recommendation #2: San Diego should identify the root cause of very low urgent service appointment requests as reported by its SUD provider network and enhance training and monitoring to assure that urgent issues of clients are being fully identified and addressed in a timely fashion.

Status: Partially Met

- After review of the urgent request data and contact log infrastructure to collect it, it was highlighted that SDCBHS currently collects urgent data for new clients requesting services at programs, and not for existing clients who may request urgent services during treatment. As a result, SDCBHS will be exploring potential ways to enhance data collection and processes to be more inclusive.

Recommendation #3: San Diego should address the low usage rate of Spanish language TPS surveys and take steps to identify issues that cause downward variances within the individual program sites impacting client's perception of care.

Status: Met

- San Diego's reporting partner, University of California San Diego – Health Services Research Center (HSRC) administered the TPS in November 2020. HSRC provided additional technical assistance (TA) including a webinar for providers on 10/29/2020 that emphasized the availability of the Spanish language version of the survey. It was mentioned during the webinar training that the TPS was offered in all threshold languages and it was emphasized that clients should be offered the survey in their preferred language. There were about 35 providers who attended the webinar live (with possibly more providers that viewed the recorded version), and HSRC also included this information about the language options in the instructions that were sent to all providers prior to the survey. Paper surveys were offered to providers in all languages, and many providers ordered Spanish paper surveys. Furthermore, the first screen of the electronic TPS survey allowed clients to select their preferred language.

- Although approximately 20 percent of surveys ordered by providers were in Spanish, the low completion rate might suggest that the issue is not with

training providers on the availability of Spanish surveys, but perhaps preferred Spanish speakers are more likely to refuse the survey. HSRC plans to look into this a bit more closely to identify if any particular programs had a greater proportion of Spanish completions than others, relative to the proportion of their clients that are preferred Spanish speakers when the final data files are received from UCLA.

Recommendation #4: San Diego should track and report timely follow-up from residential discharge and WM readmission data in a manner that is consistent with CalEQRO.

Status: Met

- SDCBHS updated the methodology for timely follow-up from residential discharge to be consistent with CalEQRO's methodology. The updated methodology excludes Residential and WM admissions as recommended. For the WM readmission data point, SDCBHS is coordinating a meeting with CalEQRO to review finalization of the updated methodology.

Recommendation #5: San Diego should establish a framework to guide, develop and establish productivity standards to measure performance, system capacity and gauge efficiency in treatment programs.

Status: Met

- SDCBHS currently contracts with two research centers within the University of California at San Diego (UCSD) to help guide required reporting and evaluation efforts to meet state requirements. The research centers recently began an in-depth analysis into established productivity standards and benchmarks for behavioral health providers available in both 1) the published scientific literature and 2) currently in use within other organized delivery systems throughout the state and across the nation. If the findings of the literature search do not provide a clear indication of appropriate productivity standards, the research centers may consider additional qualitative data collection efforts to obtain context from providers about workflows and barriers that will help inform recommendations on establishing productivity standards for both the DMC-ODS and the Mental Health Systems of Care.

Recommendation #6: San Diego should take active steps to ensure its process of enhancing SanWITS to be a fully functional electronic health record (EHR) is resourced at a level to assure completion timelines.

Status: Met

- San Diego holds monthly EHR meetings with contract providers, and multiple weekly San Diego staff meetings to work on EHR requirement documents.

- San Diego is in the process of implementing assessments to the providers, with an expected training completion date of April 2021 on assessments and June 2021 for treatment plan training.
- San Diego requested authorization to hire additional staff to assist in EHR development, however with COVID-19 and potential budget impacts, the request is on hold.

Recommendation #7: San Diego should continue to seek opportunities to expand access in the eastern and northern rural and remote areas of the county for residents with SUD in partnership with surrounding counties, FQHC clinics, mental health and using telehealth and mobile services such as the Roaming Outpatient Access Medication (ROAM) service.

Status: Met

- San Diego has met with tribal health clinic leadership in the eastern and northern rural and remote areas of the county several times over the last three years to discuss the options for contracting with the County for Drug Medi-Cal services.
- Indian Health Council, Inc. has received certification from the state and is currently in the process of developing their clinical program to align with the DMC standards. This contract is anticipated to begin 4/1/21. The remaining tribal health clinics, Southern Indian Health Council, Inc., and San Diego American Indian Health Clinic continue to evaluate the potential for contracting with the County for DMC services.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

The COVID-19 pandemic required SDCBHS and its DMC-ODS providers to rethink how to provide services. While telehealth was not widely utilized prior to the pandemic, it became a critical means of treatment after March 2020. Since that time, telehealth encounters increased from under 1percent of the total number of encounters to an average of 20.8 percent of encounters per month, excluding MAT/Methadone dosing services.

Service providers have responded to the impacts of the pandemic such as client social isolation, mental health, and relapse risk by connecting clients with appropriate resources and services. Providers have worked with the community and other partners to ensure awareness that treatment services continue to be available. Providers are supporting the individuals they serve by adjusting their service delivery models and providing more frequent check-ins, additional CM services, and enhanced care coordination. Referrals to and from programs, as well as Recovery Residences, were subsequently managed with the consideration of COVID-19 testing and quarantine responsibilities as a priority. Additional specific efforts include:

- Opioid Treatment Programs (OTPs) implemented waivers from the Federal and State government to allow additional days of “take home” medications, curbside dosing, and assessments via telehealth.

- Residential programs implemented screening processes for all visitors, staff, and clients during the pandemic. Providers increased frequency of sanitization and arranged furniture and flow of foot traffic through the facility to meet Centers for Disease Control (CDC) guidelines. The residential programs also reported capacity to coordinate COVID-19 testing for clients at the time of, or immediately following, admission. In addition, the County’s Emergency Operations Center T3 Testing Team conducted on-site COVID-19 testing at several behavioral health residential facilities that are under contract with SDCBHS.

- Outpatient Programs ensured all clients had equipment available to access treatment services, allowing for assessments and ongoing services via telehealth. Coronavirus Aid, Relief, and Economic Security (CARES) Act funding was utilized to purchase information technology (IT) equipment to support the increase in telehealth accessibility. These programs also implemented COVID-19 screening processes for all staff and clients, as well as implemented social distancing and sanitation efforts to meet guidance by the CDC.

- Perinatal programs worked to maintain access to needed services for families in the face of an ever-changing environment, including school closures, challenges in accessing food and other basic necessities, and the need for infection precautions in transportation as well as in service delivery. Outpatient perinatal programs adjusted their childcare services to be open to one family at a time with increased cleaning and disinfection protocols.

- Teen Recovery Center programs updated resources and fliers to increase outreach efforts as referrals from schools were impacted with the shift to remote learning. To support students, a SchooLink COVID-19 module was created to highlight best practices for treatment programs to engage the school community and offer services in the context of the pandemic.

Beginning March 13, 2020, SDCBHS provided staff support to address the Countywide response to the COVID-19 pandemic to include substance use services and support for homeless individuals who were at a higher risk for contracting the virus, individuals with co-occurring medical conditions that presented a higher risk for contracting the virus, and those individuals who were positive or presumptive positive and isolated at the County Public Health temporary lodging.

In partnership with the City of San Diego, San Diego Housing Commission, and several other local agencies, SDCBHS began providing on-site behavioral health services to approximately 1,200 individuals. Services include integrated mental health and substance use services including the following: crisis intervention, behavioral health screening, assessment and triage, medication management delivery and/or coordination, CM, and other supportive services as appropriate, including peer support and supported employment.

In partnership with other County departments including Medical Care Services and Public Health Services, SDCBHS currently provides on-site behavioral health services to guests residing at the public health lodging location who have either tested positive for COVID-19 or who are presumptive positive for COVID-19. Guests receive on-site integrated substance use services, behavioral health support, screening, triage, crisis intervention, and care coordination.

The County's COVID-19 Vaccine Clinical Advisory Group includes representation from the Behavioral Health Services (BHS) Clinical Directors Office (CDO). At the request of the Vaccine Clinical Advisory Group, the Assistant Clinical Director convened the Behavioral Health Subcommittee with the goal of developing recommendations to bring to the advisory group. The Subcommittee reviewed CDC Advisory Committee on Immunization Practices (ACIP), and California Department of Public Health (CDPH) guidance from a behavioral health lens to ensure sector clients and workforce have equitable access to COVID-19 vaccinations.

Past Year's Initiatives and Accomplishments

- To enhance population health surveillance that complements current system utilization monitoring within the SDCBHS, a Population Health Unit was added to the organizational structure under the Clinical Director's Office. The onboarding process includes training with the County of San Diego's Community Health Statistics Branch which provides health statistics that describe health behaviors, diseases, and injuries for specific populations, in addition to health trends and comparisons to national targets.

- In response to recent events that highlight nationwide issues on institutional/systemic racism, the SDCBHS Director has announced his intention to form a small internal workgroup and to engage a subject matter expert to address racial equity within SDCBHS. On the County level, officials have also taken steps to examine all levels of the organization to help achieve real change by amplifying the voice of the Diversity and Inclusion Executive Council, reinstating the Human Relations Commission, creating the new Office of Equity and Racial Justice, and employee listening forums.

- SDCBHS executed a contract amendment for additional MAT services at a co-occurring Assertive Community Treatment (ACT) program during the past year. Additional MAT services are also now provided as part of the ROAM Innovation Project in both East and North Inland regions to serve rural, tribal communities. Additionally, WM services were expanded to additional residential SUD contracts as of May 2020.

- SDCBHS established a meeting to offer SUD network of care Medical Directors the opportunity to interface with their peers and discuss clinical standards, common challenges, and best practices as the County of San Diego implements the DMC-ODS. Although attendance is not a County-level requirement, BHS encourages the participation of program Medical Directors or their medical representative. The dialogue is medical in nature and does not include contract or budget-related discussion or policy decision.

- To support the medical workforce and the clinical needs of DMC-ODS during the pandemic, BHS convened weekly SUD Medical Directors meetings to discuss best practices for COVID-19 infection prevention as well as operational adaptions that have been necessary to continue essential SUD service delivery during the health emergency. County of San Diego Public Health Services has collaborated with BHS to ensure appropriate subject matter expertise is available to offer appropriate guidance to the SUD Medical Directors.

- The County of San Diego Quality Management (QM) Substance Use Disorder unit launched a new licensed practitioner of the health arts (LPHA) focused meeting in June 2020, in response to the request of providers. The meeting is structured as a group discussion on questions and needs brought in by those in

attendance, to include ways to improve the LPHA role, workflow processes and compliance with DMC requirements.

- In 2020, San Diego Web Infrastructure for Treatment Services (SanWITS) was enhanced to allow for MAT split dosing on the encounter/service screen and the claim screen as per DHCS Informational Notice 20-064. This allows the provider to enter multiple doses of same MAT medication same day on one service with same or multiple national drug codes (NDCs).
- The development of numerous electronic assessments was completed in late 2020. These electronic assessments now available in SanWITS include: Adult Initial Level of Care, Adolescent Initial Level of Care, Parent Guardian Initial Level of Care, Recommended Level of Care, Risk and Safety, Diagnostic Determination Note (DDN) and Discharge Summary. Current staff training is expected to be complete by March/April 2021.

San Diego Goals for the Coming Year

- San Diego has met with tribal health clinic leadership in the eastern and northern rural and remote areas of the county several times over the last three years to discuss the options for contracting with the County for Drug Medi-Cal services. Indian Health Council, Inc., located in the North Inland Region, has recently expressed interest in moving forward with a DMC contract with the County. Indian Health Council, Inc. has received certification from the state and is currently in the process of developing their clinical program to align with the DMC standards. This contract is anticipated to begin April 2021. The remaining tribal health clinics, Southern Indian Health Council, Inc., and San Diego American Indian Health Clinic continue to evaluate the potential for contracting with the County for DMC services.
- San Diego is exploring the expansion of WM services within the DMC-ODS. Levels of WM being considered include Ambulatory Levels 1 and 2 at existing programs that may be interested in contract amendments, as well as the potential for Inpatient Level 3.7.
- San Diego has been working on the inclusion of Level 3.3 Residential services to support those in need of this level of care. The Statement of Work has been developed but the posting of the Request for Proposal was delayed due to the pandemic. The County of San Diego is currently assessing the appropriate timing for moving forward with the competitive procurement.
- San Diego has recognized the need for specialized TAY services in DMC-ODS. Efforts are currently in process for exploring options to operationalize TAY programming to include TAY specific residential and outpatient services.

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 12 performance measures to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, the TPS, California Outcomes Measurement System (CalOMS), and the ASAM level of care data for these measures.

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:

   https://www.dhcs.ca.gov/individuals/Documents/MHSUDS_Information_Notice_18046.pdf

The first six PMs are used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal levels of care based on ASAM assessments, and outcomes.

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 reviews of data related to specific programs, and documentation of key deliverables in the DMC-ODS Waiver Plan. In a desk review the documents are reviewed and the DMC-ODS responds to written questions. 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 levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percentage of clients with three or more WM episodes and no other treatment to improve engagement.

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

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

HIPAA Guidelines for Suppression Disclosure

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

Year Two of Waiver Services

This is the second year that San Diego has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 2019-20), and from UCLA for TPS, ASAM, and CalOMS data from FY 2019-20. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may be a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2019-20 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2019-20

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

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

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

San Diego primarily served adults between the ages of 18-64, with a penetration rate of 2.18 percent. Also notable was San Diego number of clients served in other age groups, which were all higher than other large counties and double the statewide penetration rates in both the youth and adult age groups.

Table 1: Penetration Rates by Age, FY 2019-20

San Diego				Large Counties	Statewide
Age Groups	**Average # of Eligibles per Month**	**# of Clients Served**	**Penetration Rate**	**Penetration Rate**	**Penetration Rate**
Ages12-17	98,334	631	0.64%	0.34%	0.32%
Ages 18-64	453,542	9,883	2.18%	1.55%	1.33%
Ages 65+	84,243	848	1.01%	0.97%	0.81%
TOTAL	**636,118**	**11,362**	**1.79%**	**1.27%**	**1.10%**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently.
Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

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

Table 2: Average Approved Claims by Age, FY 2019-20

San Diego			Statewide
Age Groups	**Average Approved Claims**	**Total Approved Claims**	**Average Approved Claims**
Ages 12-17	$3,282	$2,070,853	$2,046
Ages 18-64	$4,741	$46,857,296	$4,613
Ages 65+	$5,402	$4,581,233	$4,837
TOTAL	**$4,710**	**$53,509,382**	**$4,515**

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

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

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2019-20

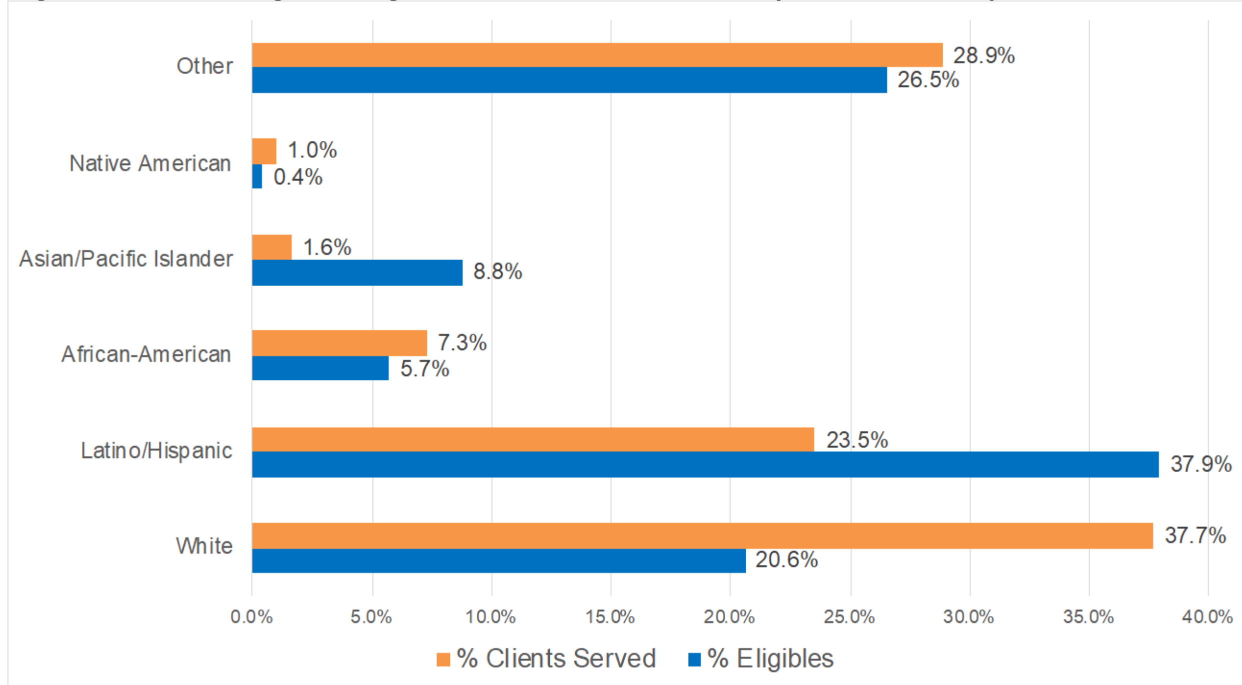


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Penetration rates by race/ethnicity are higher than other large counties as well as statewide rates.

Table 3: Penetration Rates by Race/Ethnicity, FY 2019-20

San Diego				Large Counties	Statewide
Race/Ethnicity Groups	**Average # of Eligibles per Month**	**# of Clients Served**	**Penetration Rate**	**Penetration Rate**	**Penetration Rate**
White	131,073	4,281	3.27%	2.61%	2.08%
Latino/Hispanic	241,203	2,675	1.11%	0.85%	0.76%
African American	36,365	828	2.28%	1.65%	1.44%
Asian/Pacific Islander	55,889	184	0.33%	0.20%	0.19%
Native American	2,745	114	4.15%	3.07%	1.91%
Other	168,845	3,280	1.94%	1.54%	1.38%
TOTAL	**636,120**	**11,362**	**1.79%**	**1.27%**	**1.10%**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently.
Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

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. The Affordable Care Act (ACA) is the primary eligibility category for clients in San Diego. Foster Care and Family Adult are the next most common eligibility categories. The youth eligibility categories have smaller numbers of clients served compared to adult categories, but the penetration rates are roughly double the statewide rates in the Foster Care, Other Child, and Maternal and Child Health Integrated program (MCHIP) categories.

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2019-20

San Diego				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	68,755	1,410	2.05%	1.88%
Foster Care	1,149	64	5.57%	2.46%
Other Child	59,308	396	0.67%	0.34%
Family Adult	121,294	2,054	1.69%	1.15%
Other Adult	89,213	161	0.18%	0.13%
MCHIP	42,278	233	0.55%	0.24%
ACA	252,504	7,485	2.96%	1.74%

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

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

Table 5: Average Approved Claims by Eligibility Category, FY 2019-20

San Diego				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	68,755	1,410	$4,487	$4,513
Foster Care	1,149	64	$2,044	$1,578
Other Child	59,308	396	$3,265	$1,943

San Diego				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Family Adult	121,294	2,054	$3,983	$3,792
Other Adult	89,213	161	$4,924	$4,042
MCHIP	42,278	233	$3,015	$2,039
ACA	252,504	7,485	$4,821	$4,667

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

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2019-20. The majority of clients in San Diego were served in NTPs (27.1 percent), followed by outpatient services (26.4 percent) and residential treatment (20.0 percent).

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2019-20

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	4,207	27.1%	$3,967
Residential Treatment	3,105	20.0%	$8,105
Res. Withdrawal Mgmt.	701	4.5%	$2,231
Ambulatory Withdrawal Mgmt.	-	-	-
Non-Methadone MAT	961	6.2%	$434
Recovery Support Services	631	4.1%	$912
Partial Hospitalization	-	-	-
Intensive Outpatient Tx.	1,801	11.6%	$420
Outpatient Services	4,101	26.4%	$2,034
TOTAL	**15,507**	**100.0%**	**$4,710**

Asterisks and n/a, if included, 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. Clients in San Diego were able to receive their first dose of methadone within one median day.

Table 7: Days to First Dose of Methadone by Age, FY 2019-20

San Diego				Statewide		
Age Groups	**Clients**	**%**	**Avg. Days**	**Clients**	**%**	**Avg. Days**
Ages 12-17	-	-	n/a	*	n/a	n/a
Ages 18-64	3,869	93.7%	<1	37,884	90.8%	<1
Ages 65+	261	6.3%	<1	*	n/a	n/a
TOTAL	**4,130**	**100.0%**	**<1**	**41,714**	**100.0%**	**<1**

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

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

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

San Diego NTP/OTP contract providers all provide non-methadone MAT services to clients assessed to benefit from these new medications. Two hospitals have established grant funded Bridge programs, for persons with opioid addiction seeking help in ED. These programs offer Buprenorphine induction and then assist patients to link to ongoing follow up care. In addition, there are FQHCs in San Diego who have been trained to treat opiate addicted clients with MAT through a collaborative project between Center for Care Innovation and the California Health Care Foundation. San Diego also contracts with an FQHC that provides DMC services in two regions (Central and South) county.

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

Table 8 displays 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 the EQRO.

San Diego served 961 clients with at least one non-methadone MAT service. Approximately half of these clients continued to receive three or more services (50.2 percent) which is higher than statewide rate (46.5 percent). Additionally, it is possible clients continued to receive MAT through non-DMC-ODS providers, such as FQHCs.

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2019-20

San Diego					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	-	-	-	*	n/a	*	Na
Ages 18-64	*	n/a	*	n/a	6,504	6.8%	3,036	3.2%
Ages 65+	*	n/a	*	n/a	*	n/a	*	n/a
TOTAL	**961**	**8.47%**	**482**	**4.25%**	**6,658**	**6.3%**	**3,095**	**2.9%**

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). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Transitions in Care Post-Residential Treatment – FY 2019-20

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

Table 9 shows 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. The table shows the percentage of clients who began a new level of care within 7 days, 14 days, and 30 days after discharge from residential treatment. Also shown in the table are the percent of clients who had follow-up treatment from 31 to 365 days.

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, CM, 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 Fee-for-Service (FFS)/Health Plan Medi-Cal claims data at this time.

San Diego discharged 3,964 clients from residential treatment. Of those, 23.16 percent had a follow-up service within any days. While this is higher than the statewide average of 19.85 percent, there is still an opportunity to increase linkage to follow-up care post-residential discharge to support ongoing recovery and sobriety.

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2019-20

San Diego (n= 3,964)			Statewide (n= 30,303)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	426	10.75%	2,312	7.63%
Within 14 Days	516	13.02%	3,161	10.43%
Within 30 Days	613	15.46%	3,987	13.16%
Any days (TOTAL)	**918**	**23.16%**	**6,016**	**19.85%**

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). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment of a person’s reaching out for help to address a SUD represents a critical crossroad in that person’s life, and the opportunity may pass quickly if barriers to accessing treatment are high. A county DMC-ODS is responsible to make initial access easy for prospective clients to the most appropriate treatment for their particular needs. For some people, an Access Line may be of great assistance in finding the best treatment match in a system that can otherwise be confusing to navigate. For others, an Access Line may be 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 10 shows Access Line critical indicators from 01/01/2020 through 12/31/2020.

Table 10: Access Line Critical Indicators, FY 2019-20

San Diego	
Average Volume	437 calls per month
% Dropped Calls	2.14
Time to answer calls	15 seconds
Monthly authorizations for residential treatment	740
% of calls referred to a treatment program for care, including residential authorizations	9% of callers are linked to treatment through the Access Line
Non-English capacity	San Diego has nine Access Line staff bilingual in Spanish, a primary threshold languages, however for additional threshold and other languages they do contract with Language Line, and report that 32 percent of clinicians within the system of care are bilingual in English/Spanish.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial number of DMC-ODS services in San Diego. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $12,973 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. 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 CM to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

San Diego had 5.3 percent of clients that met the threshold for HCBs, which is on par with the statewide rate of 5.1 percent. The claims for these clients accounted for 20.2 percent of San Diego's total claims.

Table 11a: High-Cost Beneficiaries by Age, San Diego, FY 2019-20

San Diego						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	631	*	n/a	$16,686	$16,686	0.8%
Ages 18-64	9,883	598	6.1%	$17,816	$10,653,815	22.7%
Ages 65+	848	*	n/a	$16,280	$32,560	0.7%
TOTAL	**11,362**	**607**	**5.3%**	**$17,798**	**$10,803,179**	**20.2%**

Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Table 11b: High-Cost Beneficiaries by Age, Statewide, FY 2019-20

Statewide					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	5,018	22	0.4%	$18,095	$398,083
Ages 18-64	91,813	5,377	5.9%	$19,374	$104,171,358
Ages 65+	10,592	41	0.4%	$18,713	$767,217
TOTAL	**107,423**	**5,440**	**5.1%**	**$19,363**	**$105,336,659**

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

Residential Withdrawal Management with No Other Treatment

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

Of the 694 clients served in residential 3.2 WM, 3.89 percent had three or more episodes and no other treatment. This was slightly higher than the statewide average of 3.4 percent.

Table 12: Residential Withdrawal Management with No Other Treatment, FY 2019-20

San Diego			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	694	3.89%	7,836	3.4%

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).

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.

Table 13 shows a high congruence between the indicated level of care at the initial screening and the level of care to which the client was then referred (91.3 percent), at the initial full assessment (87.6 percent), and at follow-up assessments (95.6 percent).

Table 13: Congruence of Level of Care Referrals with ASAM Findings, FY 2019-20

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	6,858	91.3%	1,569	87.6%	5,439	95.6%
Patient Preference	155	2.1%	45	2.5%	69	1.2%
Level of Care Not Available	152	2.0%	18	1.0%	*	n/a
Clinical Judgement	71	0.9%	37	2.1%	33	0.6%
Geographic Accessibility	55	0.7%	*	n/a	*	n/a
Family Responsibility	-	-	*	n/a	-	-
Legal Issues	66	0.9%	26	1.4%	56	1.0%
Lack of Insurance/Payment Source	18	0.2%	-	-	-	-
Other	106	1.4%	38	2.1%	28	0.5%
Actual Referral Missing	127	1.7%	49	2.7%	42	0.7%
TOTAL	**7,508**	**100.0%**	**1,791**	**100.0%**	**5,688**	**100.0%**

Initiating and Engaging in Treatment Services

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

The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client's SUD is identified. Since CalEQRO does this through claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. This second day or visit is what in this measure is defined as "initiating" treatment. In San Diego, 84.6 percent of adults and 92.0 percent of youth who had an initial visit went onto a second visit within 15 days and initiated into services. Initiation rates at the statewide level were 88.2 percent for adults and 80.4 percent for youth. San Diego's initiation rates are slightly below the statewide rate for adults but are higher for youth.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service. In terms of service engagement, 78.2 percent of adults and 80.8 percent of youth who initiated services had two more visits within the prescribed time period. The engagement rate for adults (78.2 percent) is on par with the statewide engagement rate of 78.1 percent. The youth engagement rate (80.8 percent) is higher than the statewide rate of 70.8 percent.

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2019-20

	San Diego				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	10,283		666		93,923		4,825	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	8,696	84.6%	613	92.0%	82,854	88.2%	3,877	80.4%
Clients who then engaged in DMC-ODS services	6,796	78.2%	495	80.8%	64,689	78.1%	2,744	70.8%

Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently.

Table 15 tracks the initial DMC-ODS service used by clients to determine how they first accessed DMC-ODS services and shows the diversity of the continuum of care. In San Diego, 40.1 percent of clients began DMC-ODS services in NTP/OTP, followed by 34.1 percent in outpatient treatment. These initiation rates are similar in comparison to statewide rates.

Table 15: Initial DMC-ODS Service Used by Clients, FY 2019-20

	San Diego		Statewide	
DMC-ODS Service Modality	#	%	#	%
Outpatient treatment	3,375	34.1%	34,506	34.9%
Intensive outpatient treatment	-	-	4,484	4.5%
NTP/OTP	3,972	40.1%	35,276	35.7%
Non-methadone MAT	-	-	225	0.2%
Ambulatory Withdrawal	-	-	20	-
Partial hospitalization	-	-	26	-
Residential treatment	2,547	25.7%	17,509	17.7%
Withdrawal management	-	-	6,042	6.1%
Recovery Support Services	-	-	660	0.7%
TOTAL	**9,894**	**100.0%**	**98,748**	**100.0%**

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

reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Retention in Treatment

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

The mean (average) length of stay for San Diego clients was 146 days (median 90 days), compared to the statewide mean of 133 (median 87 days). 50.5 percent of clients had at least a 90-day length of stay; 28.7 percent had at least a 180-day stay, and 18.3 percent had at least a 270-day length of stay.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2019-20

	San Diego		Statewide	
Clients with a discharge date	11,613		100,971	
Length of stay (LOS) for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	146	90	133	87
	#	%	#	%
Clients with at least a 90-day LOS	5,864	50.5%	49,332	48.9%
Clients with at least a 180-day LOS	3,331	28.7%	28,635	28.4%
Clients with at least a 270-day LOS	2,129	18.3%	17,711	17.5%

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

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential WM readmissions within 30 days of discharge. Of 970 clients admitted into residential WM in San Diego, 22.0 percent were readmitted within 30 days of discharge as compared to the 9.9 percent statewide

average for all DMC-ODS counties. This suggests that a significant percentage of clients discharged from residential WM are not successfully transitioning to outpatient treatment, showing room for improvement.

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2019-20

	San Diego		Statewide	
Total DMC-ODS admissions into WM	970		10,104	
	#	%	#	%
WM readmissions within 30 days of discharge	213	22.0%	999	9.9%

Asterisks and n/a, if included, 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 18 compares the breakdown by diagnostic category of the San Diego and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2019-20. The majority of clients receiving services in San Diego have been diagnosed with an Opioid Use Disorder (42.7 percent), reflective of the high utilization of NTP services. Other Stimulant Abuse is the next most common diagnosis (25.1 percent).

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2019-20

Diagnosis Codes	San Diego		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	18.1%	$5,712	17.1%	$5,317
Cannabis Use	10.8%	$2,957	9.0%	$2,328
Cocaine Abuse or Dependence	2.0%	$4,250	1.9%	$5,273
Hallucinogen Dependence	0.3%	$3,475	0.23%	$5,151
Inhalant Abuse	0.0%	$0	0.03%	$6,809
Opioid	42.7%	$5,072	45.7%	$5,084
Other Stimulant Abuse	25.1%	$5,015	24.4%	$4,723
Other Psychoactive Substance	0.1%	$6,171	0.11%	$6,172
Sedative, Hypnotic Abuse	0.4%	$5,993	0.52%	$5,095
Other	0.4%	$4,334	0.90%	$3,259
Total	**100.0%**	**$4,710**	**100.0%**	**$4,776**

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

Client Perceptions of Their Treatment Experience

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

San Diego adult clients who completed the TPS communicated high satisfaction with services. The two items (08 and 09) in the Care Coordination domain and the location item (01) from the Access domain, although positive, were lower than the ratings for the other items. San Diego youth clients who completed the TPS (Figure 2a) also communicated high satisfaction with services. Notably, item 06 in the Quality domain, all items in the Therapeutic Alliance domain, and item 13 in the Care Coordination domain were rated high. The lowest rating was given to item 01 in the Access domain.

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA (N =1,297)

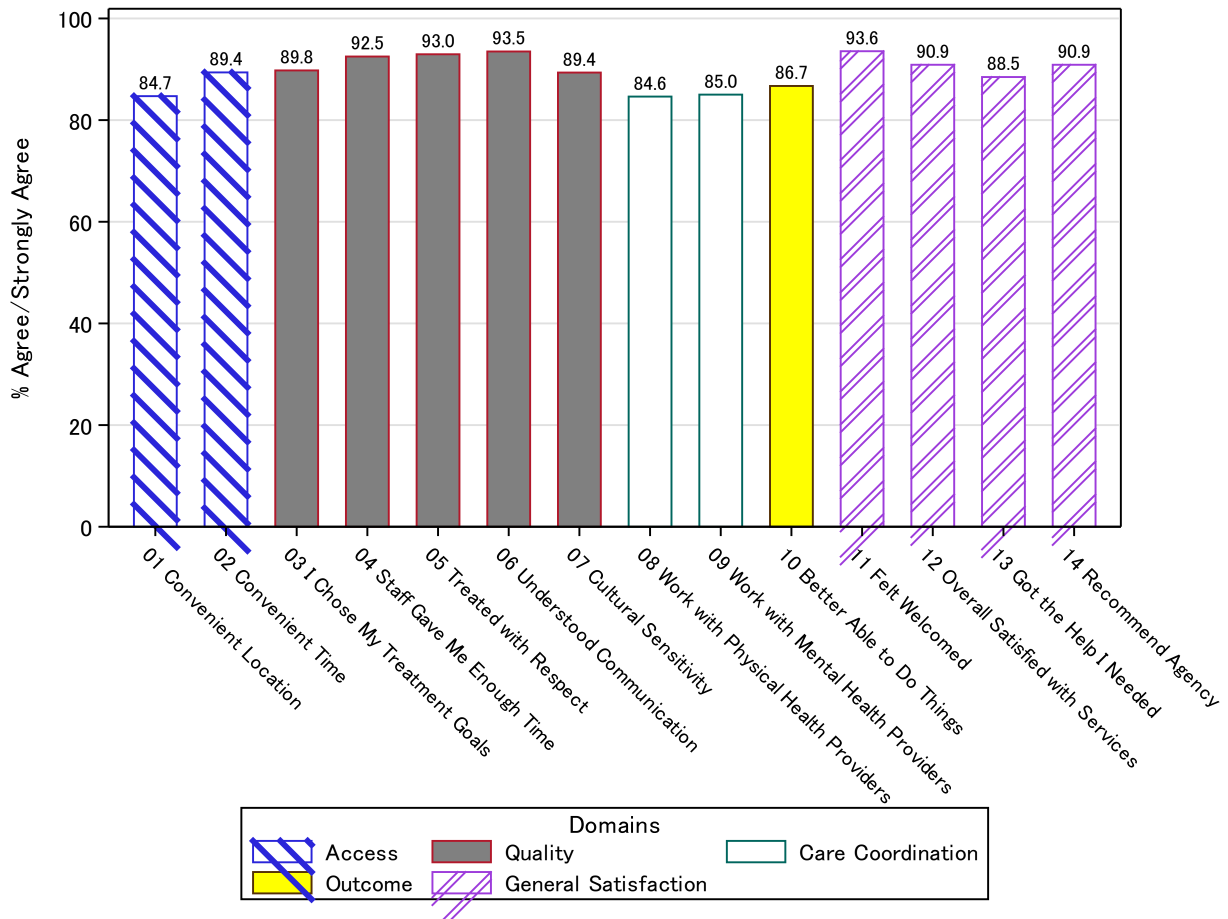
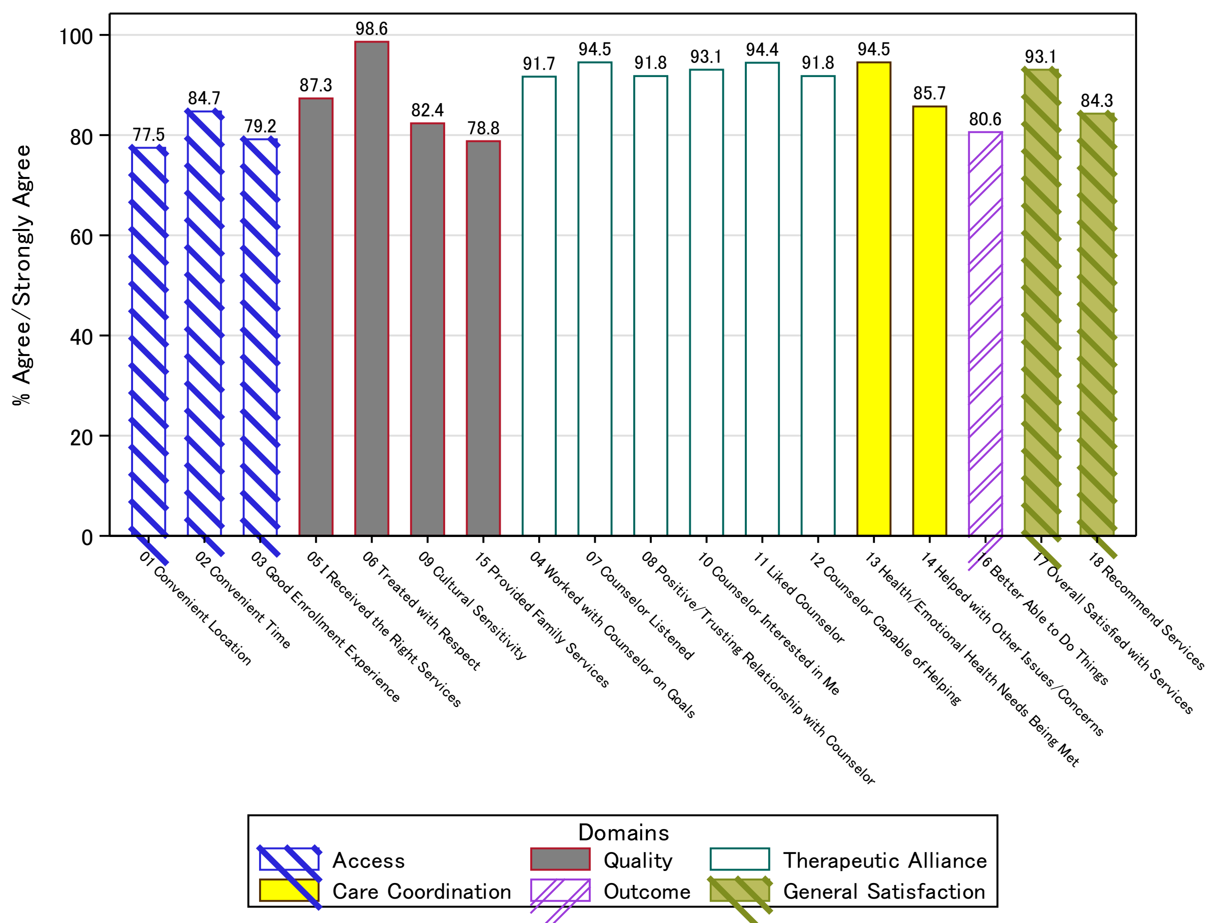


Figure 2a: Percentage of Youth Participants with Positive Perceptions of Care, TPS Results from UCLA (N =73)



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

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

Tables 19-21 depict client status at admission compared to statewide regarding three important situations: living status, criminal justice involvement, and employment status. These data provide important indicators of what additional services San Diego will need to consider and with which agencies they will need to coordinate. San Diego clients have a significantly higher rate of homelessness (39.1 percent) at admission than the statewide average (28.7 percent). The rate of clients in independent living (28.0 percent) was much lower than the statewide rate (45.8 percent). San Diego serves less clients (49.4 percent) that the statewide average (61.7 percent).

Table 19: CalOMS Living Status at Admission, FY 2019-20

Admission Living Status	San Diego		Statewide	
	#	%	#	%
Homeless	5,631	39.1%	32,027	28.7%
Dependent Living	4,740	32.9%	28,474	25.5%
Independent Living	4,032	28.0%	51,036	45.8%
TOTAL	**14,403**	**100.0%**	**111,537**	**100.0%**

Table 20: CalOMS Legal Status at Admission, FY 2019-20

Admission Legal Status	San Diego		Statewide	
	#	%	#	%
No Criminal Justice Involvement	7,110	49.4%	68,737	61.7%
Under Parole Supervision by CDCR	393	2.7%	2,255	2.0%
On Parole from any other jurisdiction	167	1.2%	1,676	1.5%
Post release supervision - AB 109	5,576	38.7%	30,671	27.5%
Court Diversion CA Penal Code 1000	456	3.2%	2,111	1.9%
Incarcerated	17	0.1%	711	0.6%
Awaiting Trial	675	4.7%	5,324	4.8%
TOTAL	**14,394**	**100.0%**	**111,485**	**100.0%**

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

Table 21: CalOMS Employment Status at Admission, FY 2019-20

Current Employment Status	San Diego		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	1,946	13.5%	13,156	11.8%
Employed Part Time - Less than 35 hours	1,164	8.1%	8,637	7.7%
Unemployed - Looking for work	5,462	37.3%	33,128	29.7%
Unemployed - not in the labor force and not seeking	5,831	41.8%	56.616	50.8%
TOTAL	**14,403**	**100.0%**	**111,537**	**100.0%**

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

The information displayed in Tables 22-23 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 22 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment. San Diego's Administrative Adult Discharge rate was 41.5 percent, lower than the statewide rate of 47.1 percent.

Table 22: CalOMS Types of Discharges, FY 2019-20

Discharge Types	San Diego		Statewide	
	#	%	#	%
Standard Adult Discharges	8,873	47.2%	49,577	42.1%
Administrative Adult Discharges	7,812	41.5%	55,467	47.1%
Detox Discharges	1,418	7.5%	10,420	8.8%
Youth Discharges	706	3.8%	2,415	2.0%
TOTAL	**18,809**	**100.0%**	**117,879**	**100.0%**

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

Table 23 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs. The first four rating options are positive. “Completed Treatment” means the client met all their treatment goals and/or the client learned what the program intended for clients to learn at that level of care. “Left Treatment with Satisfactory Progress” means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options indicate lack of satisfactory progress for different types of reasons.

San Diego's clients had a positive discharge status (50.4 percent), which is higher than the statewide average (45.8 percent). A high number of these positive discharges are “Completed Treatment - Referred” (19.4 percent).

Table 23: CalOMS Discharge Status Ratings, FY 2019-20

Discharge Status	San Diego		Statewide	
	#	%	#	%
Completed Treatment - Referred	3,508	19.4%	20,317	17.6%
Completed Treatment - Not Referred	1,603	8.9%	6,759	5.9%
Left Before Completion with Satisfactory Progress - Standard Questions	2,298	12.7%	17,115	14.8%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,697	9.4%	8,734	7.6%
Subtotal	*9,106*	*50.4%*	*52,925*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	3,001	16.6%	16,693	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	5,782	32.0%	44,609	38.6%
Death	21	0.1%	235	0.2%
Incarceration	166	0.9%	1,058	0.9%
Subtotal	*8,970*	*49.6%*	*62,595*	*54.2%*
TOTAL	**18,076**	**100.0%**	**115,520**	**100.0%**

Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement).

Performance Measures Findings: Impact and Implications

Access to Care

- San Diego's penetration rates were higher than statewide across age groups and race/ethnicity groups. Of particular note, the penetration rate of youth was double the statewide rate.
- San Diego increased from 9,574 clients served in FY 2018-19 to 11,362 clients served in FY 2019-20, a 19 percent increase.

Timeliness of Services

- San Diego's time to first dose of methadone is on par with the statewide averages.

Quality of Care

- San Diego has a higher rate than statewide average of transitioning clients discharged from residential treatment to a lower level of care.

- San Diego's TPS results within the quality domain were notably high, with the highest ratings at 93.5 percent of participants reporting understanding of communication; and 93.0 percent reporting they were treated with respect.
- San Diego had 22 percent of clients readmitted to WM residential within 30 days of discharge as compared to the 9.9 percent statewide average for all DMC-ODS counties indicating room for improvement.

Client Outcomes

- San Diego's TPS results within the client outcome domain were rated high, at 86.7 percent of participants agreeing to increased abilities following treatment.
- San Diego's CalOMS discharge results showed that providers rated 50.4 percent of their clients as having positive progression in treatment by the time of their discharge. These results are higher than the statewide average of 45.8 percent.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA)

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

ISCA Table 1 shows the percentage of DMC-ODS budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous two-year period, as well as the corresponding similar-size DMC-ODS and statewide averages.

ISCA Table 1: Percentage of Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19
San Diego	7.20%	7.10%	6.90%
Large	n/a	3.09%	3.94%
Statewide	n/a	2.40%	3.16%

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

The following business operations information was self-reported in the ISCA tool and validated through interviews with key DMC-ODS staff by CalEQRO.

ISCA Table 2: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No

Business Operations	Status	
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the DMC-ODS uses an ASP model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
There is at least one person within the DMC-ODS organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No
If no one within the DMC-ODS organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☐ Yes	☐ No
The DMC-ODS performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

ISCA Table 3 shows the percentage of services provided by type of service provider.

ISCA Table 3: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	0%
Contract providers	100%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported IT staff changes by FTE since the previous CalEQRO review are shown in ISCA Table 4.

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	15.25	3.50	0	0
2019-20	12	3	2	0
2018-19	16	3	0	0

DMC-ODS self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in ISCA Table 5.

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	15.2	4	0	0
2019-20	11.2	2	2	.25
2018-19	10	2	0	0

The following should be noted with regard to the above information:

- The increase in technology staff since the last review is due to additional resources from FEI Systems (EHR vendor) to support SanWITS system-build workflow process.

- The increase in data analytical staff since the last review is due to a new management reporting analysis team established by San Diego.

Summary of User Support and EHR Training

ISCA Table 6 provides the number of individuals with log-on authority to the DMC-ODS EHR. The information was self-reported by DMC-ODS and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	95	290	385
Clinical Healthcare Professional	4	285	289
Clinical Peer Specialist	0	0	0
Quality Improvement	21	31	52
Total	120	606	726

ISCA Table 7: EHR User Support

EHR User Support	Status	
DMC-ODS maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
DMC-ODS utilizes an ASP model to support EHR operations which is hosted at IS vendor Data Center and staffed 24/7.	☒ Yes	☐ No
DMC-ODS also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
DMC-ODS also utilizes Local Super Users to support EHR operations.	☐ Yes	☒ No

ISCA Table 8: New Users EHR Training

New Users EHR Training				
Training Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☒	☐	☐	☐
User profile and access setup	☒	☐	☐	☐
Screen workflow and navigation	☒	☐	☐	☐

ISCA Table 9: Ongoing EHR Training and Support

Ongoing EHR Training and Support	Status	
DMC-ODS maintains a formal record of EHR training activities to evaluate quality of training material.	☒ Yes	☐ No
DMC-ODS routinely administers EHR competency tests for users to evaluate training effectiveness.	☒ Yes	☐ No
DMC-ODS maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Telehealth Services Delivered by County

DMC-ODS county-operated clinics and program currently provides services to beneficiaries using a telehealth application:

☐ Yes ☒ No ☐ Implementation Phase

ISCA Table 10: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	**77**
Number of county-operated telehealth sites	**0**
Number of contract providers' telehealth sites	**77**

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult.
☒ For linguistic capacity or expansion
☒ To serve outlying areas within the county
☒ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations (i.e., children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☒ To reduce travel time for beneficiaries
☒ To support NA time and distance standard
☒ To address and support COVID-19 contact restrictions

Summarize DMC-ODS use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and DMC-ODS provider staff.

- San Diego has 77 community based organization (CBO) telehealth sites throughout the county and had served 6,232 beneficiaries and provided 89,806 telehealth encounters over the period.
- Telehealth is used to support medication support, group therapy sessions, individual therapy sessions, CM, new client intake and assessments.

Identify from the following list of California-recognized threshold languages that are directly supported by the DMC-ODS or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☐	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:
☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Central Region	**27**
East Region	**13**
North Central Region	**12**
North Coastal Region	**8**
North Inland Region	**10**
South Region	**7**

Current DMC-ODS Operations

ISCA Table 12 lists the primary systems and applications the DMC-ODS uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Drug Medi-Cal and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

ISCA Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
San Diego Web Infrastructure for treatment Services (SanWITS)	Billing, Reporting	FEI Systems, Inc.	14	FEI Systems, Inc.

The DMC-ODS Priorities for the Coming Year

- Develop data integration to electronically exchange service transactions between SanWITS and OTP/NTP EHRs (Tower Systems, Metasoft, and Dosing Pro).
- Update progress notes screen with an updated encounter screen to integrate EHR enhancements.
- Add a medication module, both for e-Prescribing and importing from Surescripts.
- Add lab module with a link directly to lab vendor.
- CalOMS outcome measures – to minimize the number of CalOMS errors, several new business rules are being added to align with the CalOMS dictionary.
- Implement Contract and Invoice Management system (CIMS) new billing module.

Major Changes since Prior Year

- Enhanced billing capabilities for MAT split dosing on the encounter and claim.
- Recovery Plan has been added to SanWITS; some issues have been identified and are being resolved; expected rollout with Treatment Plan.
- Development of numerous electronic assessments forms including: Adult Initial Level of Care, Adolescent Initial Level of Care, Parent Guardian Initial Level of Care, Recommended Level of Care, Risk and Safety, Diagnostic Determination Note (DDN) and Discharge Summary. Current staff training is expected to be completed by March/April 2021.
- Developed two datasets for Data Warehouse to include a Provider dataset and a CalOMS dataset. San Diego is in the process of developing a third dataset for services.

Plans for Information Systems Change

- There are no plans to replace the SanWITS system.

DMC-ODS EHR Status

ISCA Table 13 summarizes the ratings given to the DMC-ODS for EHR functionality.

ISCA Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	FEI/ SanWITS	☒	☐	☐	☐
Assessments	FEI/ SanWITS	☒	☐	☐	☐
Care Coordination	FEI/ SanWITS	☒	☐	☐	☐
Document Imaging/ Storage	FEI/ SanWITS	☒	☐	☐	☐
Electronic Signature—DMC-ODS Beneficiary	FEI/ SanWITS	☐	☐	☒	☐
Laboratory results (eLab)	FEI/ SanWITS	☐	☐	☒	☐
Level of Care/Level of Service	FEI/ SanWITS	☒	☐	☐	☐
Outcomes	FEI/ SanWITS	☒	☐	☐	☐
Prescriptions (eRx)	FEI/ SanWITS	☐	☐	☒	☐
Progress Notes	FEI/ SanWITS	☒	☐	☐	☐
Referral Management	FEI/ SanWITS	☒	☐	☐	☐
Treatment Plans	FEI/ SanWITS	☒	☐	☐	☐
Summary Totals for EHR Functionality:					

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
FY 2020-21 Summary Totals for EHR Functionality:		9	0	3	0
FY 2019-20 Summary Totals for EHR Functionality:		6	1	5	0

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

- San Diego made specific progress in implementing referral management, treatment plans, and progress notes.
- San Diego updated diagnosis codes, billing capabilities for MAT split dosing, and disallowance fields to the system.

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 14 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the DMC-ODS's EHR system, by type of input methods.

ISCA Table 14: Contract Providers' Transmission of Beneficiary Information to DMC-ODS EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to DMC-ODS EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and DMC-ODS EHR system	0%	Not used
Electronic batch files submitted to DMC-ODS for further processing and uploaded into DMC-ODS EHR system	0%	Not used
Direct data entry into DMC-ODS EHR system by contract provider staff	100%	Daily
Electronic files/documents securely emailed to DMC-ODS for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to DMC-ODS for data entry input by DMC-ODS staff into EHR system	0%	Not used

ISCA Table 15: Type of Input Method for NTP/OTP Providers

Type of Input Method For NTP/OTP Providers	Status	
NTP/OTP providers enter data on dosing and counseling services directly into DMC-ODS EHR system.	☒ Yes	☐ No
NTP/OTP providers enter dosing and counseling services into local EHR and submits batch file for upload into DMC-ODS EHR system.	☒ Yes	☐ No
NTP/OTP providers enter dosing and counseling services into local EHR and produces EDI 837 transaction claim file which is submitted to DMC-ODS who then submits claim file to DHCS for adjudication.	☐ Yes	☒ No

The rest of this section is applicable: ☐ Yes ☒ No

Some contact providers have EHR systems which they rely on as their primary system to support operations. ISCA Table 16 lists the information systems (IS) vendors currently in-place to support transmission of beneficiary and services information from contract providers to the DMC-ODS.

ISCA Table 16: EHR Vendors Supporting Contract Provider to DMC-ODS Data Transmission

EHR Vendor	Product	Count of Providers Supported
n/a		

Special Issues Related to Contract Agencies

- San Diego reports that although some contracted providers have their own EHR, they are required to enter service data directly into SanWITS, so providers must do double-data entry into SanWITS and their own systems.
- San Diego continues to rely on hybrid (paper of store-image record and electronic) for the medical record system.
- SanWITS does not include history of client prescriptions or lab results.

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

ISCA Table 17: Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey

Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey	Yes	No
ASAM Criteria is used for assessment for clients in all DMC Programs.	X	
ASAM Criteria is used to improve care.	X	
ASAM screening is entered directly into the EHR.	X	
ASAM assessment is entered directly into the EHR.	X	
TPS is administered in all Medi-Cal Programs.	X	
CalOMS is administered on admission, discharge, and annual updates.	X	
CalOMS is used to improve care by tracking discharge status and other outcomes.	X	

Highlights or challenges of use of outcome tools above:

- The administrative discharge rate for San Diego is at 41.5 percent and is lower than the statewide average.

Overview and Key Findings

Operations and Structure

- The annual budget dedicated to IT support in FY 2020-21 is 7.2%, more than double the large county average of 3.09% reported in FY 2019-20.
- Both technology and data analytical positions were increased since the last review. This includes additional FEI Systems support, as well as the creation of a San Diego management reporting analysis team.

Key Findings

- A number of IT/data initiatives were delayed or halted due to COVID-19.
- SanWITS data fields required for state reporting and billing protocols will be uploaded to Health Agency data warehouse, which will also include mental health data from Millennium EHR.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate Network Adequacy (NA) as required by state law. The first document to be reviewed is the NACT which outlines in detail the DMC-ODS provider network by location, service provided, population served and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Diego, the time and distance requirements are 30 minutes and 15 miles for substance use disorder services, and 30 minutes and 15 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with DMC-ODS staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

As this was a desk review, CalEQRO conducted no client and family member focus groups, no stakeholder interviews, but did communicate through email with San Diego staff and a session with staff in which access and timeliness issues were discussed to identify problems for beneficiaries in these areas.

Findings

San Diego has provisional approval on all zip codes for time and distance pending DHCS review and approval of the 16 zip codes identified as needing an AAS final approval. These zip codes were identified in two area of the county, (91934, 91935, 91901, 91905, 91906, 91916, 91962) were in the southeastern areas of the county and (92004, 92014, 92065, 92066, 92061, 92082, 92086, 92028, 92036) were in the north inland areas of the county. The southeastern areas include remote mostly very small towns with small populations. The north inland areas are in the mountains near national and state parks as well as recreational and conservation areas. All zip codes are in areas far from urban centers and were not meeting time or distance standards for outpatient substance use services or NTP/OTP services for adults and youth. The number of beneficiaries impacted within the 16 zip codes is 42 beneficiaries (with a range of 0 to 5 per service category and age group). The other zip codes for the DMC-ODS for youth and adult SUD outpatient or NTP/OTP services met time and distance standards as required by DHCS.

San Diego has received approval from DHCS on its proposed AAS minutes and miles for the following zip codes in remote and rural areas.

Zip Code	Ser-vice	Age POP	Provider closest for OP or OTP	Distance Minutes	Distance Miles	#s impact	AAS Minutes	AAS Miles
91901	OTP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	19	16	2	45	30
91905	OTP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	48	48	2	60	60
91905	OP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	48	49	2	60	60
91906	OP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	41	40	2	45	45
91906	OTP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	43	40	2	45	45
91916	OP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	24	24	1	30	30
91934	OP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	49	59	1	60	60
91934	OTP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	50	51	1	60	60
91934	OP	youth	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	57	60	0	60	60
91934	OTP	youth	San Diego Health Alliance, Inc., El Cajon Treatment Center, 234 North Magnolia Avenue, El Cajon 92020	57	60	0	60	60
91935	OP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	27	17	1	45	30
91962	OP	adult	El Cajon Tx Ctr, 234 N Magnolia, El Cajon CA 92020	30	29	1	30	30
92004	OP	adult	Interfaith RWC OP Programs 1820 S Escondido Blvd, Escondido, CA 92025	96	72	0	110	75
92004	OP	youth	Mental Health Systems Inc. 410 Hidden Trails Rd, Escondido, CA 92027	84	36	0	90	60
92004	OTP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, 92025	109	79	0	110	80

Zip Code	Ser-vice	Age POP	Provider closest for OP or OTP	Distance Minutes	Distance Miles	#s impact	AAS Minutes	AAS Miles
92004	OTP	youth	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	109	79	0	110	80
92014	OTP	adult	Capalina Clinic, 1560 Capalina Rd, San Marcos, CA 92069	23	16	1	45	30
92028	OP	adult	NCL-Vista 200 Michigan Ave, Vista, CA 92084	65	38	1	70	45
92028	OTP	adult	SOAP MAT, LLC, 3230 Waring Ct, Oceanside, CA 92056	26	16	2	45	30
92036	OTP	adult	San Diego Health Alliance, Inc., El Cajon Treatment Center, 234 North Magnolia Avenue, El Cajon 92020	47	38.4	3	60	45
92036	OP	youth	Mental Health Systems Inc., 410 Hidden Trails Rd, Escondido, CA 92027	57	36	0	60	40
92036	OP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	73	48.8	3	75	60
92036	OTP	youth	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	88	62	0	90	65
92061	OP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	34	21	1	45	30
92065	OP	adult	Interfaith RWC Outpatient Programs 1820 S Escondido Blvd, Escondido, CA 92025	33	19	5	45	30
92065	OTP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	34	19	1	45	30
92066	OP	adult	Interfaith RWC Outpatient Programs 1820 S Escondido Blvd, Escondido, CA 92025	87	62	0	90	90
92066	OP	youth	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	61	46	0	70	50
92066	OTP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	86	61	0	90	65
92066	OTP	youth	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	86	61	0	90	65
92082	OTP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	25	16	3	45	30
92086	OP	adult	North Inland RRC 200 East Washington Ave Ste 100 Escondido, CA 92025	71	55	1	15	60
92086	OP	youth	Mental Health Systems Inc. 410 Hidden Trails Rd, Escondido, CA 92027	67	44	0	70	50
92086	OTP	adult	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	65	57	5	90	60

Zip Code	Ser-vice	Age POP	Provider closest for OP or OTP	Distance Minutes	Distance Miles	#s impact	AAS Minutes	AAS Miles
92086	OTP	youth	Mission Treatment-Escondido 161 N Date St, Escondido, CA 92025	72	50	0	75	50

There are a variety of mobile-based services for clients who receive mental health and SUD treatment to mitigate the extended time and distance in these remote and rural areas of the county. These programs, targeting clients with co-occurring disorders, are primarily run by mental health clinicians. In addition, service contracts are designed to allow and utilize mobile services which are inclusive of CM and are not designed to be crisis oriented.

ROAM is a service funded through the Mental Health Services Act innovation program that also provides SUD services in both the east region and north inland region specific to Native Americans residing on reservation land. ROAM also provides MAT services to both clients in the DMC-ODS and to those in their general FQHC clinic population not contracted with San Diego. SUD services include a strong cultural component that incorporates cultural practices including sweat lodge in combination with other traditional treatment models. Both ROAM providers, which are contracted to Tribal Health Clinics, have established relationships with NTP/OTPs in the community. Telehealth utilization has been leveraged in a larger capacity in the context of the COVID-19 pandemic, allowing for improved access in AAS areas to outpatient, assessments for all ages, consults, referrals.

San Diego reported a variety of telehealth services were provided to persons living in AAS zip codes. For Calendar Year (CY) 2020, 34 programs provided telehealth services including CM, group and individual counseling, patient education, as well as group and individual recovery services. The services were provided to a total of 988 clients who indicated they lived in zip codes within the AAS areas.

To increase MAT for youth services there have been multiple discussions on the best provider for this work and has now focused on augmenting an NTP/OTP provider that holds expertise in MAT to serve youth. An OTP contractor has been identified and a contract amendment is projected to occur by the 4th quarter in FY 2021.

Plan of Correction/Improvement by DMC-ODS to Meet NA Standards and Enhance Access for Medi-Cal Patients

San Diego shared no plan of correction at this time, as the AAS are being reviewed by DHCS.

Also reviewed as part of NA were access issues for physically disabled beneficiaries. San Diego requires contracted providers to comply with all regulations related to disabilities, including Americans with Disability ACT. Providers are required to complete the Persons with Disabilities (PWD) Accessibility Assessment and submit to the QM Unit. This information is reviewed to determine if the program can provide services to all persons

with disabilities and have a contract. If not, programs are required to create a corrective action plan for removing or mitigating barriers. The QM Unit will follow up annually if needed. Some programs cannot remove barriers, such as those with a facility built prior to ADA regulations or those who cannot financially make the changes to be compliant. These programs then must use the PWD referral list to assist the client with identifying an equivalent facility in their same geographic region who can provide services to all PWD. A bi-annual PWD SUD service Report is used for monitoring and ensuring there is a sufficient number of providers available in the system. San Diego also requires contracted providers to offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to the beneficiary, to facilitate timely access to services. These requirements are identified in the County's SUDPOH as well as the PWD Accessibility Assessment as supporting documentation.

San Diego acknowledges in the SUD Provider Operations Handbook that the Deaf and Hard of Hearing (DHH) clients are currently unable to fully access the resources available to hearing individuals and as described by Substance Abuse Mental Health Services Administration Treatment Improvement Protocol (SAMHSA TIP) 56 are at a severe disadvantage in receiving and realizing long-term benefits from treatment for SUD since efforts are typically not focused on culturally specific information. While the County of San Diego explores treatment options for this special population, they have developed specific practice guidelines to better serve this population that are recommended for contractors.

An example of these guidelines is that client records should reflect the client's hearing status, use of personal hearing assistive-technology, preferred method of communication (including language and hearing assistive technology needs), preferred language for care and for written materials, presence of interpreters/communication service providers during any service delivery, preferred method(s) of contact, and communication method used to secure informed consent. In addition, for clients whose preferred communication method is sign language, access to sign-fluent staff and/or an interpreter shall be utilized for all services.

In addition, San Diego monitors transportation needs of members to support access to the transportation benefit that health plans now provide. Efforts are in place to continually inform providers and clients about these benefits. This has been a continued topic during the Healthy San Diego Behavioral Health Operations subcommittee. This subcommittee now includes regular representation from both Mental Health Contractors Association (MHCA) and Alcohol and Drug Service Provider Association (ADSPA). These representatives inform the subcommittee about the providers' experience with accessing resources and act as a bridge between the providers and the health plans for communication.

San Diego developed a frequently asked questions (FAQ) in December of 2019 that provides context on the health transportation benefit. This is disseminated to SUD providers at various forums. San Diego also distributes a Health Plan Contact Card that provides the direct contact information for transportation for each of the health plans. San Diego reported the most recent distribution of this card was on January 14, 2021.

The County of San Diego has worked collaboratively with tribal clinics serving the Native American tribes in the County for a number of years including three tribal clinics, Indian Health Council, Inc., Southern Indian Health Council, Inc., and San Diego American Indian Health Clinic. The ROAM project described above, includes two mobile units associated with two of the tribal health clinics (Indian Health Council, Inc. and Southern Indian Health Council, Inc.) in the region, both serving the local Native American community. The County has met with tribal health clinic leadership several times over the last three years to discuss the options for contracting with the county for Drug Medi-Cal services. Indian Health Council, Inc., located in the North Inland Region, has recently expressed interest in moving forward with a DMC contract with the County. Indian Health Council, Inc. has received certification from the state and is currently in the process of developing their clinical program to align with the DMC standards. This contract is anticipated to begin 4/1/21. The remaining tribal health clinics, Southern Indian Health Council, Inc., and San Diego American Indian Health Clinic continue to evaluate the potential for contracting with the County for DMC services.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as “a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner.” CMS’ EQR Protocol: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each DMC-ODS that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

CMS revised the protocols in October of 2019. On the first page of the new protocol a PIP is defined by: "A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MCP/system level. "

San Diego DMC-ODS PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated one PIP as shown below.

PIP Table 1: PIPs Submitted by San Diego

PIPs for Validation	Number of PIPs	PIP Titles
Clinical PIP	1	Connections after discharge with referral
Non-Clinical PIP	1	Connection to SUD Services after Psychiatric Emergency Response Team (PERT)

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	San Diego
PIP Title	Connections after discharge with referral
PIP Aim Statement	This PIP aims to increase connections within 10 calendar days, for clients discharged with referral from a residential or WM program, to a lower level of care by 5% by April 2022.

DMC-ODS Name	San Diego
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): 1. Adults and youth clients who meet criteria for WM who are then discharged with referral to residential treatment. 2. Adult and youth clients who meet criteria for Residential treatment who are then discharged with referral to a lower LOC.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Motivational Enhancement and Engagement in Therapy (MEET) intervention, a warm handoff between the discharging program and admitting program, and client perception via a client questionnaire at the end of the discharge planning session(s).
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training counselors in the pilot programs on the MEET intervention and use of a fidelity tool to assure intervention is consistent, administration of a client questionnaire.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may

PIP Interventions (Changes tested in the PIP)
include new programs, practices, or infrastructure, such as new patient registries or data tools): The warm hand-off using MEET model potentially expanded across the SUD system as a clinical standard between discharging clients to receiving agencies.

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Successful transitions to lower levels of care			☒ *n.a.	Too early	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05

Was the PIP validated? ☒ Yes ☐ No
Validation phase: ☐ PIP submitted for approval. ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): San Diego implemented the week of the review and so no data was yet available for consideration of impacts including review of baseline data. Though concept and design are sound and typical of many PIPs done in other DMC counties on continuity of care, no data is yet available.

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: San Diego should start their interventions as soon as possible on both PIPs.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Feedback provided to San Diego during the review period. Review of first quarter results with EQRO is recommended to discuss the impact of interventions and to see if other factors need consideration in the design or data collection.

*PIP is in planning and implementation phase if NA is checked.

Non-clinical PIP

PIP Table 5: General PIP Information, Non-Clinical PIP

DMC-ODS Name	DMC-ODS Name
PIP Title	Connection to SUD Services after PERT
PIP Aim Statement	Will improving identification of SUD and strengthening connections to SUD treatment during a contact with the PERT, improve timeliness for clients with SUD who have initially refused SUD services and 1. Increase the proportion of clients with a PERT interaction who are admitted to a SUD program by 5 percent. 2. Decrease the mean length of time between when a client with a SUD concern receives a PERT interaction and is admitted to a SUD treatment program by 5 percent. 3. Decrease the proportion of clients with a PERT interaction and a SUD concern who are admitted to a SUD program more than 30 days after their PERT contact by 5 percent.

DMC-ODS Name	DMC-ODS Name
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): Clients with a PERT interaction related to a SUD concern (either in full or in part) who initially refuse additional SUD services, but clearly have SUD treatment needs adults.	

PIP Table 6: Improvement Strategies or Interventions, Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Peer Support Specialist (PSS) engages client via a warm handoff from PERT clinician who uses Motivational Interviewing to encourage consideration of SUD treatment. PSS will listen to client and help guide client to the appropriate SUD services and uses MI and assesses stages of change.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Clinicians will provide clients, who have initially refused a needed SUD service, a warm handoff to a PSS. New intake form so all clients with SUD concerns are identified at each PERT contact for peer support engagement and effort to encourage option of considering SUD treatment.

PIP Interventions (Changes tested in the PIP)
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): A new intake form was developed so all clients with SUD concerns are identified at each PERT contact. They then receive outreach contact by a peer to listen and offer via MI some SUD treatment options even if just harm reduction.

PIP Table 7: Performance Measures and Results, Non-Clinical PIP

Was the PIP validated?	☒ Yes ☐ No
Validation phase: ☐ PIP submitted for approval. ☒ Planning phase, no baseline established yet, many repeat SUD events at PERT, PIP is attempt to engage in SUD treatment and reduce PERT revolving door. ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):	
Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.	

EQRO recommendations for improvement of PIP: The PIP interventions are scheduled to begin on March 31, 2021. The PSS model is a researched model, effective for hard to engage clients. The intervention will begin as a pilot, with one clinician, in order to get data to make any necessary modifications, and then expand to additional clinicians. Recommendations: 1. Completion of the data analysis plan. 2. For future measures consider engagement of client into SUD services. 3. San Diego should start their interventions as soon as possible on their PIP so they can be in the active phase.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Consultation calls on designing and implementing the PIPs. Feedback provided to San Diego during the review period.

*PIP is in planning and implementation phase if NA is checked.

CLIENT SURVEY GROUPS

Due to the impact of COVID-19 on San Diego staffing they were not able to support consumer focus groups so CalEQRO was not able to proceed with focus groups for this year's review. San Diego did work with providers however, and 172 clients returned client experience of care surveys that could be linked to specific LOC. The results of the surveys are included.

The client/family member focus group is an important component of the CalEQRO review process; however, without the focus group many clients were able to take the online and confidential client survey. Client feedback was obtained from this survey which provided significant information regarding quality, access, timeliness, and outcomes. The survey questions were completed by participants and sent electronically to CalEQRO using Survey Monkey format. Their responses 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.

Client Survey Group One: Residential

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.

Eighteen participants, who were receiving residential treatment, responded with surveys. The participants were primarily attending Heartland House residential, but several other residential programs were also represented. The group responding was primarily adult males but included young and older adults as well as females.

Number of participants: 18

Participants participated through an online survey. Each participant rated 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 informed there were no wrong answers, and that their input was important. Clients were informed the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. Clients were further informed the goal of the survey is to understand the clients' experiences.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.12	3-5
2. I got my assessment appointment at a time and date I wanted.	4.18	3-5
3. It did not take long to begin treatment soon after my first appointment.	3.89	2-5
4. I feel comfortable calling my program for help with an urgent problem.	3.89	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.72	1-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.33	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.39	2-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.11	2-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.28	2-5

The following comments were made by some of the 12 participants who entered services within the past year and who described their experiences as follows:

- Overall Clients were positive about program.
- Some clients feel a bit confined and wish there were bus passes to get out more.
- Clients did not feel they were provided information about MAT programs.

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

- Clients want more freedom to leave the program for outings and passes to see family.
- The clients had good comments about their counselors.

Recommendations for improving care included the following:

- Allow visitations and passes during the week that allow clients to go out for essentials and visit family.
- Allow clients to go outside more and have more outside activities even if just video contact.

- Some counselors should provide more encouragement and more positive reinforcement.

Spanish surveys used for survey group 1: No

Client Survey Group Two: Serial Inebriate Outpatient Program

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.

Nine participants, who were receiving outpatient treatment in the Serial Inebriate Program, responded with surveys. They were all adults including four adults ages 25-59 and five older adults. They were all Caucasian/white and spoke English. There were primarily males but a few females. Demographic information for this group was not complete.

Number of participants: Nine

Participants participated through an online survey. Each participant rated 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 informed there were no wrong answers, and that their input was important. Clients were informed the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. Clients were further informed the goal of the survey is to understand the clients' experiences.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.56	4-5
2. I got my assessment appointment at a time and date I wanted.	4.5	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.56	3-5
4. I feel comfortable calling my program for help with an urgent problem.	4.22	1-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.33	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.67	1-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.67	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.56	4-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.78	4-5

The following comments were made by some of the 9 participants who entered services within the past year and who described their experiences as follows:

- Clients were mostly very positive about the counselors.
- Clients would recommend the program to others.

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

- Client survey response indicated high satisfaction in getting a timely assessment and in finding the program.

Recommendations for improving care included the following:

- Client survey responses indicate some counselors need to work be more culturally sensitive.
- Clients would like more variety and less repetition of the curriculum.
- Some clients asked for a pet therapy day to lift their spirits.
- One client suggested the program and counselors learn more about trauma and post traumatic syndrome disorder (PTSD) associated with veterans, whom have serious mental health issues, which need to be addressed.

Spanish surveys used for surveys group two: No

Client Surveys Group Three: Drug Court Program:

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.

Sixty-five participants who participate in the outpatient Drug Court Program in multiple locations responded to the survey. There were 36 males and 38 females who were willing to identify their gender. They were primarily adults (57) but included 5 young adults and some older adults. All participants spoke English and were primarily Caucasian/White (38) and Hispanic/Latino (22) but also included Asian American/Pacific Islanders (5) and Native Americans. Again, demographic information was not entirely complete.

Number of participants: 65

Participants participated through an online survey. Each participant rated 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 informed there were no wrong answers, and that their input was important. Clients were informed the information sharing was regarded as confidential and reflected the participating group members’ own experiences

and feelings about the program. Clients were further informed the goal of the survey is to understand the clients' experiences.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.32	1-5
2. I got my assessment appointment at a time and date I wanted.	4.22	1-5
3. It did not take long to begin treatment soon after my first appointment.	4.31	1-5
4. I feel comfortable calling my program for help with an urgent problem.	4.45	1-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.71	1-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.11	1-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.51	1-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.34	1-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.18	1-5

The following comments were made by some of the 40 participants who entered services within the past year and who described their experiences as follows:

- Many clients felt the program was good the way it is currently operated and would not change anything.
- Survey responses indicated clients would like MAT services to be discussed more so they could see if that would help them.

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

- Clients seemed satisfied with the service delivery and were learning new things.
- Clients were very positive about their counselors.

Recommendations for improving care included the following:

- Provide bus passes to assist clients with transportation issues.
- One client suggested a return to the program structure, of reducing the amount of required attendance days per week, when a participant is successful at moving up to the next level.

- Return to in person groups once possible with COVID-19.

Spanish surveys used for survey group three: No

Client Survey Group Four: Outpatient Programs

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.

Eighty participants who participate in outpatient programs responded to the survey. Clients identified as male (52) and female (25) with several declining to state their gender. The group included 78 participants who preferred English and 2 who preferred Spanish; however, after review CalEQRO validated all participants provided thoughtful comments in English. The participants were primarily Caucasian/White (43) and Hispanic/Latino (24) but included African American/Black (8), and Asian Pacific Islanders and Native Americans. Some demographics were partially completed.

Number of Participants: 80

Participants participated through an online survey. Each participant rated 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 informed there were no wrong answers, and that their input was important. Clients were informed the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. Clients were further informed the goal of the survey is to understand the clients' experiences.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.47	2-5
2. I got my assessment appointment at a time and date I wanted.	4.41	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.57	2-5
4. I feel comfortable calling my program for help with an urgent problem.	4.42	1-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.65	1-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.40	1-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.48	2-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.44	2-5

Question	Average	Range
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.45	1-5

The following comments were made by some of the 69 participants who entered services within the past year and who described their experiences as follows:

- Clients generally provided feedback that the program was good and helping them live with their SUD or improve.

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

- Survey results showed the clients found programs easily and got the help they needed in a timely manner.
- Some clients want to return to meet in person and stop using zoom.
- Counselors were well liked by clients who wrote comments that spoke highly of them and saw them as working to make a difference.

Recommendations for improving care included the following:

- Clients want more one-on-one time with their counselors to work on their individual issues.
- Clients want the program to have fewer hours each day and more days, such as going 1.5 hours each day for 5 days rather than 3 hours a day for 3 days.

Interpreter used for focus group four: No

Client Focus Group Findings and Experience of Care

Overview

There was a total of 172 surveys collected that could be connected to programs in the categories of residential, Drug Court, outpatient and specifically the Serial Inebriate outpatient program. Survey respondents identified as male (110) female (67) or transgender/declined to state (5). All survey respondents were primarily adults, ages 25 to 59, but included young (18 – 24) and older adults (60+). Respondents were primarily Caucasian/White (97) and Hispanic/Latino (54) but included persons who identify as African Americans/Black (14), Asian American/Pacific Islander (97) and Native American (5). All surveys were written in English.

Access Feedback from Client Focus Groups

- Survey responses indicated clients found the treatment and received their assessment at the time and date they wanted.
- Survey responses report that the first day of service came quickly in outpatient and Drug Court but was often delayed for residential treatment.
- Survey responses report that all outpatient programs (including Drug Court and the Serial Inebriate Program) were easy to access but the residential programs were more challenging.
- For some transportation was a challenge and bus passes or other options were needed.

Timeliness of Services Feedback from Client Focus Groups

- Residential programs were scored the lowest for getting services in a timely manner (3.89 out of 5:00).
- Many clients gave high scores, across all outpatient programs, indicated services were provided in a timely manner.

Quality of Care Issues from Client Focus Groups

- Most survey respondents, across all program, reported they enjoyed their treatment experience and would not change anything to the quality of care they were receiving.
- Survey respondents consistently gave lower scores to the question of whether the benefits of MAT were discussed, indicating increased MAT assessment and education is needed in all programs.
- Most survey respondents reported they liked their counselors and would recommend them to friends and family. Some wanted more individual time to work on individual issues and more flexibility with the schedule.
- Some clients felt cultural sensitivity and awareness needed improvement with some counselors.
- Feedback on the Serial Inebriate program was the groups and modules were too repetitive and more varied information and activities around alcohol problems and MAT for alcohol and trauma would be good.

Client Outcomes Feedback from Client Focus Groups

- Some survey respondents reported they would benefit from more one on one time with their counselors.

- Some survey respondents reported they wanted to meet in person rather than through zoom.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
	Component	Quality Rating
1A	Service Access are Reflective of Cultural Competence Principles and Practices	M
San Diego provided services in Spanish, German, Armenian, Tagalog, Arabic, American Sign Language, and other languages to single clients. The San Diego Cultural Competence Three-Year Strategic Plan is focused primarily on mental health services and needs to be expanded with specific strategies for beneficiaries who may need services through the DMC-ODS. San Diego has met with the tribal health clinic leadership in eastern and northern areas to discuss contracting for DMC-ODS services. Indian Health Council has received certification from the state and is developing their clinical program, anticipated to begin services in April 2021. MAT services have been added to the ROAM project. The program integrates culturally competent treatment practices within the program. The TPS results found youth scored their perception of quality differently across cultures with Caucasian/Whites being lowest (66 percent) and Blacks/African-Americans highest (83 percent). Adults felt that staff were sensitive to their cultural needs scoring high (88 percent). Additionally, most African American/Black youth believed there was a good therapeutic alliance scoring this high (93 percent), Asian/Pacific Islander and Hispanic/Latino youth scored less high		

KC Table 1: Access to Care Components		
Component		Quality Rating
(80 percent) and Caucasian/White youth scored lower (75 percent) indicating less satisfaction with the therapeutic alliance.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
The county utilized data collected on the yearly Total Units of Service (TUOS) Report for FY 2019-20 to ensure there are adequate services in North County and other areas. The county analyzed the number of MAT encounters and units for North County SUD programs, stratified by quarter to ensure there are adequate MAT services OTPs. MAT services were expanded through a contract amendment at the co-occurring Assertiveness Community Treatment program. San Diego is exploring the expansion of WM services within DMC-ODS including Ambulatory Levels 1 and 2 at existing programs that may want to expand. San Diego has developed a statement of work for the expansion of residential level 3.3; however, the request for proposal was delayed due to the pandemic. San Diego has also recognized the need for specialized TAY services and efforts are currently in process for exploring options to operationalize TAY specific programming in TAY residential and outpatient services. San Diego is addressing rural areas with few beneficiaries by requesting AAS through DHCS. In addition, San Diego has Telehealth services available at all program locations. Services have continued to expand since the beginning of the Waiver even with challenges of COVID-19 and efforts will continue to meet local needs per DMC administration.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
The Teen Recovery Center programs based in the community and linked to school sites, updated resources, and fliers to increase outreach efforts as referrals from schools were impacted with the shift to remote learning. San Diego established a population health unit that utilized training with the Community Health Statistics Branch of Public Health as it launched. San Diego works with hospitals creating Bridge programs for early identification of patients in need of opioid treatment that can coordinate with local SUD providers. In addition, there are designated emergency departments conducting buprenorphine inductions. San Diego also works with the local health plans and Federally Qualified Health Centers to expand MAT treatment options. San Diego is an integrated behavioral health system with multiple efforts to effectively treat clients who need both mental health and SUD treatment. San Diego work closely with the criminal justice system to provide Drug Court and other services to beneficiaries involved in that system.		

KC Table 1: Access to Care Components	
Component	Quality Rating
The San Diego continuum collaborates through the contract providers with a variety of non-profit community groups for referrals for clients including AA/NA, SMART Recovery, and other community-based self-help groups. The County's DMC-ODS network of providers includes Episcopal Community Services (ECS, a faith-based provider of SUD outpatient services) and Interfaith Community Services (an ecumenical, non-specific faith provider of SUD residential and SUD outpatient services). In addition, DMC-ODS providers are expected to collaborate with faith-based providers if needed in a client's treatment plan.	

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
	Component	Quality Rating
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
San Diego tracks and trends the average length of time from first request to first contact. The average length of time from first request to first offered appointment is 3.9 days for adults and 3.3 days for youth with 90.7 percent of adults and 92.6 of youth meeting the standard of 10 business days. San Diego reported this data with and without residential, with residential it was slightly timelier. This high percentage of adults and youth receiving timely first appointments have continued from the previous year.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
San Diego tracks and trends the time between initial request and first face to face Methadone MAT appointment, reporting 95.5 percent of initial MAT requests to NTP appointment meet the DHCS standard of 3 business days, with have an average of 1.6 days. This high percentage of clients within the standard has continued from the previous year.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	M
San Diego has a clear definition of urgent which includes the client perception but also a condition that disrupts normal activities of daily living and requires an		

KC Table 2: Timeliness to Care Components		
	Component	Quality Rating
assessment and treatment within 48 hours. San Diego reports the average length of time from request to urgent visit is 3.7 days for adults with 67.5 percent seen within the state standard of 48 hours. San Diego has taken steps to improve the percent of urgent requests that are seen within 48 hours with the Regional Recovery Programs, Perinatal Outpatient and Teen Recovery Centers having extended hours multiple days per week. In addition, there is now availability to schedule appointments outside of regular business hours as needed by clients. The Quality Performance and Improvement division is also partnering with the contract monitors to ensure contracted providers meet the required timely access standards, this includes supporting programs by providing technical assistance, requiring corrective action plans for deficiencies, and follow-up to verify corrective action was implemented as part of a continuous improvement process. San Diego has updated methodologies for all access time reports to reflect calendar days so urgent requests can be tracked. This was not in place for youth in the prior year. In addition, the review by contract monitors, as identified above, is in place to assure youth service requests for urgent appointments are timely.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	M
San Diego has established a minimum standard of seven days for beneficiaries receiving follow up services following discharge from residential treatment. San Diego uses a process to track follow up appointments and reports that in FY 2019-20 of 2,038 discharges it took an average of 23.8 days to access follow-up services. Adults had follow-up services within 7 days 36 percent of the time with an average of 23.4 days. Youth had follow-up services within 7 days 28.6 percent of the time with an average of 35.3 days. San Diego has a specific goal to in their Quality Improvement Program and Work Plan to increase the number getting timely follow-up by 25 percent. They have exceeded that percentage and it is hoped that target would be increased.		
2E	Tracks and Trends Data on Follow-up and Re-Admission to Residential Withdrawal Management	M
San Diego CalEQRO claims data for FY 2019-20 shows an overall all readmission rate of 22 percent within 30 days to residential WM. San Diego has been tracking the rate of re-admission within 30 days with data analysis by specific programs during this same time period. This data, which is shared with the providers, is reported by San Diego to be demonstrating consistent improvement, with 6.1 percent of clients being readmitted within 30 days with a range of 2.3 percent to 11.3 percent in the last quarter of FY 2019-20. This is much better than the prior rate, but still high than the state average.		

KC Table 2: Timeliness to Care Components		
	Component	Quality Rating
2F	Tracks Data and Trends No Show Data for Initial Appointment	PM
San Diego routinely tracks the data related to rescheduled appointments. San Diego tracks all levels of care and reports 14.8 percent of clients' rescheduled their initial outpatient appointment, 11.7 percent rescheduled for IOT, 10.5 percent rescheduled their first residential contact, and 10.4 rescheduled for residential 3.2 WM. San Diego reports the average rescheduled appointments across all programs is 11.3 percent. When combining no-shows and reschedules across all LOC the total average is 33.8 percent. No-shows cannot be tracked by LOC at this time.		

Quality of Care

CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including client/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
	Component	Quality Rating
3A	Quality management and performance improvement are organizational priorities	M
San Diego has a current integrated Quality Improvement (QI) Work Plan with separate measurable goals linked to quality improvement for mental health and SUD. The San Diego QI structure includes the Executive Quality Improvement Team (EQIT), QI Performance Improvement Team (QI PIT), QM Team, Management Information Systems (MIS) Team, Quality Review Council (QRC) and QR Committees (QIC). The QRC is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities, meets quarterly, and includes clients and family members as well as stakeholders from the behavioral health communities representing regions. San Diego produces regular reports through data extraction for analysis pertaining to access, timeliness, quality, and outcomes. Although San Diego is an integrated behavioral health department, there are specific DMC-ODS meetings that engage the appropriate persons involved with DMC-ODS across the system. San Diego produced a Substance Use Disorder Services Work Plan Evaluation for FY 2019-20.		

<table>
<tr><th colspan="3">KC Table 3: Quality of Care Components</th></tr>
<tr><th colspan="2">Component</th><th>Quality Rating</th></tr>
<tr><td colspan="3">San Diego uses tools such as a SUD Admission checklist and monitoring tools to assure that through a medical records review process the expectations for CM are monitored for individual clients and programs, providing feedback and requests for plans of correction to achieve improvement. The warm handoff expectation for transitions to care is monitored; however, San Diego has designed a PIP to increase tools for this process to occur more frequently.</td></tr>
<tr><td>3B</td><td>Data is used to inform management and guide decisions</td><td>M</td></tr>
<tr><td colspan="3">The QI Work has specific SUD goals within the QI Work Plan. The QRC has SUD representation from both Outpatient and Residential programs. In addition, feedback is continuously received from SUD client representatives on the QI Work Plan and goals are set annually.

As a result of stakeholder input, recovery services related questions were added to the Cultural and Linguistic Competency Assessment for providers, administered in February 2020. This was discussed at the January 23, 2020 QRC meeting. San Diego reported that the results of provider competence in this area was presented to the QRC on July 23, 2020 and a copy was provided to CalEQRO.

Supplemental questions were added to the TPS to get more feedback on why clients did not follow through on referrals to additional services. In addition, questions were added to better understand a sense of client's well-being and their receptiveness to telehealth services during the pandemic.

TA sessions with providers are individualized to the program/contract based on needs, including issues on program capacity, implementation of telehealth, or other factors that impact volume of services. TA is expected to result in increased DMC billable unit production and corresponding revenue. Using overall outpatient SUD data as an example, the data shows that phone and telehealth services have supplemented in-person services to increase DMC-billable services to levels that, in some cases, exceed pre-COVID-19 volume of billable service. Also, there is an upward trend for in-person services. Specific TA sessions may range from ensuring that program staff are equipped with technology to having sufficient training in documentation. Other TA strategies include best practices for schedule management, adjusting admin to direct staff ratios, increasing service capacity, and best practices for outreach and engagement to identify new sources of referrals.</td></tr>
<tr><td>3C</td><td>Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation</td><td>M</td></tr>
<tr><td colspan="3">A new LPHA focused meeting began in June 2020, in response to the request of providers. The meeting is structured as a discussion by those in attendance to improve the LPHA role, workflow process and compliance with DMC requirements. To support the medical workforce and the clinical needs of DMC-ODS a Medical</td></tr>
</table>

KC Table 3: Quality of Care Components		
	Component	**Quality Rating**
Directors meeting was established for increased interface with peers to discuss common challenges and best practices. San Diego has shown they can work with providers to solicit and receive client feedback as evidenced by 300+ clients participating in the EQRO online consumer feedback survey. There was evidence of consumer and family member feedback in the QRC as well as action taken as a result of the feedback. San Diego is collaborative and works closely with community groups. In addition, they meet regularly with their stakeholder/partners including health plans and contract providers, hospitals, and criminal justice partners.		
3D	Evidence of an ASAM continuum of care	M
The county has developed school-based services as well as community-based services including OP, IOT and residential services for adolescents. DMC-ODS providers are contractually expected to have the capacity to provide recovery services within 90 days of a client's treatment conclusion, including "graduates" from other treatment providers' programs. Programs complete LOC forms to align or match treatment which may include outpatient individual or group counseling; recovery monitoring; substance abuse assistance; education and job skills; family support; support groups; and ancillary services such as housing linkages, transportation, CM, and service coordination that supports clients in their recovery. San Diego has provided funding to contracts providers with outpatient and IOT services to fund RR as needed for their clients. There are 42 RR in their directory that meet the outlined standards and are available, each RR has a varying number of beds. The probation department has additional RR for some persons they serve, contracting directly with RR providers for these services.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
San Diego with county partners in the San Diego County Prescription Drug Abuse Task Force (PDATF) actively educate community and providers on treatment and prevention. They also provide an annual report card and in 2020 reported a rise in all death categories but especially fentanyl deaths which increased 64% between 2018 and 2019; however, prescriptions alone or with other drugs continues to be the leading cause of death in San Diego. The County has a medication monitoring process that requires programs to form a Medication Monitoring Committee comprised of two or more representatives from different disciplines (but at least one of the members must be a physician) to review internal medication monitoring practices (inclusive of MAT) with specific areas monitored including effectiveness of medication, adverse drug reactions and side		

KC Table 3: Quality of Care Components		
	Component	**Quality Rating**
effects, and client medication education. Reports from these program activities are submitted to San Diego. MAT access times and encounters are included in high level dashboards that are reviewed by San Diego routinely for monitoring purposes. There are also current discussions regarding the creation a BHS medication review committee to potentially review system, program, prescriber, and individual client level data as well. MAT services are scheduled to be available in outpatient programs through contract amendments with HealthRight360 and Mental Health Systems; however, although the contract for HealthRight350 is effective, the services have not yet begun. San Diego produces a MAT services report, combining methadone and non-methadone, and finds the majority of clients (97 percent) receive 3 or more MAT services. They also track client characteristics and living situation at admission. Feedback from client surveys indicates that additional education is needed to provide all clients information on the benefits of MAT during the assessment and treatment planning process. Although Patient Education is a required component in San Diego, there is not a current process to monitor that education on MAT benefits is provided during the assessment and treatment planning process for all clients and documented in the client's chart. The San Diego County Sheriff's Department has programs in place to help ensure that pregnant women on MAT keep receiving services while incarcerated. Acadia Healthcare, one of the County's NTP/OTP providers, received funding through the State's Targeted State Opioid Response grant to provide MAT during periods of incarceration. Unfortunately, there is not yet a continuation of medication for other populations except on a per client basis. The Las Colinas Jail project has a goal to continue medications with a current prescription for inmates on Buprenorphine or Naloxone (Suboxone).		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
San Diego continues to be successful regarding the use of ASAM criteria for individualized placement and treatment planning. There is an extensive training schedule for contract provider staff that includes, in part, training in ASAM, CM, evidenced-based treatment and relapse prevention. San Diego supports changes in treatment based on treatment needs including relapse. Treatment programs receive regular reports from San Diego regarding the specific clients they are serving which cover a variety a quality metrics. TA is provided to contract providers by county staff to assure they are able to meet the quality goals		

KC Table 3: Quality of Care Components		
	Component	**Quality Rating**
embedded in their contracts. San Diego may need to work with contract providers who want to develop internal monitoring systems for their clients.		
3G	Measures clinical and/or functional outcomes of clients served	M
San Diego used a Relapse Prevention Evidence-Based Practice model to decrease the rates of early discharges without satisfactory progress from treatment programs by 5 percent. The county evaluated responses on TPS and provided thorough reports. They also utilized ACL Call Statistics to analyze ACL access times and types of calls received.		
3H	Utilizes information from client perception of care surveys to improve care	PM
The county annually provides the results of the TPS including key findings from each domain for both adults and youth. For the October 2019 survey they reported 2,424 adult and 137 youth surveys were collected. They also sorted the satisfaction by level of care, race/ethnicity, and age. San Diego has utilized the TPS to ensure adult clients received services in their preferred language. It also utilized the youth TPS question, “I received the services right for me,” to compare placement in the youth’s LOC. For adults, the perception of quality was consistent across ethnicities, ranging from 88 to 92 percent. San Diego did not show evidence of comparing the most recent TPS findings to prior data.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- San Diego exceeds both the penetration rates for large counties and the statewide averages in every age group. For example, the county adolescent penetration rate is 0.64 percent, compared to the large county rate of 0.34 percent and the statewide penetration rate of 0.32 percent. Similarly, the county exceeds the large county and statewide penetration rate for each ethnicity group and for each Medi-Cal eligibility category.

- The beneficiary access line is an integrated MHP and DMC-ODS ACL operated by Optum 24 hours each day including weekends and holidays. The data is sorted for specific DMC-ODS statistics reporting callers wait only 15 seconds, with a low abandon rate of 2.14 percent.

- The San Diego BHS web page has the ACL number listed clearly on the front page, with options for chat and a number for hearing impaired. The website is easy to navigate and can be easily translated into many languages. The alcohol and drug page has two big boxes clearly identifying prevention programs and treatment services. The Beneficiary Handbook is easy to find and is in large print as well as in multiple languages.

- Youth programs have community-based clinics in each San Diego region but are expanding their additional school locations to increase access and coordination with school personnel. San Diego is providing outpatient, IOT and residential services for the adolescent population.

- San Diego NTP/OTP contract providers all provide non-methadone MAT services to clients. San Diego expanded MAT services since the last review through an expanded contract serving clients with co-occurring disorders and within the ROAM project serving rural tribal communities in the remote areas of eastern and north inland San Diego. Additionally, WM services were expanded with residential SUD contracts as of May 2020.

- In addition, outside of the DMC-ODS three hospitals have established grant funded ED Bridge programs for persons with opioid addiction seeking help for SUD. These programs offer Buprenorphine induction and then assist patients in linking to ongoing follow up care. In addition, there are FQHCs in San Diego who have been trained to treat opiate addicted clients with MAT through a collaborative project between Center for Care Innovation and the California Health Care Foundation. San Diego also contracts with an FQHC that provides DMC services in two regions (Central and South county).

- San Diego has engaged with tribal health clinics and anticipates beginning a contracted partnership for certified DMC services with one tribal partner, and continued conversations with other county tribal health clinics.

- San Diego works with partners in the San Diego County PDATF actively educating community and providers on treatment and prevention. They also provide an annual report card and in 2020 reported a rise in all death categories but especially fentanyl deaths which increased 64 percent between 2018 and 2019; however, prescriptions alone or with other drugs continues to be the leading cause of death in San Diego.

- San Diego outpatient data shows that phone and telehealth services have supplemented face-to-face services to increase DMC-billable services to levels that, in some cases, exceed pre-COVID-19 volume of billable service. Also, there is an upward trend for face-to-face service.

Opportunities:

- The ACL has the capacity to use a three-way call, but is only successful in linking callers to providers, using this best practice, a small percent of the time. Optum is now collecting feedback from clients to better understand why they are declining. There is an opportunity to increase linkages to programs.

- San Diego has identified level 3.3 residential services and TAY specialty care as areas for expansion. A request for proposal (RFP) for level 3.3 residential services was delayed due to COVID-19, and San Diego is assessing the appropriate time to move this forward as well as exploring options and timelines to expand services to TAY.

Timeliness of DMC-ODS Services

Strengths:

- San Diego reports after the initial contact 94 percent adults and youth receive their first offered appointment in an average of 3.1 days 94.5 percent of the time, their first face-to-face visit in an average of 3.9 days 90.7 percent of the time and their first NTP/OTP face to face in 1.6 days 95.5 percent of the time.

- San Diego creates reports monthly and tracks year to date average time to access each provider site location. They use this data as a tool to increase timely access to services across the system.

- San Diego has updated methodologies for all access time reports to reflect calendar days so urgent requests can be tracked. This was not in place for youth in the prior year. In addition, the review by contract monitors is in place to assure youth service requests for urgent appointments are timely.

- San Diego has a clear definition of urgent which includes the client perception but also a condition that disrupts normal activities of daily living and requires an assessment and treatment within 48 hours. San Diego has taken steps to improve their timely response to urgent requests with programs adding extended hours multiple days per week. In addition, there is now availability to schedule appointments outside of regular business hours as needed by clients.

- San Diego tracks the timeliness of authorizations for residential treatment, completed by Optum, and provided a report to show timeliness of the turnaround time for a two-month period, was on average 1.3 days for all authorizations from request to determination.

Opportunities:

- San Diego reports that after the initial contact urgent visits occur on average in 3.7 days 67.5 percent of the time, showing a need for improvement for more clients to be seen in the standard of 48 hours.

- San Diego has reviewed urgent service requests and identified the gap of collecting these requests for clients already connected to treatment and will be exploring ways to include these requests in their data collection processes.

- San Diego routinely tracks the data related to cancellations and reschedules for initial appointments by LOC. San Diego reports the average reschedule across all programs is 11.3 percent. When combining no-shows and reschedules across all LOC the total average is 33.8 percent; however, no shows cannot be tracked by LOC at this time.

- San Diego reports concern on decreasing rates (33 percent in April 2019 to 13 percent in December 2019) of connection to a program after discharge with referral from residential and WM. San Diego is developing a clinical PIP to address this issue in the coming year.

Quality of Care in DMC-ODS

Strengths:

- San Diego has clear expectations on care coordination and requires that each contract provider create policies/procedures, with minimum considerations, focusing on seamless client transitions without disruption to services. In addition, programs are expected to provide specific direction on response to missed scheduled appointments with the goal of client engagement.

- As a result of stakeholder input recovery service-related questions were added to the Cultural and Linguistic Competency Assessment for providers administered in February 2020 and results reported to QRC on July 23, 2020. In addition, supplemental questions were added to the TPS to get more

feedback on why clients did not follow through on referrals to additional services as well as questions to better understand a sense of client's well-being and their receptiveness to telehealth services during the pandemic.

- Recovery services are included with both outpatient and residential programs eliminating the need to transition to a new provider for this service. Clients have the option to receive these services at the program from which they completed treatment or another program of their choosing.

- A new LPHA focused meeting began in June 2020, in response to the request of providers. The meeting is structured as a discussion by those in attendance to improve the LPHA role, workflow process and compliance with DMC requirements.

- The County has a medication monitoring process that requires programs to form a Medication Monitoring Committee comprised of two or more representatives from different disciplines (but at least one of the members must be a physician) to review internal medication monitoring practices with specific identified areas monitored. Reports from these program activities are submitted to San Diego.

- A Population Health Unit was added to the organizational structure under the Clinical Director's Office to enhance population health surveillance in an effort to better understand the need for levels of care such as WM. The unit will train with the County of San Diego's Community Health Statistics Branch.

- In response to recent events that highlight nationwide issues on institutional/systemic racism, the San Diego BHS Director has announced his intention to form a small internal workgroup and to engage a subject matter expert to address racial equity within San Diego BHS.

- San Diego produces a MAT services report the majority of clients (97 percent) receive 3 or more MAT services. They also track client characteristics and living situation at admission.

- San Diego is successful at initiating and engaging youth at a higher percentage compared to statewide averages. San Diego initiates youth into treatment 92 percent compared to the statewide average of 80.4 percent. San Diego then engages youth 80.8 percent compared to 70.8 percent statewide.

Opportunities:

- San Diego is working to increase competency in serving clients with co-occurring disorders, specifically those who are utilizing PERT who have a SUD issue. Findings indicate almost half of the clients (40 percent) who received a PERT services were diagnosed with SUD but only 19 percent were admitted to a SUD treatment provider within the DMC-ODS. San Diego is

implementing a Non-Clinical PIP as an opportunity for better SUD screenings and linkage to SUD services during a PERT contact.

- San Diego should start their PIP interventions as soon as possible so that both PIPs can be in the active phase.

- Feedback from client surveys indicates that additional education is needed to provide all clients information on the benefits of MAT during the assessment and treatment planning process.

- The San Diego County Sheriff’s Department has programs in place to help ensure that pregnant women on MAT keep receiving services while incarcerated. Unfortunately, there is not yet a continuation of medication for other populations except on a per client basis. San Diego is working collaboratively to expand the continuation of MAT to more populations and hopes to see progress in this next year.

Client Outcomes for DMC-ODS

Strengths:

- Clients rated their experience in treatment as highly positive on the TPS. Ratings were highest in feeling welcomed, understanding communication, and being treated with respect.

- Clients rated their treatment outcomes positively, agreeing they are better able to function and accomplish what they want as a result of treatment.

- San Diego completed a PIP in FY 2019-20 that developed and implemented a relapse prevention evidenced-based practice (EBP) model to decrease rates of early discharges without satisfactory progress from treatment. San Diego succeeded in reducing early discharges by 16 percent (goal was 5 percent).

- San Diego’s CalOMS discharge results showed that providers rated 50.4 percent of their clients as having positive progression in treatment by the time of their discharge. These results are higher than the statewide average of 45.8 percent.

Opportunities:

- Youth clients responding to the TPS survey reported that they were less satisfied their counselor provided necessary services for their family.

Recommendations for DMC-ODS:

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

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

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

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

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

6. Continue plans to expand the continuum of care with RFPs as indicated with 3.3 residential treatment and TAY services.

ATTACHMENTS

Attachment A: CalEQRO Review Agenda

Attachment B: Review Participants

Attachment C: County Highlights

- None at this time

Attachment D: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO Review Agenda

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

Table A1: CalEQRO Review Sessions - San Diego DMC-ODS
Wrap up session and exit interview

Attachment B: Review Participants

CalEQRO Reviewers

Maureen F. Bauman, LCSW, MPA, Lead Reviewer
Sue Nelson, EdD, Second Reviewer
Joel Chain, IS Reviewer
Bill Ullom, IS Reviewer
Laura Bemis, Client/Family Consultant

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

San Diego's DMC-ODS Review

DMC-ODS Sites

As this was a hybrid video desk review no sites were visited.

Table B1: Participants Representing San Diego			
Last Name	**First Name**	**Position**	**Agency**
Blanchard	Michael	Quality Management Supervisor - QI Quality Management	SDCBHS
Esposito	Nicole	Assistant Clinical Director – Clinical Directors Office	SDCBHS
Gonzaga	Alfie	Program Coordinator – Clinical Directors Office	SDCBHS
Guevara	Christopher	Principal Administrative Analyst – QI Management Information Systems	SDCBHS
Kang	Terri	Behavioral Health Program Coordinator - Children, Youth & Families System of Care	SDCBHS
Lang	Tabatha	Assistant Medical Services Administrator – QI	SDCBHS
Miles	Liz	Principal Administrative Analyst – QI Performance Improvement Team	SDCBHS
Murguia	Krystle	Administrative Analyst III – QI Performance Improvement Team	SDCBHS
Ramirez	Ezra	Administrative Analyst II – QI Performance Improvement Team	SDCBHS
Shapira	Erin	Administrative Analyst III – QI Quality Management	SDCBHS
Tran	Phuong	Administrative Analyst II – QI Performance Improvement Team	SDCBHS
White-Voth	Charity	Assistant Medical Services Administrator - Adult and Older Adult	SDCBHS

Attachment C: County Highlights

None at this time.

Attachment D: 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 LOC Referral Data
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California’s Outcomes Measurement 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	Integrated Medication Assisted Treatment
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
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
MCBHD	Medi-Cal Behavioral Health 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 Survey on Drug Use and Health (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
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	Web Infrastructure for Treatment Services
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version