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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 18-20, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Drug Medi-Cal Organized Delivery System (DMC-ODS) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "San Diego" may be used to identify the San Diego County DMC-ODS program, unless otherwise indicated.

DMC-ODS INFORMATION

Review Type — Virtual

Date of Review — April 18-20, 2023

DMC-ODS Size — Large

DMC-ODS Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the DMC-ODS on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	2	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	3	3	0
Quality of Care	8	6	2	0
Information Systems (IS)	6	4	2	0
TOTAL	**24**	**17**	**7**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Pharmacotherapy for Opioid Use Disorder (POD)	Clinical	07/2022	Planning	Low
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Non-Clinical	06/2022	Planning	Low

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP ☐ Perinatal ☒ Other	13
2	☐Youth ☐ Residential ☐ Outpatient ☒ MAT/NTP ☐ Perinatal ☐ Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The DMC-ODS demonstrated significant strengths in the following areas:

- The DMC-ODS website is user friendly, easy to navigate, and informative.
- The DMC-ODS has a high level of congruence of American Society of Addiction Medicine (ASAM) findings and level of care (LOC) referrals/placement demonstrating that staff are well trained in adherence to the ASAM model.
- The DMC-ODS has leveraged IS and data analytics resources to build an experienced and supportive framework for electronic health record (EHR) development, data analysis, and reporting.
- San Diego has a strong data analytics team that supports its goal of being a data driven organization.
- San Diego is developing and supporting a peer workforce, many of whom can now provide Medi-Cal reimbursable services.

The DMC-ODS was found to have notable opportunities for improvement in the following areas:

- In collaboration with contract providers and in response to a previous EQR recommendation, San Diego has begun planning to improve workflow issues for timely documentation of urgent service requests but has yet to develop and implement improvement strategies.

- San Diego has high rates of no-shows to initial residential and outpatient appointments. Despite the DMC-ODs giving TA to providers this past year, rates have slightly increased.
- San Diego would benefit from added IS and data analytics positions within the behavioral health department with its ongoing EHR updates.
- Contract provider line staff report miscommunication and unclear directions from DMC-ODS leadership regarding policy and system changes resulting in unclear and inconsistent messaging for providers and line staff who provide 100 percent of direct services.
- San Diego does not consider calls to its Access Call Line (ACL) as requests for service and consequently, does not include these calls as part of its timeliness data making unclear the length of time it takes from the call to service access.

FY 2022-23 CalEQRO recommendations for improvement include:

- Develop and implement improvement strategies to assure accurate and complete data collection of urgent service requests.
- Address low rate of timely follow-up after residential discharge and address high no-show rates to initial appointments for outpatient and residential treatment.
- Add both IS and data analytics positions to support the ongoing development of San Diego's EHR system as well as for data analytics and reporting.
- Take steps to improve two-way communication with contract provider line staff, including providing clear and consistent direction across all programs, and soliciting input from staff who provide direct service regarding the implementation of system changes.
- Review processes for timely access to services following initial calls to the ACL.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

DHCS requires the CalEQRO to evaluate DMC-ODSs on the following: delivery of SUD in a culturally competent manner, coordination of care with other healthcare providers, and beneficiary satisfaction. CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (Section 14197.05 of the California Welfare and Institutions Code [WIC]).

This report presents the FY 2022-23 findings of the EQR for San Diego DMC-ODS by BHC, conducted as a virtual review on April 18-20, 2023.

REVIEW METHODOLOGY

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

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from multiple source files: Monthly Medi-Cal Eligibility Data System Eligibility File; DMC-ODS approved claims; Treatment Perception Survey (TPS); the California Outcomes Measurement System (CalOMS); and the ASAM LOC data.

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY 2021) and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each DMC-ODS is provided a description of the source of data and a summary report of Medi-Cal approved claims data. These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the DMC-ODS identified as having a significant impact on access, timeliness, and quality of the DMC-ODS service delivery system in the preceding year. DMC-ODS' are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- DMC-ODS activities in response to FY 2021-22 EQR recommendations.
- Summary of DMC-ODS-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the DMC-ODS' two contractually required PIPs as per 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii).
- Validation and analysis of each DMC-ODS' NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the DMC-ODS and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county DMC-ODS' reporting systems and methodologies for calculating PMs, and whether the DMC-ODS and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the DMC-ODS' service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of DMC-ODS strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then “<11” is indicated to protect the confidentiality of DMC-ODS beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

DMC-ODS CHANGES AND INITIATIVES

In this section, changes within the DMC-ODS' environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING DMC-ODS OPERATIONS

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic. The DMC-ODS experienced service delivery impacts due to a second major wave of a COVID-19 variant including an associated outbreak during FY 2021-22. They continue to experience workforce shortages at every level of treatment services, which has contributed to increased wait times for beneficiaries to access some levels of service, especially residential treatment. CalEQRO worked with the DMC-ODS to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- San Diego is in the process of operationalizing and implementing broad-based comprehensive system, program, and payment reform changes in conjunction with California Advancing and Innovating Medi-Cal (CalAIM). The DMC-ODS has deployed a systematic roll-out of policy changes and documentation expectations that align with the CalAIM initiatives to date and continues to engage in planning efforts to prepare for other upcoming changes at all system levels.
- San Diego is currently experiencing a behavioral health workforce crisis. The ongoing shortage of qualified, culturally diverse behavioral health staff continues to severely impact services within the DMC-ODS. Contract service providers have begun to request a reduction in capacity and delayed execution of new programs due to high rates of staff attrition, inability to hire, non-competitive salaries, and vacancies that have gone unfilled for months.
- One of the strategies the DMC-ODS is using to address workforce challenges is adding certified peer support staff as a new county classification. San Diego is collaborating with CalMHSA to implement Medi-Cal Peer Support Specialist certification. Peer Support staff in DMC-ODS programs were able to access scholarships to cover costs associated with the certification process.
- San Diego's Board of Supervisors declared the impacts of fentanyl within the county a public health crisis, which has paved the road for substantial investments in and enhancements of interventions to address the opioid crisis. Appropriations of Opioid Settlement funds were established to implement a multi-pronged approach to addressing the opioid crisis, including expansion of

medication-assisted treatment, implementation of a peer-delivered ED-based response system for nonfatal opioid overdose, public health messaging, naloxone distribution, and other initiatives.

- Beginning in October 2022, Early Intervention (ASAM Level 0.5) services for youth and young adults who are at risk of developing substance-related problems were added county-wide to the Teen Recovery Centers. Services are available to those up to age 21, regardless of income, Medi-Cal eligibility, and insurance coverage.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: San Diego should take steps to identify and remedy protocol issues and introduce workflow solutions to assure a complete and an accurate data collection process for urgent service requests including ongoing monitoring, system adjustments and routine reporting.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- In collaboration with contract providers, the DMC-ODS investigated access data integrity to identify workflow issues, barriers for timely documentation of urgent service requests, and to clarify definitions within the data collection process. Barriers have been identified and San Diego is developing improvement strategies.
- Planning has begun to develop on-demand training for provider staff for data collection processes. Discussions are occurring to determine updated reporting and technology needs to improve monitoring of access data collection and integrity. Improvement strategies have not yet been developed and implemented as discussions to address these issues are still in process. This recommendation is being carried over.

Recommendation 2: The DMC-ODS needs to address performance issues pertaining to its elevated no-show rates for both outpatient and residential initial appointments, as well as timely follow-up following residential discharge.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- San Diego has begun addressing its elevated no-show rates to outpatient and residential initial appointments through various actions such as the provision of TA to provider programs, discussion of best practices, implementing dedicated counselors for intakes, and ensuring providers have policies and procedures in place regarding the monitoring of missed appointments. San Diego utilized these same approaches to address low rate of follow-up services after residential discharge.
- Despite these measures, more effort is needed as no-show rates have slightly increased from last year's EQR and follow-up services post-residential discharge have slightly decreased from last year's EQR. Though discussions have been held between the DMC-ODS and providers, it appears that improvement strategies at the provider level have not sufficiently been implemented to effect improvement in these areas. This recommendation is being carried over.

Recommendation 3: Youth service levels need continued focus and prioritization to assure expansion and San Diego should take active steps to identify additional school locations and increase access for outpatient, intensive outpatient treatment (IOT), and residential services for the adolescent population.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- San Diego has taken several steps during the past year to increase access for outpatient, intensive outpatient treatment and residential services for the adolescent populations. One such step is the establishment of the Screening to Care Initiative to screen middle school students to determine social-emotional need and provide prevention and early intervention supports utilizing the Multi-Tiered System of Supports Framework.
- The DMC-ODS has implemented use of early intervention ASAM level 0.5 services for youth and young adults who are at risk of developing substance-related problems county-wide to the seven Teen Recovery Centers (TRC). Services are available to those up to age 21, regardless of income, Medi-Cal eligibility, and insurance coverage. Additionally, each TRC is required to partner with a minimum of two schools to provide services on campuses. TRCs have developed MOUs with several schools to provide services to youth and their families.
- San Diego has a new outpatient contract and a new residential contract specifically designed for the transitional age youth (TAY) population to address identified needs for TAY clients.

Recommendation 4: San Diego should expand the number of goals in the QI Workplan that are QI-oriented, making sure they have stated objectives that are measurable with regards improving client experiences with access to or quality of care, and include specific action plans designed to help achieve the objectives. Revise the Cultural Competence Plan (CCP) to be more balanced to SUD services and the unique aspects of that service population. Seek TA from CalEQRO as needed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Based on the recommendations and TA received from EQRO, San Diego enhanced the QI Workplan for FY 2022-23. The enhanced plan includes domains that align with EQRO priorities including access, timeliness, effectiveness of care, and consumer reported outcomes. Each of the goals were developed based on the systemwide data available from internal reports, client feedback, and the data received from last year's EQR. Goals were developed to ensure the objectives were clear and measurable.
- San Diego's CCP reflects a good balance in focus and goals between mental health (MH) and SUD with strategic three-year goals that are specific to the substance use system. Examples of SUD goals in the CCP that were achieved are the launching of a specific on-line dashboard that shows substance use data, the increase of SUD provider representation on the Cultural Competence Resource Team, and results from the TPS report which note that 100 percent of SUD clients and family members state they had access to written information in their primary language and/or received services in the language they prefer.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Representatives from the San Diego Behavioral Health Services (BHS) Executive Leadership, as well as county health agency executive leadership, and health agency IT services have been meeting to strategize regarding the internal IT structure, capacity, and expertise.
- Since the prior review, an embedded IT contractor position was added to support the DMC-ODS Management Information Systems team in assessing processes and priorities related to CalAIM requirements.
- Specific adjustments or internal staffing additions were not made since the last review but would be necessary in order to rate this recommendation as fully addressed. This recommendation is being revised to add focus on the creation of BHS-dedicated staffing capacity.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE DMC-ODS

SUD services are delivered by contractor-operated providers in the DMC-ODS. Regardless of payment source, approximately 0 percent of services were delivered by county-operated/staffed clinics and sites, and 100 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 93 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: 92 DMC-ODS treatment provider sites, including residential, outpatient and medication assisted treatment (MAT) outpatient clinics. The DMC-ODS operates a centralized access team that is responsible for providing referrals to beneficiaries for appropriate, medically necessary services. The ACL receives calls for both SUD and MH inquiries. When a call comes into the ACL, staff conduct a brief SUD screen based on the ASAM and a brief MH screen to determine the need and the most appropriate referral for the caller. When it is determined that a caller is appropriate for a SUD referral, the ACL staff attempts to do a warm handoff while on the phone with the caller to a contract provider. From there an appointment is made for further assessment and determination of LOC placement. When a beneficiary calls or walks into a contract provider directly, the provider will schedule an assessment appointment and perform the ASAM to determine LOC placement. If the beneficiary walks into a residential program and is determined appropriate for that LOC, the provider will seek authorization from Optum, the County's Administrative Services Organization, which is responsible for residential placement authorization and for coordinating intakes to SUD providers. The Optum clinician will make a clinical determination within 24 hours of receipt of the initial authorization request and will notify the SUD Provider.

In addition to clinic-based SUD services, the DMC-ODS provides telehealth services via video/phone to youth and adults. In FY 2021-22, the DMC-ODS reports having provided telehealth services to 2,839 adult beneficiaries, 194 youth beneficiaries, and 126 older adult beneficiaries across 0 county-operated sites and 64 contractor-operated sites. Among those served, 115 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of WIC Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all Mental Health Plans (MHP) based upon its review and analysis of each DMC-ODS' Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual BHIN.

For San Diego County, the time and distance requirements are 15 miles and 30 minutes for outpatient SUD services, and 15 miles and 30 minutes for Narcotic Treatment Program/ Opioid Treatment Program (NTP/OTP) services. These services are further measured in relation to two age groups – youth (0-17) and adults (18 and over).

Table 1A: DMC-ODS Alternative Access Standards, FY 2021-22

Alternative Access Standards				
The DMC-ODS was required to submit an AAS request due to time and distance requirements	☒ Yes ☐ No			
AAS Details	**Opioid Treatment**		**Outpatient SUD Services**	
	Adults (ages 18+)	Youth (ages 0-17)	Adults (ages 18+)	Youth (ages 0-17)
# of zip codes outside of the time and distance standards that required AAS request	n/a	102	n/a	n/a
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)	n/a	0	n/a	n/a
Distance and driving time between nearest network provider and zip code of the beneficiary furthest from that provider for AAS requests	n/a	98 miles, 100 minutes	n/a	n/a
Approximate number of beneficiaries impacted by AAS or allowable exceptions	n/a	385, 184	n/a	n/a
The number of AAS requests approved and related zip code(s)	n/a	86 requests *	n/a	n/a
Reasons cited for approval	n/a	Out-of-network (OON) provider was not within the 15 miles distance standards for San Diego	n/a	n/a
The number of AAS requests denied and related zip code(s)	n/a	n/a	n/a	n/a
Reasons cited for denial	n/a	n/a	n/a	n/a

* 92105; 92113; 92114; 92154; 91911; 91950; 91910; 91977; 92102; 92021; 92020; 92115; 92173; 92019; 92111; 92126; 92139; 91945; 91932; 92040; 92071; 92104; 92117; 92065; 91942; 91913; 92064; 91941; 92129; 92082; 92123; 92116; 92110; 92124; 92109; 91915; 91902; 92120; 92119; 91901; 92107; 92122; 92101; 92108; 92128; 92131; 92037; 92130; 92028; 91906; 91978; 92103; 91914; 91935; 92106; 92127; 92118; 92061; 92036; 92004; 92027; 91905; 91963; 92059; 91916; 91980; 92070; 91917; 91934; 92086; 92121; 92026; 91962; 92025; 92066; 92067; 92091; 91931; 92060; 92024; 92014; 92134; 92029; 92009; 92140; 91948

- The DMC-ODS did not meet all time and distance standards and was required to submit an AAS request.
- The DMC-ODS engaged in the following improvement activities to enhance access to services for beneficiaries living within AAS areas:
- The DMC-ODS amended contracts to include services to beneficiaries 0-17 years old, effective July 2021. San Diego released an RFP for countywide services to include the services to this age group beginning July 2023.
- The DMC-ODS continues to work with OTP providers to provide telehealth services when clinically indicated and desired, and will assist in coordinating transportation for beneficiaries who do not desire telehealth services when a provider is not available within time and distance standards.
- The DMC-ODS continues to have OON accommodation agreement policies and procedures in place if required treatment services are not available in San Diego's provider network. This flexibility allows the ability to contract with OON providers that will meet required standards and/or are selected by beneficiaries to support their freedom of choice.

Table 1B: DMC-ODS Out-of-Network Access, FY 2021-22

OON	
The DMC-ODS was required to provide OON access due to time and distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the DMC-ODS have existing contracts with OON providers?	☐ Yes ☒ No
Contracting status:	☒ The DMC-ODS is in the process of establishing contracts with OON providers ☐ The DMC-ODS does not have plans to establish contracts with OON providers
Contracting efforts and barriers cited by DMC-ODS	The DMC-ODS does not currently have contracts with OON providers and has not had requests. Capacity is available to execute OON contracts when needed.
OON Access for Beneficiaries	
The DMC-ODS ensures OON access for beneficiaries in the following manner:	☐ The DMC-ODS has existing contracts with OON providers ☒ Other: Wil execute as needed.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The DMC-ODS website has the access number listed clearly on the front page, with options for chat and a number for hearing impaired. The website is easy to navigate, is informative, and can be translated into six languages.
- San Diego has an impressive connection to the deaf and hard of hearing community providing a significant number of services as demonstrated by the high percentage of American Sign Language (ASL) interpretation services provided. ASL accounted for 11 percent of interpretation services utilized by San Diego, second only to Spanish.
- The DMC-ODS expanded its reach into the youth population by increasing its presence on school campuses and by adding ASAM level 0.5 services for youth and young adults at the seven regional TRCs.

ACCESS PERFORMANCE MEASURES

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) 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. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 0.85 percent, with an average approved claim amount of $5,821. Using PR as an indicator of access for the DMC-ODS, the PR for San Diego is 1.33 percent which is higher than the statewide and similar size county PRs.

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SUD through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Table 3: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	# of Eligibles	# of Clients Served	County PR	Similar Size Counties PR	Statewide PR
Ages 0-17	216,179	371	0.17%	0.10%	0.10%
Ages 18-64	503,596	10,196	2.02%	1.43%	1.30%
Ages 65+	142,066	903	0.64%	0.51%	0.43%
TOTAL	**861,841**	**11,470**	**1.33%**	**0.93%**	**0.85%**

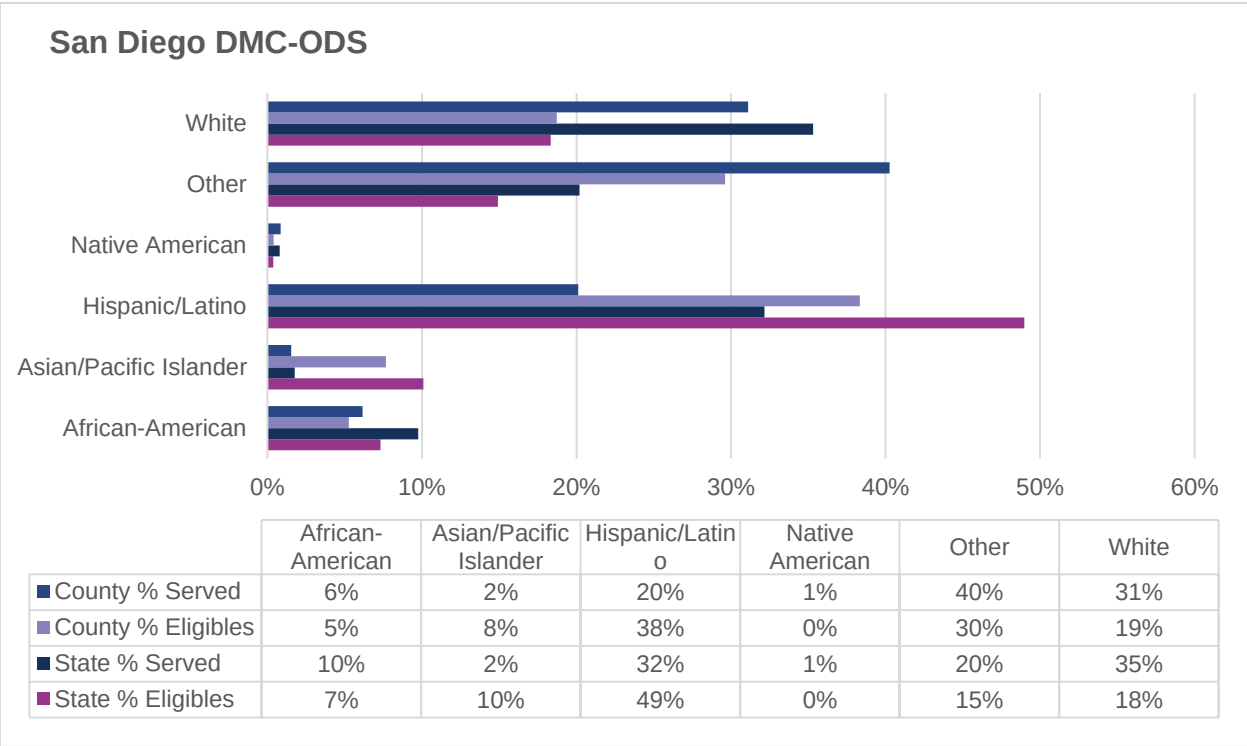
- Total PR was higher than in similar sized counties and statewide, as were PRs for all age groups. Total PR decreased from prior EQR in the DMC-ODS as well as statewide.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2021

Race/Ethnicity Groups	# of Eligibles	# of Clients Served	County PR	Similar Size Counties PR	Statewide PR
African-American	45,313	705	1.56%	1.18%	1.13%
Asian/Pacific Islander	66,085	177	0.27%	0.15%	0.15%
Hispanic/Latino	330,408	2,306	0.70%	0.58%	0.56%
Native American	3,445	98	2.84%	2.13%	1.75%
Other	255,218	4,617	1.81%	1.32%	1.15%
White	161,374	3,567	2.21%	1.84%	1.64%
TOTAL	**861,840**	**11,470**	**1.33%**	**0.93%**	**0.85%**

- Native Americans, Whites, and African-Americans were the groups with the highest PRs. PRs for all groups were higher than statewide.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2021



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	6%	2%	20%	1%	40%	31%
County % Eligibles	5%	8%	38%	0%	30%	19%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

- Proportionally, Whites were the most overrepresented racial/ethnic group in the DMC-ODS, and Hispanics/Latinos were the most underrepresented group.

Table 5: Beneficiaries Served and PR by Eligibility Category, CY 2021

Eligibility Categories	# Eligibles	# Beneficiaries Served	County PR	Similar Size Counties PR	Statewide PR
ACA	319,330	7,724	2.42%	1.66%	1.55%
Disabled	72,205	1,269	1.76%	1.74%	1.54%
Family Adult	151,389	2,222	1.47%	1.15%	1.05%
Foster Care	1,791	45	2.51%	1.25%	1.25%
MCHIP	79,124	106	0.13%	0.09%	0.08%
Other Adult	107,332	160	0.15%	0.09%	0.07%
Other Child	138,758	260	0.19%	0.11%	0.10%
Total	**861,840**	**11,470**	**1.33%**	**0.93%**	**0.85%**

- The largest client eligibility category was ACA, which also represented the largest group of beneficiaries served.
- The eligibility category with the highest PR was Foster Care, followed by ACA. PRs for all eligibility categories were higher than similar size counties and statewide.

Table 6: Average Approved Claims by Eligibility Category, CY 2021

Eligibility Categories	County AACB	Similar Size Counties AACB	Statewide AACB
ACA	$7,291	$5,493	$5,999
Disabled	$5,645	$5,205	$5,549
Family Adult	$6,308	$4,789	$5,010
Foster Care	$5,944	$2,870	$2,826
MCHIP	$6,762	$3,989	$3,783
Other Adult	$4,118	$4,379	$4,547
Other Child	$7,132	$3,888	$3,460
Total	**$7,061**	**$5,395**	**$5,821**

- Total AACB in the DMC-ODS was higher than similar sized counties and statewide.

Table 7: Services Used by Beneficiaries, CY 2021

County			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	0	0.00%	41	0.03%
Intensive Outpatient	2,971	17.24%	14,586	9.73%
Narcotic Treatment Program	4,111	23.85%	40,196	26.81%
Non-Methadone MAT	1,129	6.55%	7,837	5.23%
Outpatient Drug Free	3,599	20.88%	44,111	29.42%
Partial Hospitalization	0	0.00%	19	0.01%
Recovery Support Services	937	5.44%	5,439	3.63%
Res. Withdrawal Mgmt	1,138	6.60%	10,869	7.25%
Residential Treatment	3,351	19.44%	26,859	17.91%
Total	**17,236**	**100.00%**	**149,957**	**100.00%**

- NTP services had the highest utilization, followed by Outpatient services, and Residential Treatment. Residential and Intensive Outpatient Treatment were utilized at a higher rate than statewide, while NTP and Outpatient were used at a lower rate than statewide.
- Ambulatory Withdrawal Management (WM) and Partial Hospitalization had no utilization in the DMC-ODS, and Non-Methadone MAT, and Recovery Support Services (RSS), had higher rates of utilization as compared with the state as a whole.

Table 8: Average Approved Claims by Service Categories, CY 2021

Service Categories	County AACB	Similar Size Counties AACB	Statewide AACB
Ambulatory Withdrawal Mgmt	$0	$47	$996
Intensive Outpatient	$811	$1,189	$1,630
Narcotic Treatment Program	$3,619	$3,935	$4,271
Non-Methadone MAT	$1,423	$1,340	$1,454
Outpatient Drug Free	$4,074	$2,370	$2,581
Partial Hospitalization	$0	$5,027	$5,027
Recovery Support Services	$2,104	$1,870	$1,761
Res. Withdrawal Mgmt	$2,905	$2,396	$2,438
Residential Treatment	$12,581	$10,433	$10,157
Total	**$7,061**	**$5,395**	**$5,821**

- The AACBs for Outpatient, RSS, Residential WM and Residential Treatment were higher than in similarly sized counties and statewide.

IMPACT OF ACCESS FINDINGS

- San Diego's PR is higher than similar size counties and the statewide average overall as well as within each age and race/ethnic category. This is indicative of strong and balanced outreach into the community making services accessible to each demographic category in the county.
- Services used by beneficiaries are evenly distributed between each of the different service categories, which demonstrates availability and accessibility of different LOCs within the DMC-ODS, as well as transitions between LOCs.
- San Diego has deployed a systematic roll-out of policy changes and documentation expectations that align with the CalAIM initiatives to date and continues to engage in planning efforts to prepare for other upcoming changes at all system levels.

TIMELINESS OF CARE

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors DMC-ODS' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate DMC-ODS timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

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

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

Table 9: Timeliness Key Components

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

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

- The DMC-ODS reports a very high level of timely access for those seeking MAT services in CY 2022, especially individuals accessing methadone treatment. San Diego reports that, on average, beneficiaries received first delivered OTP

services 0.9 business days following first request for service with 96.6 percent meeting the DMC-ODS standard of three business days for first delivered services. San Diego also reports that, on average, the first non-urgent OTP appointments were offered in 0.1 business days with 99.3 percent meeting the DHCS standard of three business days. While time to service standards are referenced in the QI workplan, the 71 percent rate of meeting timeliness for urgent service requests remains unaddressed.

- Calls to San Diego's ACL are typically not tracked from call to first treatment appointment as these calls are not considered requests for service. Timeliness tracking begins from first contact with the contract provider though actual first contact to the DMC-ODS may have previously been to the ACL. Of all calls to the ACL, only 1.29 percent are reported to be SUD related, which is very low for a large system such as San Diego. It is difficult to ascertain timely and successful access to treatment for beneficiaries whose initial contact is to the ACL.
- The DMC-ODS reports monthly no-show for first service across all programs is 37 percent, including an average rate of 46 percent no-show for outpatient services. As noted earlier in this report, no performance improvement activities have been identified or implemented at the provider level.
- Medi-Cal claims data shows that 17.16 percent of clients received care following residential treatment within seven days, which is fewer than two clients out of ten. While data from the DMC-ODS denotes an average that is higher than found statewide, improvement strategies to improve coordination of care appears indicated for this more acute population.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, DMC-ODS' complete and submit the Assessment of Timely Access form in which they identify DMC-ODS performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2022-23 EQR, the DMC-ODS reported in its submission of the Assessment of Timely Access (ATA), representing access to care during the 12-month period of CY 2022. Table 10 and Figures 2–4 display data submitted by the DMC-ODS; an analysis follows. This data represented the entire system of care which is fully contractor-operated services.

For first non-urgent service rendered, the DMC-ODS reported timeliness data for OTP, outpatient, and residential treatment separately, but aggregated data for all three combined was not provided. Outpatient timeliness data is reflected as first non-urgent service rendered in Table 10.

No-show data was not available for multiple modalities including IOT and RSS.

Data collection related to timeliness tracking is pulled from the contact screen/log within the San Diego Web Infrastructure for Treatment Services (SanWITS) EHR system. The DMC-ODS process for tracking timeliness to services does not include initial calls received from the ACL unless the callers are referred to a program and entered within the EHR contact log.

Claims data for timely access to post residential care and readmissions are discussed in the Quality of Care section.

DMC-ODS-Reported Data

Table 10: FY 2022-23 DMC Assessment of Timely Access

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	3.6 Business Days	10 Business Days*	94.3%
First Non-Urgent Service Rendered**	5.2 Business Days	10 Business Days***	90.6%
Non-Urgent MAT Request to First NTP/OTP Appointment	0.1 Business Days	3 Business Days*	99.3%
Urgent Services Offered	52.2 Hours	48 Hours**	70.9%
Follow-up Services Post-Residential Treatment	35.7 Days	7 Days***	33.0%
WM Readmission Rates Within 30 Days	6.6%	n/a	n/a
No-Shows	37.0%	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** Outpatient services only, OTP and residential reported separately *** DMC-ODS-defined timeliness standards			
For the FY 2022-23 EQR, the DMC-ODS reported its performance for the following time period: CY 2022			

Figure 2: Wait Times to First Service and First MAT Service

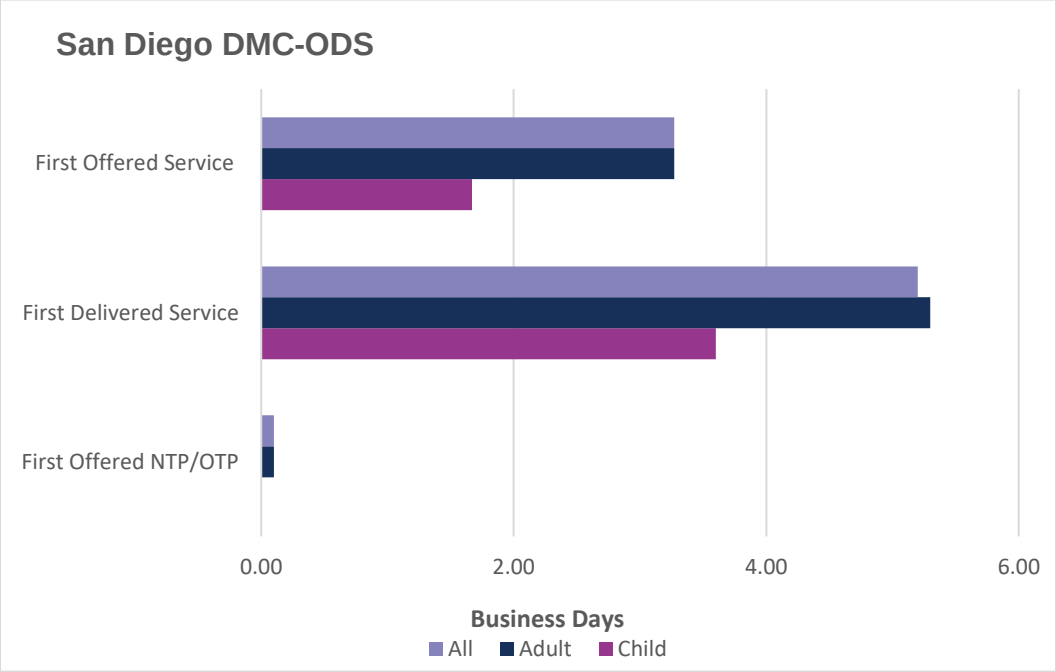


Figure 3: Wait Times for Urgent Services

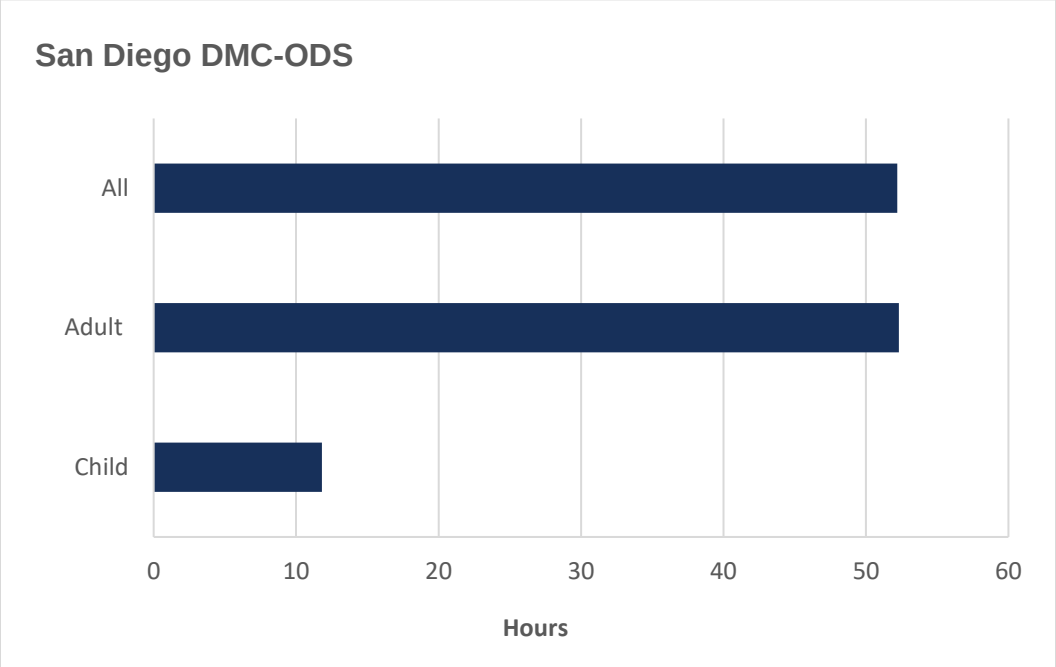
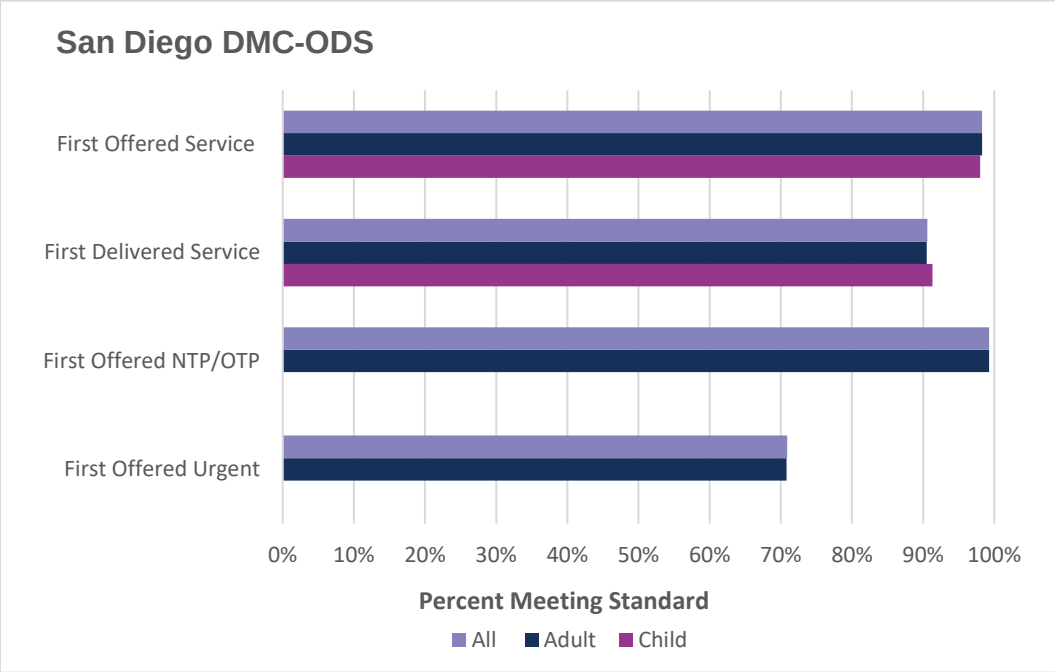


Figure 4: Percent of Services that Met Timeliness Standards



- The current DMC-ODS process for timeliness data collection may result in an underestimation of time to care in the data and/or an incomplete data set as it omits the time of first contact and request at the ACL.
- Variance between the DMC-ODS submitted ATA and the EQR performance measures data are also impacted due to the ATA reporting on CY 2022 data, while the EQR claims data is for CY 2021.

Medi-Cal Claims Data

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the CY 2021 claims.

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

Table 11: Days to First Dose of Methadone by Age, CY 2021

County				Statewide		
Age Groups	Clients	%	Avg. Days	Clients	%	Avg. Days
0 to 17	0	0.00%	0.00	10	0.03%	10.20
18 to 64	3,489	85.75%	4.06	33,162	84.03%	3.41
65+	579	14.23%	0.32	6,292	15.94%	0.41
TOTAL	**4,069**	**99.98%**	**3.52**	**39,464**	**100.00%**	**2.94**

- The average number of days to first dose of Methadone is higher than the statewide average (3.52 days for the DMC-ODS versus 2.94 days statewide). No youth received methadone in CY 2021 in San Diego.

Transitions in Care

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

Table 12: Timely Transitions in Care Following Residential Treatment, CY 2021

County	N = 3,275		Statewide N = 58,923	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	562	17.16%	5,740	9.74%
Within 14 Days	659	20.12%	7,610	12.92%
Within 30 Days	739	22.56%	9,214	15.64%

- Of the 3,275 beneficiaries who discharged from Residential Treatment, 17.16 percent transitioned to another service within seven days, and 22.56 percent transitioned within 30 days.
- The cumulative percentages of beneficiaries transitioning to other services are all higher those seen statewide; however, the majority of beneficiaries are not receiving timely transitions to lower LOCs within 30 days.

Residential Withdrawal Management Readmissions

Table 13: Residential Withdrawal Management Readmissions, CY 2021

County			Statewide	
Total DMC-ODS admissions into WM	1,388		14,120	
	#	#	#	%
WM readmissions within 30 days of discharge	88	6.34%	1,128	7.99%

- The readmission rate in San Diego was slightly lower than the statewide readmission rate for WM.

IMPACT OF FINDINGS

- The rapid linkage of beneficiaries to OTP services that San Diego reports is commendable. The quicker an individual receives services from the time of request, which is typically the time of crisis for the beneficiary and greatest receptivity to treatment, the more likely they are to engage and receive services.

As noted above, the data reported by BHC and the DMC-ODS within this report are from different CYs.

- As stated, the closer to the time individuals request services to the time services are received, the greater the chance for treatment engagement and successful outcomes. As previously noted, it is difficult to ascertain timely access to treatment in San Diego for those whose initial contact is to the ACL. Without accurate data from time of contact to the ACL to the time an individual receives services, the DMC-ODS would be challenged to implement effective system improvement strategies to improve timely access to treatment.
- A high rate of no-shows to initial services may indicate a need to strengthen engagement approaches of those whose responsibility it is to schedule appointments for beneficiaries. Not only do those in need of services not receive them when they don't show up for appointments, but in a time of critical workforce issues, the impact is compounded by inefficient use of staff when time is set aside for individuals that don't arrive for appointments.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

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

QUALITY IN THE DMC-ODS

In the DMC-ODS, the responsibility for QI is shared among multiple teams after a San Diego BHS organizational change that occurred during the past fiscal year. To ensure a more comprehensive approach, there are now multiple teams which have responsibility for enhancing QI. The new structure consists of collaboration from the following departments: Populations Health, Data Sciences, Quality Assurance, Management Information Systems, and Health Plan Administration. These departments report to the Executive Quality Improvement Team, which consists of the BHS senior leadership including the BHS Director.

The DMC-ODS monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, which for San Diego is named the Quality Review Committee (QRC) is comprised of clients or family members, as well as stakeholders from the behavioral health communities representing all regions and is scheduled to meet quarterly. Since the previous EQR, the DMC-ODS QRC met four times. Of the twelve identified FY 2021-22 QAPI workplan goals, the DMC-ODS met six and did not meet six.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SUD healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 14: Quality Key Components

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

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

- The DMC-ODS has a high level of congruence of LOC referrals and ASAM findings at initial screenings, assessments, and follow-up assessments. It is evident that San Diego has provided ample trainings and monitoring to ensure assessment fidelity to the ASAM model which enables beneficiaries to access the LOC most likely to lead to successful treatment outcomes.
- The DMC-ODS use of TPS data to guide service delivery is exemplary. San Diego not only distributes the survey as required by DHCS, but also regularly adds supplemental questions seeking input from beneficiaries to help inform management regarding needs and gaps that need additional focus and intervention. These data are analyzed and presented to the QRC for evaluation and input.
- The DMC-ODS has done significant work in preparing to bring on a peer workforce and has begun hiring peer support staff within the system of care. Providers report that the San Diego provided scholarships to facilitate peer training and enabled several to become certified. Peers are now able to provide Medi-Cal reimbursable services.
- Contract provider leadership staff report being involved in multiple QI subcommittees, including as co-chairs of some subcommittees. Providers report generally feeling like partners with the DMC-ODS leadership but shared a great deal of concern regarding CalAIM payment reform. Providers feel “in the dark” about upcoming changes that will have significant impact on their organizations. They want to be involved in discussions and decision making that will impact their ability to operate programs, especially regarding CalAIM initiatives. For

example, they report that recent changes have not reduced the administrative burden but have increased the burden on operations. Additionally, there is a sense that access to DMC-ODS leadership has diminished, and providers vocalized a need to increase forums for them to meet with executive management, including the BHS Director, to share concerns and to give meaningful input into system issues.

- Line staff report that multiple system changes have been difficult to implement due to unclear direction from San Diego leadership. Changes such as problem lists, use of Z codes, and documentation have come with insufficient and sometimes conflicting directions from the DMC-ODS. Line staff shared a great deal of frustration with miscommunication. Staff interviewed during this review stated they have not been aware of any official forums or focus groups to give input but would welcome the opportunity to participate and give input directly to county staff.

QUALITY PERFORMANCE MEASURES

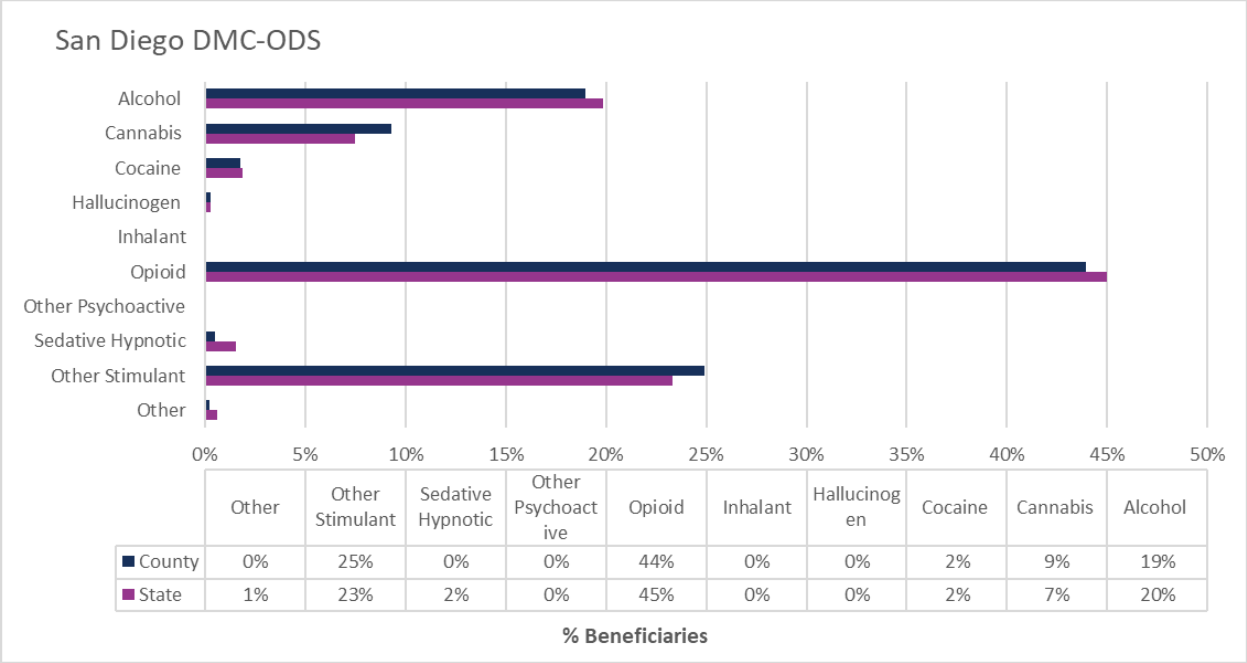
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the DMC-ODS:

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

Diagnosis Data

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SUD, is a foundational aspect of delivering appropriate treatment. Figure 5 and Figure 6 represent the primary diagnosis as submitted with the DMC-ODS' claims for treatment. The first table shows the percentage of DMC-ODS beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. The second table shows the percentage of approved claims by diagnostic category compared to statewide.

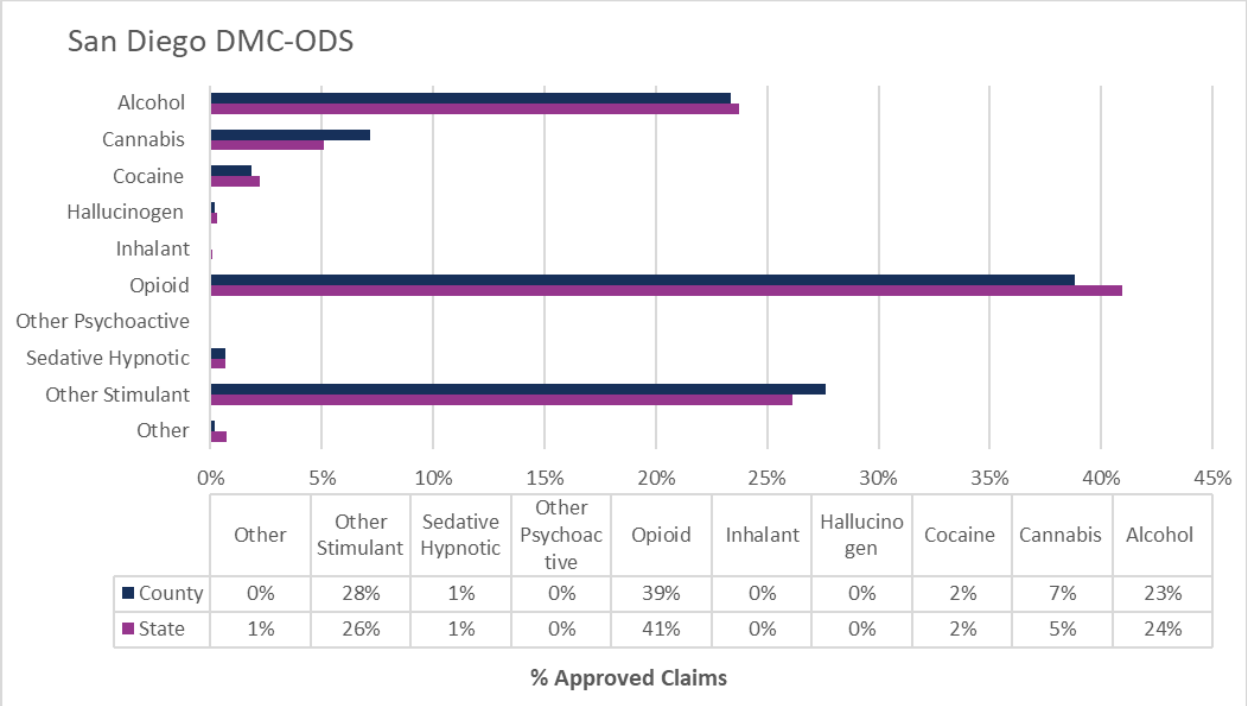
Figure 5: Percentage of Beneficiaries by Diagnosis Code, CY 2021



	Other	Other Stimulant	Sedative Hypnotic	Other Psychoactive	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0%	25%	0%	0%	44%	0%	0%	2%	9%	19%
State	1%	23%	2%	0%	45%	0%	0%	2%	7%	20%

- The most common diagnostic categories in the DMC-ODS were Opioid, Other Simulant, and Alcohol. Opioid and Alcohol related diagnoses were slightly less prevalent than statewide, whereas Other Stimulant was more prevalent.

Figure 6: Percentage of Approved Claims by Diagnosis Code, CY 2021



	Other	Other Stimulant	Sedative Hypnotic	Other Psychoactive	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0%	28%	1%	0%	39%	0%	0%	2%	7%	23%
State	1%	26%	1%	0%	41%	0%	0%	2%	5%	24%

- Claims by diagnostic categories were generally congruent with diagnostic patterns in the DMC-ODS.

Non-Methadone MAT Services

Table 15: DMC-ODS Non-Methadone MAT Services by Age, CY 2021

County					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 0-17	<11	-	<11	-	12	0.37%	6	0.19%
Ages 18-64	1,071	10.50%	563	5.52%	7,505	7.96%	3,873	4.11%
Ages 65+	-	-	-	-	447	5.01%	172	1.93%
Total	**1,141**	**9.95%**	**592**	**5.16%**	**7,964**	**7.15%**	**4,051**	**3.63%**

- The majority of non-methadone MAT was provided to adults 18-64, with 10.50 percent of clients in the age group receiving at least one non-methadone MAT service in CY 2021.
- Of the 1,141 clients that received at least one non-methadone MAT service, 592 clients (approximately 52 percent of all non-methadone MAT clients), remained engaged and received three or more services.

Residential Withdrawal Management with No Other Treatment

Table 16: Residential Withdrawal Management with No Other Treatment, CY 2021

	# WM Clients with 3+ Episodes & No Other Services	% WM Clients with 3+ Episodes & No Other Services
County	11	0.98%
Statewide	370	3.46%

- The DMC-ODS had a low number of clients who received WM with no other treatment received.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. In SUD treatment, this may reflect multiple admissions to residential treatment or residential WM. High-cost beneficiaries may be receiving services at a LOC not appropriate to their needs. HCBs for the purposes of this report are defined as those who incur SUD treatment costs at or above the 90th percentile statewide.

Table 17: High-Cost Beneficiaries by Age, County DMC-ODS, CY 2021

Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages 0-17	371	30	8.09%	$24,440	$733,186	26.01%
Ages 18-64	10,200	1,192	11.69%	$22,817	$27,197,484	37.21%
Ages 65+	903	59	6.53%	$21,938	$1,294,332	25.38%
Total	**11,474**	**1,281**	**11.16%**	**$22,814**	**$29,225,002**	**36.07%**

Table 18: High-Cost Beneficiaries by Age, Statewide, CY 2021

Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB% by Total Claims
Ages 0-17	3,230	66	2.04%	$23,446	$1,547,458	13.12%
Ages 18-64	94,361	5,669	6.01%	$23,766	$134,727,122	23.65%
Ages 65+	8,925	289	3.24%	$23,432	$6,771,773	13.99%
TOTAL	**106,516**	**6,024**	**5.66%**	**$23,746**	**$143,046,352**	**22.71%**

- The percentage of HCBs in San Diego (11.16 percent) was higher than statewide (5.66 percent). HCB claims accounted for 36 percent of the DMC-ODS total claims in CY 2021.
- The AACB for HCBs in the DMC-ODS was also higher than statewide, as was the proportion of total claims attributed to HCBs.

ASAM Level of Care Congruence

Table 19: Congruence of Level of Care Referrals with ASAM Findings, CY 2021 – Reason for Lack of Congruence (Data through Oct 2021)

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable/No Difference	3,443	88.7%	7,375	94.6%	12,870	91.0%
Patient Preference	248	6.2%	152	1.9%	659	4.6%
Level of Care Not Available	28	0.7%	77	1.0%	64	0.4%
Clinical Judgement	38	1.0%	45	0.6%	78	0.5%
Geographic Accessibility	11	0.3%	<11	-	<11	-
Family Responsibility	0	0.0%	0	0.0%	0	0.0%
Legal Issues	0	0.0%	0	0.0%	0	0.0%
Lack of Insurance/Payment Source	13	0.3%	-	-	-	-
Other	41	1.0%	58	0.7%	276	1.9%
Mental or Physical Health	62	1.6%	34	0.4%	124	0.9%
Court Mandated	20	0.5%	37	0.5%	51	0.4%
Total	**3,898**	**100.0%**	**7,795**	**100.0**	**14,147**	**100.0**

- The DMC-ODS had a high congruence between ASAM determinations and LOC referrals for initial assessments, with the majority of non-congruent referrals being attributed to patient preference. Congruence slightly decreased to 91 percent at follow-up assessment.

Initiation and Engagement

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. Table 21 displays results of measures for two early and vital phases of treatment-initiating and then engaging in treatment services. Research suggests that those who can engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. 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. Based on claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. This second day or visit is what in this measure is defined as "initiating" treatment.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service.

Table 20: Initiating and Engaging in DMC-ODS Services, CY 2021

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	9,898		330		101,279		3,051	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	8,502	86%	311	94%	89,055	88%	2,583	85%
Clients who then engaged in DMC-ODS services	6,592	78%	253	81%	69,161	78%	1,823	71%

- 86 percent of adults received another service within 14 days of intake or assessment, and 78 percent received two or more services within 30 days after initiation.
- 94 percent of youth received another service within 14 days of intake or assessment, and 81 percent received two or more services within 30 days after initiation.

Length of Stay

Table 21: Cumulative LOS in DMC-ODS Services, CY 2021

	County		Statewide	
Clients discharged from care (no treatment for 30+ days)	9,709		89,610	
LOS for clients across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	124	89	123	87
	#	%	#	%
Clients with at least a 90-day LOS	4,820	50%	43,937	49%
Clients with at least a 180-day LOS	2,753	28%	25,334	28%
Clients with at least a 270-day LOS	1,588	16%	14,774	16%

- Both average (mean) and median LOS in San Diego were similar to those seen statewide, as are the percentages of beneficiaries with at least 90-day, 180-day, and 270-day LOS.

CalOMS Discharge Ratings

Table 22: CalOMS Discharge Status Ratings, CY 2021

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment - Referred	3,278	20.9%	20,256	19.1%
Completed Treatment - Not Referred	1,067	6.8%	7,645	6.1%
Left Before Completion with Satisfactory Progress - Standard Questions	1,942	12.4%	14,696	17.5%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,040	6.5%	7,834	7.4%
Subtotal	*7,327*	*46.7%*	*50,431*	*50.1%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	2,268	14.5%	16,775	17.3%
Left Before Completion with Unsatisfactory Progress - Administrative	5,895	37.6%	30,398	29.7%
Death	33	0.2%	1,609	2.1%
Incarceration	176	1.1%	785	0.8%
Subtotal	*8,372*	*53.3%*	*49,567*	*49.9%*
TOTAL	**15,699**	**100.0**	**99,998**	**100.0%**

- The first four listed discharge statuses in Table 22 are generally considered "positive" because they indicate treatment was either completed, or the beneficiary was making satisfactory progress when treatment ended. The DMC-ODS had lower proportions of beneficiaries leaving treatment with these positive discharges than statewide (46.7 percent in San Diego as compared to 50.4 percent statewide).
- The bottom four discharge statuses are generally not considered positive, as they include ending treatment with unsatisfactory progress, or due to incarceration or death. The DMC-ODS had higher rates of beneficiaries discharging for these reasons as compared to statewide (53.3 percent in San Diego versus 50.4 percent statewide).

IMPACT OF QUALITY FINDINGS

- Assessment staff in the DMC-ODS are well trained in the use of the ASAM as evidenced by the high congruence of actual placement compared to the ASAM screening results. In cases where placement diverges from the assessment findings, the reasons for lack of congruence are spread across the spectrum indicating that assessment staff are meeting their goal of "meeting clients where they are at", balancing client personal needs with assessment results. This

enables clients to be placed in the LOC that maximizes opportunities for successful treatment outcomes.

- TPS data and supplemental TPS data are regularly considered by the highest levels of leadership in the DMC-ODS and are used to guide decisions and implement performance improvement strategies where indicated.
- Part of San Diego's strategy to overcome workforce shortages is to train and hire peer support staff who are certified to provide Medi-Cal reimbursable services. Not only is the use of peer counselors a strategy to build a critically needed workforce, but peers are proven to be effective in assisting SUD clients to achieve successful treatment outcomes.
- Contract provider line staff report feeling increasingly frustrated with the multiple changes that have affected their work in the past year, especially with the lack of clear communication and conflicting directions from DMC-ODS leadership. This is having a significant impact on workforce morale and is reflecting poorly on DMC-ODS management resulting in a lack of confidence in leadership. San Diego should provide contract line staff with opportunities to have direct communication with DMC-ODS leadership to give meaningful input in system change and how best to implement on the line level. Doing so may have a positive impact on morale, build confidence in DMC-ODS leadership, and engender staff buy-in and ownership on future system changes.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION

All DMC-ODSs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[1] and 457.1240(b)[2]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or DMC-ODS system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual DMC-ODSs, hosts quarterly webinars, and maintains a PIP library at www.calegro.com.

Validation tools for each PIP are located in Table C1 and Table C2 of this report. Validation rating refers to the EQRO's overall confidence that the DMC-ODS (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Pharmacotherapy for Opioid Use Disorder (POD)

Date Started: July 2022

Aim Statement: "This POD PIP aims to increase the proportion of beneficiaries with new pharmacotherapy treatment events for Opioid Use Disorder (OUD) among members aged 16 and older that continue for at least 180 days (six months) by 5 percent by March 2024. BHS intends to achieve this goal by increasing knowledge of the benefits of MAT among clients and providers."

Target Population: The beneficiary population is individuals aged 16 years or older with OUD and a new pharmacotherapy event for OUD. Additional client demographics will be provided after analysis of the pharmacy claims data is complete.

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

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

Validation Information: The DMC-ODS' clinical PIP is in the planning phase.

Summary

This clinical EQRO PIP is San Diego's CalAIM Behavioral Health Quality Improvement Program (BHQIP) PIP focusing on increasing the proportion of beneficiaries with OUDs that begin and continue in POD for a minimum of six months by five percent. The DMC-ODS is still in the process of conducting root cause analysis and plans to fine tune the root causes after claims data are analyzed. Several potential root causes have been identified by stakeholders and include: not enough providers with the ability to prescribe MAT, conservative and traditional attitudes towards MAT among SUD treatment program staff, a lack of knowledge about the benefits of MAT among both providers and clients, the stigma of pharmacotherapy, and difficulty obtaining housing due to not accepting MAT.

San Diego will continue to obtain, analyze, and examine data to further its root cause analysis and develop interventions. An early intervention has already been identified whereby the DMC-ODS will take steps to increase client knowledge of the benefits of MAT. The improvement strategy will be finetuned with stakeholders after the baseline data analysis is complete.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: it is still in the planning phase and though the methods and processes outlined thus far appear to be credible and reliable, some aspects of the interventions have yet to be determined pending completion of baseline data analysis and additional stakeholder input.

CalEQRO provided TA to the DMC-ODS in the form of recommendations for improvement of this clinical PIP including:

- Continue with the plan to start small with a pilot approach.
- Include stigma as an issue in education regarding MAT.
- As this PIP is further planned and developed, ensure that identified interventions meet criteria as a "clinical" PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).

Date Started: June 2022

Aim Statement: “The goal of the FUA PIP is to increase the proportion of beneficiaries that receive a follow-up within seven and 30 days after an ED visit for alcohol and other drug (AOD) by 5 percent from baseline by March 2024.”

Target Population: The beneficiary population for the FUA HEDIS measure is individuals aged 13 years or older with an ED visit where the principal diagnosis was AOD abuse or dependence. Once the claims data are analyzed, DMC-ODS client-specific demographics will be provided.

Validation Information: The DMC-ODS’ non-clinical PIP is in the planning phase.

Summary

This non-clinical EQRO PIP is San Diego’s CalAIM BHQIP PIP focusing on providing follow-up DMC-ODS services to beneficiaries who enter EDs with a primary diagnosis of a SUD. The DMC-ODS is still in the process of conducting root cause analysis and plans to finetune the root causes after claims data are analyzed. Several potential root causes have been noted by stakeholders such as: data sharing barriers due in part to federal confidentiality regulations cited in 42 CFR, Part 2; real time data exchange challenges with hospital EDs and Managed Care Plans; challenges for patients trying to navigate SUD treatment services, including delayed access; the availability of services at the time patients are motivated to seek treatment; and staffing shortages/high turnover at SUD programs which contributes to the administrative burden of Medi-Cal documentation requirements and program capacity limitations.

San Diego will continue to obtain, analyze, and examine data to further its root cause analysis and obtain needed context to inform and develop interventions. Pending findings of the claims data analysis, the evaluation team plans to design an intervention with the stakeholder workgroup that will utilize peers to follow up with ED patients and help connect them to SUD treatment services.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: it is still in the planning phase and though the methods and processes outlined thus far appear to be credible and reliable some aspects of the interventions have yet to be determined pending completion of baseline data analysis and additional stakeholder input.

CalEQRO provided TA to the DMC-ODS in the form of recommendations for improvement of this non-clinical PIP including:

- Contact other counties that have successfully co-located SUD specialists in hospital ED to learn from their successes for how they were able to obtain buy-in and partnership from local hospitals.
- Utilize the ACL phone number to give to beneficiaries who seek services in the EDs.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE DMC-ODS

The EHRs of California's DMC-ODSs are generally managed by county, DMC-ODS IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the DMC-ODS is FEI Systems, Inc./SanWITS, which has been in use for 16 years. Currently, the DMC-ODS has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 6.9 percent of the DMC-ODS budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving DMC-ODS control and another county department or agency.

The DMC-ODS has 843 named users with log-on authority to the EHR, including approximately 150 county staff and 693 contractor staff. Support for the users is provided by 15.75 full-time equivalent (FTE) IS technology positions. Currently all positions are filled. Since the prior EQR there was a 0.5 FTE increase due to shifting priorities.

As of the FY 2022-23 EQR, San Diego continues its efforts to allow contract providers system access to directly enter clinical data into the DMC-ODS' EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data to the DMC-ODS IS as reported in the following table:

Table 23: Contract Provider Transmission of Information to DMC-ODS HER

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

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The DMC-ODS does not currently have a PHR but does anticipate implementation of a PHR within the next year.

Interoperability Support

The DMC-ODS is not a member or participant in an HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, and electronic consult. The DMC-ODS engages in electronic exchange of information with the following departments/agencies/organizations: DMC-ODS contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 24: IS Infrastructure Key Components

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

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

- With regards to investment in IT infrastructure and resources and data collection and processing, San Diego has successfully leveraged support from internal staffing, contracted IS and data analytics positions, and University of California San Diego (UCSD) data support positions to implement, develop, and report on the system of care. There are currently 15.75 FTE IS positions and 16 FTE data analytics positions supporting the DMC-ODS. While there are a number of important system updates on the horizon that would benefit from additional resources, the DMC-ODS has moved the SanWITS system forward well.
- In terms of data collection and processing, the DMC-ODS does not currently have an operational data warehouse, however this is a current project under development.
- The missing components for rating interoperability are the lack of system functionality for contract providers to enter progress notes, which is anticipated to be addressed in a future system update, and the fact that the DMC-ODS is not currently a participant in an HIE.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

Table 25 shows the amount of denied claims by denial reason, and Table 26 shows approved claims by month, including whether the claims are either adjudicated or denied. This may also indicate if the DMC-ODS is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

The DMC-ODS claim denial rate for CY 2021 of 8.2 percent is lower than the statewide rate of 16.80 percent.

Table 25: Summary of Denied Claims by Reason Code, CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Exceeds maximum rate	67,169	$6,653,090	89.67%
Other Healthcare Coverage	6,087	$569,271	7.67%
Duplicate/same day service	3,914	$147,243	1.98%
Beneficiary not eligible	173	$35,201	0.47%
Other	203	$7,912	0.11%
Service location not eligible	48	$5,157	0.07%
Missing valid diagnosis	11	$722	0.01%
Late submission	3	$610	0.01%
Total Denied Claims	**77,608**	**$7,419,206**	**100.00%**
Denied Claims Rate	**8.20%**		
Statewide Denied Claims	**16.80%**		

Table 26: Approved Claims by Month, CY 2021

Month	# Claim Lines	Total Approved Claims
Jan-21	49,643	$6,367,095
Feb-21	45,688	$6,146,800
Mar-21	53,576	$7,042,904
Apr-21	54,440	$6,742,750
May-21	54,820	$6,650,719
Jun-21	54,326	$6,883,563
Jul-21	54,561	$7,256,201
Aug-21	54,905	$7,193,103
Sep-21	58,993	$7,002,079
Oct-21	66,435	$7,507,770
Nov-21	66,826	$7,197,791
Dec-21	68,965	$7,080,528
Total	**683,178**	**$83,071,303**

- This chart appears to reflect a substantially complete claims data set for the time frame.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The DMC-ODS is prioritizing projects as efficiently as possible despite multiple overlapping and conflicting timelines. The use of contracted consultants as well as UCSD partners is one successful strategy of the DMC-ODS to supplement department resources. Even with the strength of the IS and data analytics teams, additional technical IS and data analytics positions would benefit the DMC-ODS as they move towards an important system update bringing interoperability and data collection enhancements. Additionally, the data exchange, payment reform, and other CalAIM related projects will require additional staffing resources to develop, implement, and maintain.
- The scale of the system updates San Diego is implementing is substantial and requires dedicated resources for long-term implementation, testing, and validation. Other important system updates and development are simultaneously needed, including but not limited to the launch and implementation of the PHR, continuing review and validation of data collection and timeliness tracking (with the potential to incorporate the ACL data), and enhancing the monitoring and reporting available to staff and contract providers. With the volume of development work for these IS and data analytics projects, the DMC-ODS would benefit from added IS and data analytics positions within the behavioral health department to implement and maintain these system-specific updates.

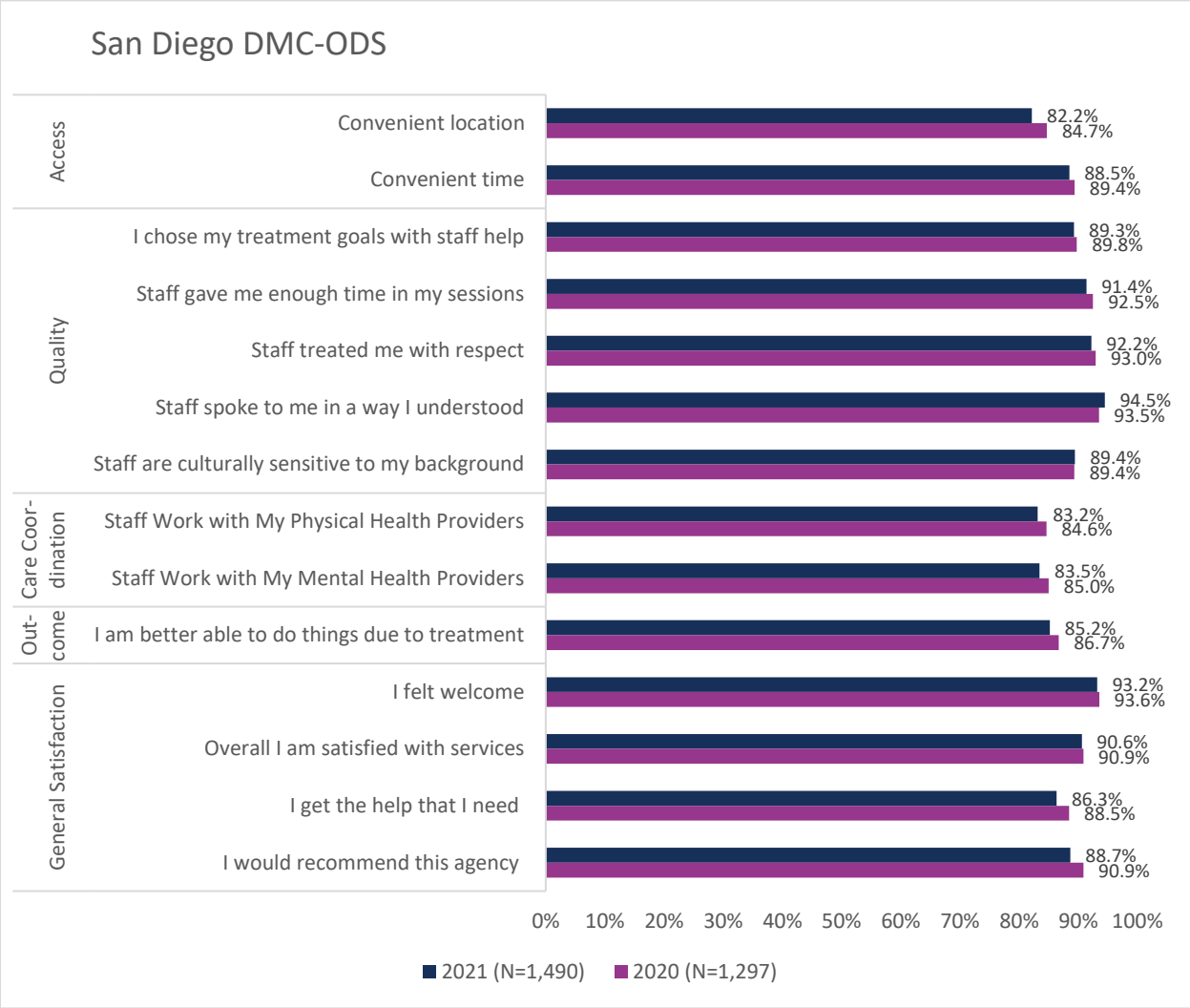
VALIDATION OF CLIENT PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

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

The DMC-ODS clients gave higher ratings in the Quality and General Satisfaction domains, and rated Access and Care Coordination items lowest. Response ratings for 2021 are generally consistent with those found in the TPS results of 2020. San Diego has a high response rate and has seen increase adoption by programs giving its beneficiaries an opportunity to rate their experience with services. There were 1470 valid TPS responses in 2021 nearly 200 more than the 1297 in the prior administration of 2020.

Figure 7: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA



- While the majority of ratings decreased compared to the prior year, the change was slight. The lowest TPS ratings for CY 2021 pertained to access due to convenient location and care coordination with physical and MH providers. The highest rated items were “Staff spoke to me in a way I understood” and “I felt welcome.”

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with consumers (DMC-ODS beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of eight to ten adult beneficiaries receiving women's residential DMC-ODS treatment, including a mix of ongoing and new clients within the past 12 months. The focus group was held virtually and included 13 participants. All consumers participating receive clinical services from the DMC-ODS.

Participants in this focus group reported that they receive services from staff who are very caring and helpful. Participants were complimentary toward the programs and stated they would refer family and friends if the need arises. Several clients were referred to their residential services by their probation officer or other law enforcement. Others were referred by other entities or were self-referred. The assessment process was reported to be a positive experience that was quick and easy, with some saying they were assessed and admitted the same day. One program is reported to do admissions over the weekend. Each of the residential programs are reported to be very open to MH and MAT services with staff educating clients on these treatment options. Most of the participants in this focus group reported currently receiving MAT services while in residential care. Some programs connect clients to recovery homes, but others have to find their own housing before discharge, which is difficult because, as one client stated, "you have to have your own income, yet during residential you cannot work". If a client relapses while in treatment, each program is reported to manage them on a case-by-case basis and strive to keep clients in treatment.

Recommendations from focus group participants included:

- Resume 12-step meetings in the programs to help clients establish recovery connections following treatment.
- Coordination of 12-step sponsorship "and working on the steps within programs would be great".
- Involve family members in the recovery process while in treatment.
- Programs need more support for staff.

Consumer Family Member Focus Group Two

CalEQRO conducted a second 90-minute focus group with consumers (DMC-ODS beneficiaries) during the review of the DMC-ODS. CalEQRO requested a culturally diverse group of eight to ten adult beneficiaries receiving MAT within the DMC-ODS, including a mix of ongoing and new clients within the past 12 months. The focus group was held virtually and included six participants. All consumers participating receive clinical services from the DMC-ODS

The clients in this focus group have been receiving MAT services from less than a year to about 20 years. Participants were very complimentary toward the services they are receiving, crediting their medication for changing their lives. One client, who has been in the program for many years, stated that his program has been “the best thing that has happened”. He further stated, “The medicine works… great, great program and I would not change it for the world.” Another stated, “I can accomplish much more with my wife and kids, and job.” He also shared, “I have not worked in 10 years and today I am working.” Yet another client stated, “I am as healthy as I can be and can focus.” Some clients are receiving non-methadone MAT and shared that they have been successful. Access to services was typically the same day as request and the intake process was generally reported to be easy. Regarding the treatment staff, one client shared, “They are respectful and polite.” Another shared about staff, “There are only two case workers with 200 clients, they are always busy and it is hard to catch them.” Clients reported that therapy and psychiatry is available and “plenty of resources are available”. When asked about what happens if someone relapses while in the program, participants reported that programs treat it as part of the “recovery journey” and continue to work with the clients. Some participants shared concerns about what will happen in cases of disaster or emergency, wondering if their medication will be available. They strongly advocate for making the medication more accessible for those who demonstrate they are stable.

Recommendations from focus group participants included:

- Make the medication more accessible and easier for people to access once someone shows they are stable. “I travel, and I would like not to have liquid handcuffs. Provide more options, like those who need insulin.”
- Bus passes and better transportation options to get medications.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The two client focus groups were well attended, and the participants were very favorable toward their treatment programs and the services they were receiving. MAT is very integrated into the represented treatment programs and clients who receive MAT appear to be thriving. Program staff are caring and helpful; however, focus group participants are aware that staff shortages exist, and that staff are stretched impacting availability to clients. A notable finding from the TPS survey is that clients feel “that staff spoke to me in a way that I understood”, which was the highest rated domain in the survey. A common concern from the MAT focus group is the availability and accessibility of medications in cases of disaster or other emergency reinforcing their advocacy for take-home medication for those who demonstrate stability in recovery. All clients shared that they would refer their program or counselor to family and friends.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the DMC-ODS' programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SUD managed care system.

STRENGTHS

1. The DMC-ODS website is up to date, easy to navigate, translatable into multiple languages, and informative for all community members desiring information regarding SUD concerns, prevention, and treatment services. The website is often the first exposure to DMC-ODS services available in the county and the ease of navigating San Diego's website to obtain information is commendable. (Access)
2. The high congruence of LOC referrals with ASAM findings within the DMC-ODS is demonstrative of a well-trained workforce in the proper application of the assessment as well as the use of treatment strategies such as motivational interviewing to help clients enter treatment at the LOC most conducive to successful treatment. (Access, Quality)
3. The DMC-ODS has leveraged IS and data analytics resources to build an experienced and supportive framework for EHR development, data analysis, and reporting. (IS)
4. The DMC-ODS has a strong research and data analytics team that continually examines and analyzes data, including performance outcomes and client feedback from TPSs as well as other sources. These data are regularly used by San Diego leadership to improve access to and quality of services for beneficiaries. (Quality)
5. San Diego has prioritized the inclusion of peers as an important component of its workforce. The DMC-ODS has hired peers and provided scholarships for them to be trained and certified as peer support specialists that now provide Medi-Cal reimbursable services. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. In response to a recommendation from last year's EQR, San Diego has collaborated with providers to identify workflow issues and barriers for timely documentation of urgent service requests, including ongoing monitoring, system adjustments, and routine reporting. Though the DMC-ODS identified issues and barriers, and has made some plans, it has yet to develop and implement improvement strategies. (Access, Timeliness)

2. In addressing its elevated no-show rates for both outpatient and residential initial appointments, as well as its rate of follow-up services following residential discharge, the DMC-ODS provided TA to providers, ensured policies and procedures were in place at provider programs, and other measures. However, no-show rates have slightly increased in the past year, and rates of follow-up services post-residential discharge slightly decreased. It should be noted that San Diego's rates of follow-up services after residential discharge are still higher than statewide averages. (Access, Timeliness, Quality)
3. The ongoing system updates in SanWITS for payment reform, interoperability with contract provider systems, continued data analytics efforts, and meeting CalAIM deadlines are in process. With the volume of development work for these IS and data analytics projects, the DMC-ODS would benefit from added IS and data analytics positions within the behavioral health department. (IS)
4. The system of care within the DMC-ODS is large and complex, and with 100 percent of services provided by contract providers, there are multiple levels of communication that occur between the county and those who provide services directly to beneficiaries. Miscommunication and lack of clear direction has been reported by line staff providing direct services resulting in inconsistent messaging regarding procedural changes, including implementation of CalAIM driven system changes. (Quality)
5. Phone calls to the ACL are not considered as requests for service in San Diego and are not included in the timeliness data that are tracked and reported. As such, it is unknown how many beneficiaries who initially contact the ACL for assistance do or do not access treatment services in a timely manner. Without this data, it would be difficult to know whether improvement strategies for the engagement of callers at the ACL are needed and, if needed, what those strategies would be to assist them in accessing treatment services. (Access, Timeliness)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the DMC-ODS in its QI efforts and ultimately to improve beneficiary outcomes:

1. San Diego should develop and implement improvement strategies to assure a complete and an accurate data collection process for urgent service requests including ongoing monitoring, system adjustments and routine reporting.

   This recommendation is a carry-over from FY 2021-22. (Access, Timeliness)
2. Continue to address performance issues pertaining to elevated no-show rates for both outpatient and residential initial appointments, as well as timely follow-up services after residential discharge.

   This recommendation is a carry-over from FY 2021-22. (Access, Timeliness, Quality)

3. San Diego should add both IS and data analytics positions to specifically support the ongoing development of the SanWITS EHR as well as its data analytics and reporting initiatives.

   This recommendation is a carry-over from FY 2021-22. (IS)

4. The DMC-ODS should take steps to improve two-way communication with contract provider staff to improve consistency of care across programs, to avoid confusion, and to solicit input from line staff on how to best implement changes that affect service delivery and documentation. San Diego should also ensure consistent messaging from its managers to contract providers to avoid confusion as policy and system changes are implemented. (Quality)

5. Review processes for tracking timeliness from initial calls to the ACL to treatment access by beneficiaries and implement a mechanism for collecting this data to accurately evaluate the effectiveness of the ACL in assisting callers to access services in a timely manner and within DHCS standards. (Access, Timeliness)

EXTERNAL QUALITY REVIEW BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

There were no barriers to this FY 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from DMC-ODS Director

ATTACHMENT F: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – San Diego DMC-ODS
Opening session – Significant changes in the past year, current initiatives, and status of previous year's recommendations, baseline data trends and comparisons, and dialogue on results of PMs
Access to Care
Timeliness of Services
Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the DMC-ODS Network Adequacy
Validation and Analysis of the DMC-ODS Health Information System
Validation and Analysis of Beneficiary Satisfaction
Fiscal/Billing
Quality Improvement Plan, implementation activities, and evaluation results
General data use: staffing, processes for requests and prioritization, dashboards, and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments
Mental Health coordination with DMC-ODS
Criminal justice coordination with DMC-ODS
Clinic managers group interview – county
Clinic managers group interview – contracted
Clinical line staff group interview – county and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family

CalEQRO Review Sessions – San Diego DMC-ODS
Key stakeholders and community-based service agencies group interview
Closing session: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Brett O'Brien, Lead Quality Reviewer
Sharon Loveseth, Quality Reviewer
Joel Chain, Information Systems Reviewer
Diane Mintz, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the DMC-ODS and its Partners

Last Name	First Name	Position	County or Contracted Agency
Amacher	Carlie	Utilization Review QI Supervisor	San Diego County Behavioral Health Services (SDCBHS) - Quality Improvement
Alcaraz	Laurie	Registered Clinician	Vista Hill – ParentCare Central
Alonso	Karla	Licensed Practitioner of the Healing Arts	Episcopal Community Services
Alvarez	Monic	SUD Counselor	Episcopal Community Services
Aston	Heather	Access and Crisis Line Manager	Optum - Access and Crisis Line
Bergmann	Luke	Director	SDCBHS
Blanchard	Michael	Behavioral Health Program Coordinator	SDCBHS - Quality Management-SUD
Briones	Melanie	Senior Project Manager	SDCBHS – Project Management Office
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum
Bauers	Brian	Executive Director	The Way Back
Cacho	Janet	Behavioral Health Program Coordinator	SDCBHS – Healthcare Oversight Unit
Cook	Robert	Executive Director	Heartland House
Cooper	Fran	Assistant Medical Services Administrator	SDCBHS – Children, Youth, and Families System of Care
Cosio	Alexander	Program Manager	Union of Pan Asian Communities (UPAC) – Teen Recovery Center

Last Name	First Name	Position	County or Contracted Agency
Eftekhari	Alisha	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Emerson	Cynthia	Principal Administrative Analyst	SDCBHS – Management Information Systems
Esposito	Nicole	Chief Population Health Officer	SDCBHS – Population Health Unit
Evans Murray	Cara	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Fallow	Claudine	Lead SUD Case Manager	Vista Hill – ParentCare Central
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	SDCBHS – Adult and Older Adult System of Care
Glezer	Natanya	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Gonzaga	Alfie	Program Coordinator	SDCBHS – Health Plan Administration
Gonzalo	Marc	Director	SOAP MAT
Guevara	Christopher	Program Coordinator	SDCBHS – Management Information Systems
Hardge	Carly	Program Manager	McAlister Inc. - South Teen Recovery Center
Hayes	Skylar	Reporting and Application Development Manager	Optum
Hess	Laurie	Program Manager	ElDorado Community Services
Higgins	Alan	Data Analytics Manager	Optum

Last Name	First Name	Position	County or Contracted Agency
Hillery	Naomi	Senior Evaluation Research Associate	UCSD - Health Services Research Center
Jackson	Shannon	Behavioral Health Program Coordinator	SDCBHS – Children, Youth, and Families System of Care
Kang	Teresa	Behavioral Health Program Coordinator	SDCBHS – Children, Youth, and Families System of Care
Kattan	Jessica	Medical Consultant	SDCBHS – Inpatient Health Services
Kelly	Channa	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Kiviat Nudd	Aurora	Assistant Director and Chief Operations Officer	SDCBHS
Kneeshaw	Stacey	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult System of Care
Koenig	Yael	Deputy Director, Children, Youth and Families System of Care	SDCBHS – Children, Youth, and Families System of Care
Krelstein	Michael	Chief Medical Officer	SDCBHS – Healthcare Oversight Unit
Lance-Sexton	Amanda	Assistant Medical Services Administrator	SDCBHS – Children, Youth, and Families System of Care
Lang	Tabatha	Operations Administrator	SDCBHS - Health Plan Operations Unit
Loyo-Rodriguez	Raul	Department Budget Manager	SDCBHS – Strategy and Finance Unit

Last Name	First Name	Position	County or Contracted Agency
Lucas	Lavonne	Medical Claims Manager	CoSD – Health and Human Services Agency - Fiscal Services Division
Madden	Matthew	Quality Assurance	ElDorado Community Services
Marquez	Samantha	Administrative Analyst I	SDCBHS – Health Plan Administration
Mendoza	Raymundo	Behavioral Health Intake Counselor	Optum – Access and Crisis Line
Miles	Liz	Program Coordinator	SDCBHS – Population Health, Quality Improvement
Mockus-Valenzuela	Danyte	Health Planning and Program Specialist	SDCBHS – Prevention and Community Engagement
Morgan	Maria	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Nishihara	Emi	Administrative Analyst II	SDCBHS - Data Sciences
Olaoshebikan	Shola	Executive Vice President	TURN Behavioral Health Services
O'Reilly	Kristyn	Senior Account Manager	FEI Systems
Panczakiewicz	Amy	Senior Evaluation Research Associate	UCSD - Health Services Research Center
Pauly	Kimberly	Chief, Agency Operations	SDCBHS – Program and Operations Unit
Perez	Stacey	Vice President of Programs	Episcopal Community Services
Privara	Nadia	Acting Assistant Director, Chief Strategy & Finance Officer	SDCBHS

Last Name	First Name	Position	County or Contracted Agency
Pyper	Rosemary	Program Manager	Acadia Healthcare
Ratajczak	Brian	Program Manager	Acadia Healthcare
Ramirez	Ezra	Administrative Analyst III	SDCBHS – Health Plan Administration
Ramirez-Sicairos	Valerie	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult System of Care
Ramos	Nilanie	Chief, Agency Operations	SDCBHS – Healthcare Oversight Unit
Raymond	Rebecca	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Reis	Eliza	Program Manager	TURN Behavioral Health Services North Inland TRC
Romo	Isabella	ASW	Vista Hill – Bridges Teen Recovery Center
Rowe	Angela	Sr. Operations Director	Vista Hill
Ruiz	Felipe	Health Planning and Program Specialist	County of San Diego (CoSD) – Health and Human Services Agency - Public Health Services
Saline	Maria Carmen	Administrative Analyst III	CoSD – Health and Human Services Agency - Fiscal Services Division
Salmond	Stephanie	Program Manager	Mission Treatment Services Inc.
Shapira	Erin	Program Coordinator	SDCBHS - Quality Management
Sheaves	David	Implementation Manager	FEI Systems

Last Name	First Name	Position	County or Contracted Agency
Shucart	Mason	Data Analyst I	Optum
Stone	Danny	Vice President	TURN Behavioral Health Services
Tally	Steve	Assistant Director of Evaluation Research	UCSD - Health Services Research Center
Thorpe	Mychele	Behavioral Health Intake Counselor	Optum – Access and Crisis Line
Thornton-Stearns	Cecily	Assistant Director and Chief Program Officer	SDCBHS
Tomic	Tatjana	Chief, Agency Operations	SDCBHS - Data Sciences
Touisithiphonexay	Mali	Administrative Analyst III	SDCBHS - Quality Management
Tran	Phuong	Administrative Analyst III	SDCBHS - Data Sciences
Vargas	Angel	Behavioral Health Program Coordinator	SDCBHS – Adult and Older Adult System of Care
Vleugels	Laura	Supervising Psychiatrist	SDCBHS – Children, Youth, and Families System of Care
White-Voth	Charity	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult System of Care
Williams	Seth	Behavioral Health Program Coordinator	SDCBHS – Children, Youth, and Families System of Care

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	This PIP is still in the planning phase and is rated as low confidence because though the methods and processes outlined thus far appear to be credible and reliable some aspects of the interventions have yet to be determined pending completion of baseline data analysis and additional stakeholder input.
General PIP Information	
MHP/DMC-ODS Name: San Diego	
PIP Title: Pharmacotherapy for Opioid Use Disorder (POD)	
PIP Aim Statement: "This POD PIP aims to increase the proportion of beneficiaries with new pharmacotherapy treatment events for Opioid Use Disorder (OUD) among members aged 16 and older that continue for at least 180 days (six months) by 5 percent by March 2024. San Diego County Behavioral Health Services (SDCBHS) intends to achieve this goal by increasing knowledge of the benefits of MAT among clients and providers."	
Date Started: July 2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The beneficiary population is individuals aged 16 years or older with OUD and a new pharmacotherapy event for OUD. Additional client demographics will be provided after analysis of the pharmacy claims data is complete.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The DMC-ODS will increase client knowledge of the benefits of MAT. The improvement strategy will be finetuned with stakeholders after the baseline data analysis is complete.
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): The DMC-ODS will increase client knowledge of the benefits of MAT. The improvement strategy will be finetuned with stakeholders after the baseline data analysis is complete.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1: Proportion of clients with OUD and a new pharmacotherapy event who receive pharmacotherapy for at least 180 days.	Spring 2023 (anticipated)	Pending baseline data analysis	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

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:

1) Continue with plan to start small with a pilot approach.
2) Include stigma as an issue in education regarding MAT.
3) As this PIP is further planned and developed, ensure that identified interventions meet criteria as a "clinical" PIP.

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	This PIP is still in the planning phase and is rated as low confidence because though the methods and processes outlined thus far appear to be credible and reliable some aspects of the interventions have yet to be determined pending completion of baseline data analysis and additional stakeholder input.
General PIP Information	
MHP/DMC-ODS Name: San Diego	
PIP Title: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA).	
PIP Aim Statement: The goal of the FUA PIP is to increase the proportion of beneficiaries that receive a follow-up within seven and 30 days after an ED visit for AOD by 5 percent from baseline by March 2024.	
Date Started: June 2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The beneficiary population for the FUA HEDIS measure is individuals aged 13 years or older with an ED visit where the principal diagnosis was AOD abuse or dependence. Once the claims data are analyzed, DMC-ODS client-specific demographics will be provided.	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): Provide peer navigator services to SUD treatment programs and provide provider and client education around the importance of clients contacting SUD treatment program after an ED visit for an SUD concern.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Beneficiaries with an ED visit with a principal diagnosis of AOD abuse or dependence1b. Beneficiaries with a follow-up visit with a principal diagnosis of AOD abuse or dependence within 7 or 30 days of the ED visit.	Spring 2023 (anticipated)	Pending baseline data analysis	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2. Contact dates for clients found in Plan Data Feed Files and in SanWITS2b. Type of treatment services for clients found in Plan Data Feed Files and in SanWITS.	Spring 2023 (anticipated)	Pending baseline data analysis	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 3. Clients seen in a San Diego County ED with a principal diagnosis of AOD abuse or dependence.	Spring 2023 (anticipated)	Pending baseline data analysis	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 4. Navigator contacts.	Spring 2023 (anticipated)	Pending baseline data analysis	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 5. Distribution of educational materials.	Spring 2023 (anticipated)	Pending baseline data analysis	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): 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: 1. Contact other counties that have successfully co-located SUD specialists in hospital emergency departments (ED) to learn from their successes for how they were able to obtain buy-in and partnership from local hospitals. 2. Utilize the ACL phone number to give to beneficiaries who seek services in the EDs.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

A letter from the DMC-DOS Director was not required to be included in this report.

ATTACHMENT F: ADDITIONAL PERFORMANCE MEASURE DATA

Table F1: CalOMS Living Status at Admission, CY 2021

Admission Living Status	County		Statewide	
	#	%	#	%
Homeless	4,315	36.3%	24,459	28.0%
Dependent Living	3,656	30.7%	19,800	22.7%
Independent Living	3,919	33.0%	43,052	49.63%
Total	**11,890**	**100.0%**	**87,311**	**100.0%**

Table F2: CalOMS Legal Status at Admission, CY 2021

Admission Legal Status	County		Statewide	
	#	%	#	%
No Criminal Justice Involvement	6,398	53.8%	56,468	64.7%
Under Parole Supervision by CDCR	333	2.8%	1,641	1.9%
On Parole from any other jurisdiction	167	1.4%	1,575	1.8%
Post release supervision - AB 109	4,130	34.7%	21,095	24.2%
Court Diversion CA Penal Code 1000	138	1.2%	1,321	1.5%
Incarcerated	8	0.1%	350	0.4%
Awaiting Trial	715	6.0%	4,798	5.5%
Total	**11,889**	**100.0%**	**87,248**	**100.0%**

Table F3: CalOMS Employment Status at Admission, CY 2021

Current Employment Status	County		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	1,734	14.6%	11,089	12.7%
Employed Part Time - Less than 35 hours	806	6.8%	6,543	7.5%
Unemployed - Looking for work	4,167	35.0%	26,943	30.9%
Unemployed - not in the labor force and not seeking	5,183	43.6%	42,736	48.9%
Total	**11,890**	**100.0%**	**87,311**	**100.0%**

Table F4: CalOMS Types of Discharges, CY 2021

Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	7,198	45.9%	50,245	50.2%
Administrative Adult Discharges	7,124	45.4%	40,626	40.6%
Detox Discharges	1,060	6.7%	7,740	7.7%
Youth Discharges	297	1.9%	1,387	1.4%
Total	**15,679**	**100.0%**	**99,998**	**100.0%**