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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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March 19-21, 2024

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 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.

DMC-ODS INFORMATION

Review Type — Virtual

Date of Review — March 19-21, 2024

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 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	4	1	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	6	0	0
Quality of Care	8	6	2	0
Information Systems (IS)	6	4	2	0
TOTAL	**24**	**20**	**4**	**0**

Table C: Summary of PIP Submissions

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

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	8
2	☐ Youth ☐ Residential ☒ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	3

*Medication Assisted Treatment (MAT), Narcotic Treatment Program (NTP)

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

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

- San Diego's Medication Assisted Treatment (MAT) service delivery system exhibits an impressive degree of collaboration between its 10 opioid treatment programs (OTP), which provide methadone and buprenorphine to over 5,000 members. They adopted flexible take-home dosing models without requiring daily visits to obtain doses based on program progress. Moreover, MAT services are expanding to outpatient clinics within the DMC-ODS, some of which have begun launching integrated MAT services with grant funding and increased partnerships.
- The DMC-ODS's system of care for youth evidences a robust and well-integrated network of alliances and partnerships spanning across outpatient teen recovery centers, school-based services, justice system partnerships and strong coordination with allied mental health (MH) and physical health providers.
- Exceptional levels of inter-agency coordination with allied partners, such as courts and probation, vital for assuring access to substance use services for members involved with the criminal justice system, is evident in San Diego.
- The decision to align the DMC-ODS electronic health record (EHR) with the current MH EHR transition has the potential to provide substantial efficiencies in

system administration efforts as well as providing a framework for integration of data collection, reporting, and interoperability development moving forward.

- The continued investment in county Information Systems (IS) and Data Analytic resources speaks to the effort being made in improving the quality and availability of data to inform the system of care. Notable progress is seen since the prior EQR tied to prior recommendations, including the addition of the IS Principal position.

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

- The DMC-ODS has a small number of Withdrawal Management (WM) beds (77) relative to need within a large county that provided substance use disorder (SUD) treatment services to more than 11,000 members in calendar year (CY) 2022.
- Feedback obtained during focus groups with providers revealed a need for expanded bed capacities in both residential treatment and recovery residences.
- The lack of a formal referral management process and care coordination is evident, specifically with the DMC-ODS' Access and Crisis Line (ACL) and appears to be impacting the timeliness of transitions between levels of care (LOC).
- While San Diego has taken steps at improving bi-directional communication with contract providers since the last EQR cycle, providers expressed a need for greater transparency and sense of collaboration in their interactions with the DMC-ODS.
- The recent decision to transition from the San Diego Web Infrastructure for Treatment Services (SanWITS) EHR to the SmartCare EHR impacts many high-priority system development projects that have been in process. The timeline for system functionality will now be delayed due to the shift to a new system.

Recommendations for improvement based upon this review include:

- San Diego should take meaningful steps to increase system capacity for member access to WM services.
- The DMC-ODS should continue its efforts to build more capacity in both residential treatment and recovery residences.
- The DMC-ODS should improve and develop more transparent communication pathways with its providers while continuing to engage with them to improve data tracking, analysis, and integrity via groups such as the SUD provider association.
- The DMC-ODS should seek to revise the structure and processes of the ACL in order to provide referral management and the ability to provide an initial American Society of Addiction Medicine (ASAM) screening or assessment for member callers seeking services. This can increase the likelihood of referral to the appropriate LOC.
- San Diego should be proactive in exploring SmartCare functionality to fully implement available system options upon transition.

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 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 February 2023.

The State of California Department of Health Care Services (DHCS) contracts with 31 county DMC-ODSs, comprised of 37 counties, to provide SUD treatment services to Medi-Cal Plan members 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 Plan members.

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 Plan member satisfaction. CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205 (Section 14197.05 of the California Welfare and Institutions Code [WIC]).

This report presents the FY 2023-24 findings of the EQR for San Diego DMC-ODS by BHC, conducted as a virtual review on March 19-21, 2024.

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, Plan members, family, 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 ASAM LOC data.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. 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-ODSs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- DMC-ODS activities in response to FY 2022-23 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 Plan member 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 Plan members' perception of the DMC-ODS' service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members 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, and then “<11” is indicated to protect the confidentiality of DMC-ODS members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or corresponding penetration rate (PR) percentages.

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 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING DMC-ODS OPERATIONS

The DMC-ODS did not experience any significant issues affecting its operations.

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 notes a reorganization of the quality review committee (QRC) which has transitioned to the Population Health unit under the leadership of Dr. Nicole Esposito, Chief Population Health Officer. This shift will expand the focus on continuous QI and a vision to address findings and recommendations of the EQRO, with a focus on access, timeliness, quality, and equity across all domains.
- Over the past year, Behavioral Health Services (BHS) has presented to the Board of Supervisors (BOS) two comprehensive updates on the implementation of the opioid settlement framework. In May 2023, BHS launched the harm reduction outreach and education campaigns, including a media campaign to prevent fentanyl overdoses among youth, and obtained approval to expand public outreach. In October 2023, BHS provided the BOS with a comprehensive review of all prevention efforts and new programs which collectively advance the County's Comprehensive Harm Reduction Strategy.
- As part of California Advancing and Innovating Medi-Cal (CalAIM), BHS participates in the justice involved initiative, which requires correctional facilities to build infrastructure and launch specific pre-release services to Medi-Cal members between April 2024 and March 2026. Behavioral Health (BH) linkage is a distinct component within this initiative and will go live by October 2024. San Diego participates in workgroups with jail and BH partners to develop required implementation plans and processes to support a successful system. The county was awarded Providing Access and Transforming Health (PATH) funds to assist with these efforts.
- October 2023, San Diego implemented a partnership with the Viejas Band of Kumeyaay Indians (Viejas) for the provision of approximately 150 new opioid treatment program slots at the Revive Pathway clinic, located in El Cajon, and wholly owned by Viejas. Services include MAT. This adds critical capacity in a region that has a proportionally high rate of opioid overdose deaths and opioid related emergency department (ED) visits and, as a Tribal Compact Clinic, will

have the added benefit of specializing in care for the American Indian and Alaska Native community.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 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 not addressed may be presented as a recommendation again for this review. However, if the DMC-ODS has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 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.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- San Diego reports that QI efforts to ensure fulsome and accurate data collection were achieved by obtaining provider feedback, thus enhancing communication surrounding data aggregation processes, and analyzing urgent service data to identify areas of need.
- While acknowledging that accurate data collection presents a challenge, in part due to the referral-based system of the access call log (ACL), numerous efforts have been made to improve the current system, including retraining providers on the correct definition of urgent service requests and providing them with a tip sheet that describes the tracking process.

- An upcoming pilot program is intended to track the timeliness of urgent service requests for WM through the ACL to continue these efforts.

Recommendation 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.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The QRC conducted a root cause analysis that identified workforce challenges, transportation needs, provider variance in standards or communication of no-show policies, flexible appointment availability, and mandated vs. non-mandated services, all impact upon no show rates.
- Guided by this analysis, San Diego developed and implemented strategies to address performance issues related to elevated no-show rates and timely follow-up for services after residential discharge.

Recommendation 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.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS has reorganized to include a data science unit with added positions in data acquisition, data integration, management reporting and analytics, data governance, and training and engagement branches to support enhanced data analytics efforts.
- An IT principal position was added to support the EHR development efforts.
- Prior to the EQR, the DMC-ODS made the decision to transition from the SanWITS EHR and implement the SmartCare EHR as part of the California Mental Health Services Authority (CalMHSA) multi-county EHR initiative. The decision aligns with the ongoing implementation of SmartCare within the San Diego mental health plan (MHP).

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- While San Diego has taken some steps during FY 2023-24 to enhance two-way communication with contract provider staff to improve consistency across

programs, including conducting a root cause analysis which led to the reinstating of bimonthly provider meetings in January 2024, it is too soon to assess whether the increased meeting frequency will fully resolve the interagency communication challenges.

- Providers' feedback to CalEQRO during the current review cycle included continued frustration at the "partial answers" they have received from the DMC-ODS on topics such as CalAIM-mandated payment reform and reconciling inconsistent or missing data. Providers also reported that they have yet to receive the tip sheets that San Diego stated it has developed to mitigate procedural confusion among their contract partners.
- As a result, this recommendation is being continued into the current EQR review cycle's report.

Recommendation 5: Review processes for tracking timeliness from initial calls to the ACL, to treatment access by members 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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- San Diego has taken steps to review processes for tracking timeliness from initial calls to the ACL, data analysis revealed that the number of individuals who contact treatment programs directly (2,622 per month, on average) far exceed the number who call the ACL (312 per month, on average).
- A small-scale pilot program intervention was then launched, with a focus on the tracking of requests for urgent services requested through the ACL for WM, with a longer-term plan to expand this endeavor throughout the continuum of care.

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 members 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 Plan members 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 Plan members 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 solely by contractor operated providers in the DMC-ODS. Regardless of payment source, approximately 100 percent of services were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 94 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free access line available to Plan members 24-hours, seven-days per week that is operated by contract provider staff; members may request services through the access line as well as by contacting contract provider facilities directly. If it is determined that the LOC offered at that site is not appropriate, staff are required to link the member via warm hand-off to appropriate referrals.

In addition to clinic-based SUD services, the DMC-ODS provides telehealth services to youth and adults. In FY 2022-23, the DMC-ODS reports having provided telehealth services to 1,833 adults, 174 youth, and 79 older adults across 65 contractor-operated sites. Among those served, 106 members received telehealth services in a language other than English.

NETWORK ADEQUACY

An adequate network of providers is necessary for Plan members 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 May 2023, DHCS issued its FY 2022-23 NA Findings Report for all DMC-ODSs 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 Behavioral Health Information Notice (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 2022-23

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 (age 18+)	Youth (age 12 -17)	Adults (age 18+)	Youth (age 12-17)
# of zip codes outside of the time and distance standards that required AAS request	n/a	85	n/a	n/a
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)	n/a	unknown	n/a	n/a
Distance and driving time between nearest network provider and zip code of the member furthest from that provider for AAS requests	n/a	102 miles, 103 minutes	n/a	n/a
Approximate number of members impacted by AAS or allowable exceptions	n/a	unknown	n/a	n/a
The number of AAS requests approved and related zip code(s)	n/a	85	n/a	n/a
Reasons cited for approval	n/a	Newly awarded OTP contracts now include youth services. In-network providers offer telehealth, and if member refuses telehealth, providers arrange for transportation for an in-person visit.	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

- The DMC-ODS engaged in the following improvement activities to improve access to services for members living within AAS areas:

1) The DMC-ODS awarded new contracts that include opioid treatment services to youth. The DMC-ODS continues to work with contracted programs to provide telehealth services when clinically indicated and desired by the member. In cases where a provider is not available within the time and distance standard, and if the member does not want to receive services via telehealth, the DMC-ODS will continue to arrange transportation for the member to an in-person visit.
2) In addition, the DMC-ODS will continue to leverage existing mechanisms to contract with OON providers when needed.

Table 1B: San Diego DMC-ODS Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
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
OON Access for Plan Members	
The DMC-ODS ensures OON access for members in the following manner:	☐ The DMC-ODS has existing contracts with OON providers ☒ Other: The DMC-ODS does not have executed contracts with OON providers due to a lack of prior demand. If there is future demand, Optum has been designated by the DMC-ODS to execute OON contracts on their behalf.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to Plan members and their family. 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 Plan member 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 Member Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

A particular strength associated with the access components identified above includes:

- San Diego ensures that information regarding system access is readily available to Medi-Cal eligibles and ensures that required services are available to members.
- The DMC-ODS demonstrates a consistent pattern of collaborative engagement with its partner stakeholders and other public and private agencies to better meet the clinical, cultural, and linguistic needs of plan members.
- San Diego assesses, identifies, implements, and evaluates the implementation of strategies to provide the appropriate types and numbers of practitioners and providers necessary to meet the needs of its members.

ACCESS PERFORMANCE MEASURES

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

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

The Statewide PR is 0.95 percent, with a statewide average approved claim amount of $5,998. Using PR as an indicator of access for the DMC-ODS, San Diego demonstrates better access to care than was seen statewide, reflecting an increase from the prior year's PR to 1.42 percent.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SUD treatment services 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 Plan members served.

Table 3: San Diego DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Ages 12-17	113,237	508	0.45%	0.29%	0.25%
Ages 18-64	577,232	10,008	1.73%	1.29%	1.19%
Ages 65+	102,616	718	0.70%	0.56%	0.49%
Total	**793,085**	**11,234**	**1.42%**	**1.04%**	**0.95%**

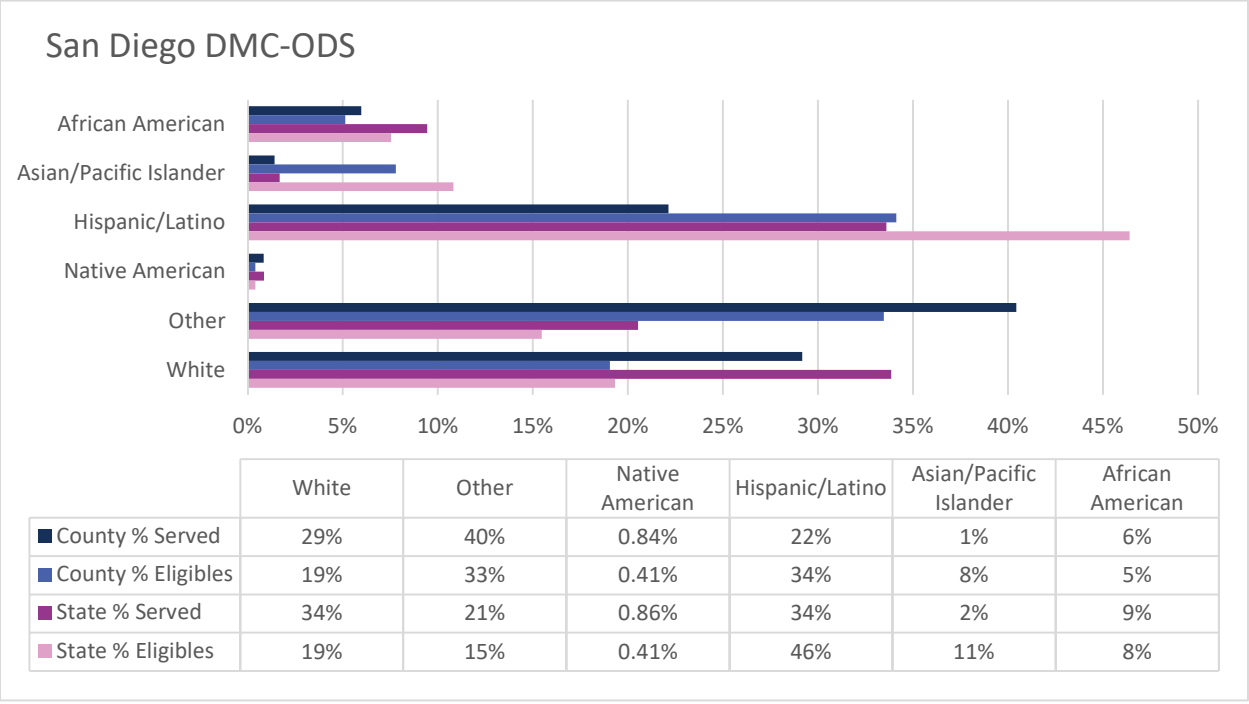
- The DMC-ODS primarily served adults between the ages of 18-64, with a PR of 1.73 percent within that age group. PRs for all age groups are higher than the corresponding statewide and similar-size county PRs.

Table 4: San Diego DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, CY 2022

Racial/Ethnic Groups	# Members Eligible	# Members Served	County PR	Same Size Counties PR	Statewide PR
African American	40,763	672	1.65%	1.29%	1.19%
Asian/Pacific Islander	61,790	158	0.26%	0.15%	0.15%
Hispanic/Latino	270,738	2,488	0.92%	0.74%	0.69%
Native American	3,239	94	2.90%	2.34%	2.01%
Other	265,419	4,544	1.71%	1.34%	1.26%
White	151,139	3,278	2.17%	1.89%	1.67%

- The DMC-ODS remains above the statewide PRs for all racial/ethnic groups.

Figure 1: Percentage of Eligibles and Members Served by Race/Ethnicity, CY 2022



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
County % Served	29%	40%	0.84%	22%	1%	6%
County % Eligibles	19%	33%	0.41%	34%	8%	5%
State % Served	34%	21%	0.86%	34%	2%	9%
State % Eligibles	19%	15%	0.41%	46%	11%	8%

- The largest gaps between percentages of eligibles and members accessing services are seen in the Hispanic/Latino and Asian/Pacific Islander groups. White and Other groups are proportionally overrepresented.

Table 5: San Diego DMC-ODS Plan Members Served and PR by Eligibility Category, CY 2022

Eligibility Categories	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
ACA	355,669	7,572	2.13%	1.53%	1.42%
Disabled	68,018	990	1.46%	1.51%	1.37%
Family Adult	169,567	2,269	1.34%	1.03%	0.94%
Foster Care	968	25	2.58%	2.08%	1.84%
Medicaid Children's Health Insurance Program (MCHIP)	44,913	159	0.35%	0.20%	0.18%
Other Adult	81,907	122	0.15%	0.10%	0.09%
Other Child	74,115	348	0.47%	0.32%	0.27%

Note: Eligibles may be in more than one aid code category during a year.

- The primary eligibility categories for members served in the DMC-ODS are Affordable Care Act (ACA), Family Adult, and Disabled.

Table 6: San Diego DMC-ODS Average Approved Claims by Eligibility Category, CY 2022

Eligibility Categories	County AACM	County Size Group AACM	Statewide AACM
ACA	$7,922	$5,742	$6,216
Disabled	$6,293	$5,393	$5,707
Family Adult	$6,979	$5,180	$5,296
Foster Care	$3,802	$2,578	$2,716
MCHIP	$5,824	$3,692	$3,594
Other Adult	$5,328	$3,880	$4,075
Other Child	$5,635	$3,427	$3,194
Total	**$7,627**	**$5,607**	**$5,998**

- Total AACMs in the DMC-ODS are higher than the county size group and statewide averages.

Table 7: San Diego DMC-ODS Services Used by Plan Members, CY 2022

County			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	0	0.00%	56	0.04%
Intensive Outpatient	2,543	14.61%	14,422	9.58%
Narcotic Treatment Program	3,704	21.27%	37,134	24.67%
Non-Methadone MAT	1,311	7.53%	7,782	5.17%
Outpatient Treatment	4,273	24.54%	46,441	30.85%
Partial Hospitalization	0	0.00%	13	0.01%
Recovery Support Services	1,029	5.91%	6,400	4.25%
Res. Withdrawal Mgmt	1,139	6.54%	10,429	6.93%
Residential Treatment	3,412	19.60%	27,841	18.50%
Total	**17,411**	**100.00%**	**150,518**	**100.00%**

- The plurality of members receiving services were in outpatient treatment with 24.54 percent of members having utilized the service. NTP was the next most-accessed modality (21.27 percent in the DMC-ODS compared to 24.67 percent statewide).
- Intensive outpatient treatment, non-methadone MAT, and recovery support services (RSS) are provided at rates higher than statewide.

Table 8: San Diego DMC-ODS Approved Claims by Service Categories, CY 2022

Service Categories	County AACM	County Size Group AACM	Statewide AACM
Ambulatory Withdrawal Mgmt	$0	$234	$484
Intensive Outpatient	$909	$1,207	$1,729
Narcotic Treatment Program	$3,929	$4,279	$4,526
Non-Methadone MAT	$1,756	$1,601	$1,660
Outpatient Treatment	$4,105	$2,304	$2,547
Partial Hospitalization	$0	$2,802	$2,802
Recovery Support Services	$1,802	$1,660	$1,669
Res. Withdrawal Mgmt	$3,146	$2,278	$2,392
Residential Treatment	$12,762	$10,379	$10,178
Total	**$7,627**	**$5,607**	**$5,998**

- The AACMs by service category for the DMC-ODS are higher than the county size group and statewide averages for non-methadone MAT, outpatient treatment, RSS, residential WM, and residential treatment.
- The DMC-ODS AACMs increased for all service categories except RSS compared to the previous year.

IMPACT OF ACCESS FINDINGS

- While San Diego's PRs, when measured by age, race/ethnicity and eligibility category exceed same size counties as well as statewide, when viewed by service category, pockets of lower relative penetration can be seen within the NTP and outpatient categories when compared with statewide.
- Capacity issues in Residential Treatment, Outpatient Treatment combined with Recovery Residences, and Withdrawal Management, respectively, were mentioned by staff as particularly challenging and has resulted in members experiencing lengthy wait times before entering into these LOC's. Moreover, San Diego acknowledges that often lengthy wait times to access outpatient MH services are also experienced with by plan members.

TIMELINESS OF CARE

The amount of time it takes for Plan members 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 greater the likelihood that 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 Plan members. 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 member 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	Met
2B	First Non-Urgent Request to First Offered MAT Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Residential Treatment	Met
2E	Withdrawal Management Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- A particular strength of the DMC-ODS is the median time to first NTP/OTP appointment, which San Diego reports to be the same day as the request.

- At outpatient LOC, intakes average 1,233 scheduled each month and an average of 573 no-shows (46.5 percent).
- Of the 4,337 members who were discharged from residential treatment, just 1,471, or 33.9 percent, received follow-up services within the 7-day standard. The rate of timely follow-up improved slightly at 30 days to 39.7 percent.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, DMC-ODS' complete and submit the Assessment of Timely Access (ATA) 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 2023-24 EQR, the DMC-ODS reported in its submission of the ATA, representing access to care during the 12-month period of CY 2023. Table 10 and Figures 2-4 display data submitted by the DMC-ODS; an analysis follows. These data represent the entire system of care, with all services provided through contractor-operated services. For first non-urgent service rendered the DMC-ODS submitted data split into OTP, outpatient, and residential categories rather than aggregated total results. Outpatient metrics are reflected in Table 10 below as that was the category with the largest number of requests.

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 2023-24 San Diego DMC-ODS Assessment of Timely Access

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	3.2 Business Days	10 Business Days*	95.2%
First Non-Urgent Service Rendered***	4.2 Business Days	10 Business Days**	93.4%
Non-Urgent MAT Request to First Offered NTP/OTP Appointment	0.1 Business Days	3 Business Days*	99.7%
Urgent Services Offered	58.6 Hours	48 Hours**	70.2%
Follow-up Services Post-Residential Treatment	26.4 Calendar Days	7 Calendar Days	33.9%
WM Readmission Rates Within 30 Days	8.6%	n/a	n/a
No-Shows	38.2%	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 22-033 ** DMC-ODS-defined timeliness standards *** Outpatient services only, OTP and residential reported separately in the ATA form.			
For the FY 2023-24 EQR, the DMC-ODS reported its performance for the following time period: CY 2023			

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

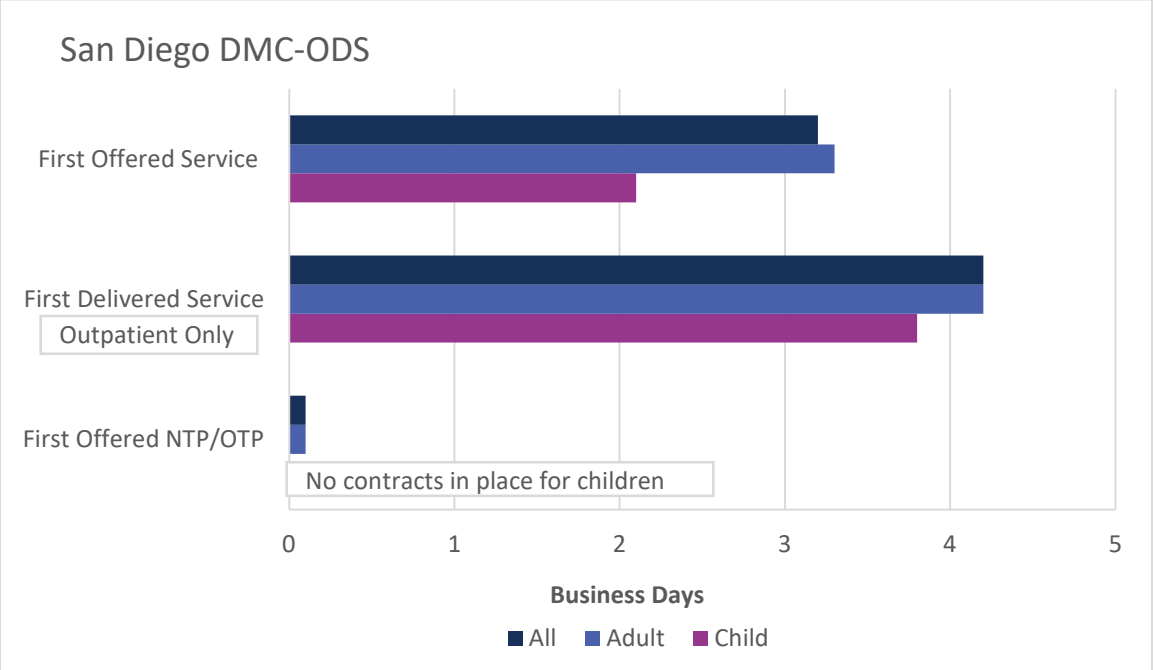


Figure 3: Wait Times for Urgent Services

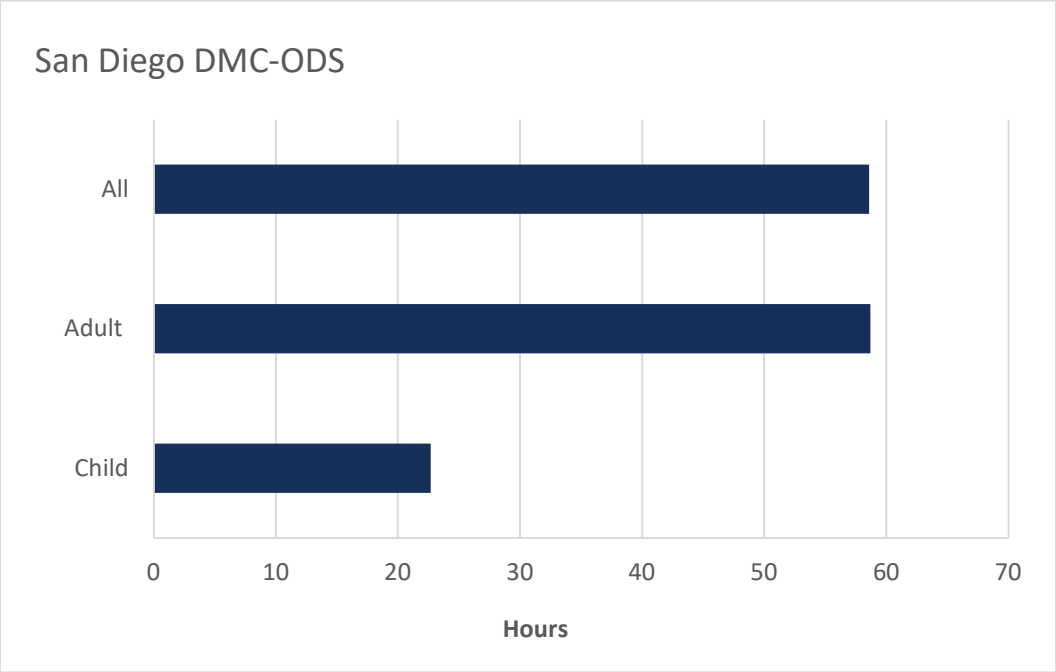
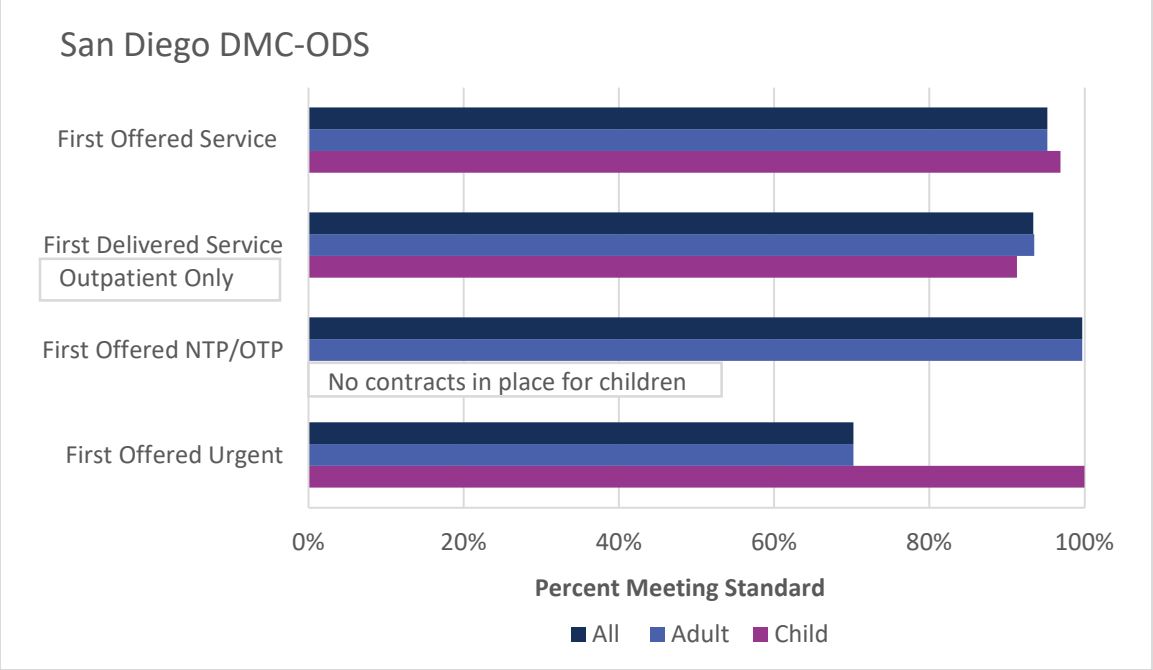


Figure 4: Percent of Services that Met Timeliness Standards



- As San Diego's ACL only generates referrals to treatment in response to callers' requests for SUD treatment services, the DMC-ODS' timeliness data reflects its contracted agencies' ability to swiftly enroll members into their programs.

- San Diego's overall rate of no-shows for first service, across the continuum of care, is 38 percent, or almost four in ten members. This represents a slight increase from the 37 percent reported during the last EQR cycle.

TIMELINESS FROM 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 2022 claims.

Timely Access to Methadone Medication in NTP's after First Plan Member Contact

Table 11: San Diego DMC-ODS Days to First Dose of Methadone by Age, CY 2022

County				Statewide		
Age Groups	# of Members	%	Avg. Days	# of Members	%	Avg. Days
12 to 17	<11	-	0.00	15	0.04%	12.60
18 to 64	3,271	89.54%	4.65	31,839	87.46%	3.59
65+	-	-	0.32	4,551	12.50%	0.56
Total	**3,653**	**100.00%**	**4.19**	**36,405**	**100%**	**3.19**

- On average, members in the DMC-ODS received their first dose of methadone in 4.19 days, which was one day longer than the statewide average of 3.19 days. The DMC-ODS average increased slightly from the prior year average of 3.52 days.

Transitions in Care

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

Table 12: San Diego DMC-ODS Timely Transitions in Care Following Residential Treatment, CY 2022

	N = 3,355		Statewide N = 27,232	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	346	10.31%	3,243	11.91%
Within 14 Days	486	14.49%	4,515	16.58%
Within 30 Days	590	17.59%	5,706	20.95%

- Approved claims data shows 3,355 members discharged from residential treatment in CY 2022, which was a slight increase of 2.5 percent from the prior year. Of members discharged, 17.59 percent had a follow-up service within 30

days, which was lower than the statewide rate of 20.95 percent. More than three-quarters of members are not receiving a transition within 30 days of residential discharge. This differs from San Diego's locally maintained data for FY 2022-23.

- DMC-ODS timely transitions to follow-up services decreased in CY 2022 and is now slightly below the statewide rate in all measured time periods.

Residential Withdrawal Management Readmissions

Table 13: San Diego DMC-ODS Residential Withdrawal Management Readmissions, CY 2022

County			Statewide	
Total DMC-ODS admissions into WM	1,406		13,062	
	#	#	#	%
WM readmissions within 30 days of discharge	125	8.89%	1,148	8.79%

- The DMC-ODS had 1,406 members admitted into residential WM in CY 2022. The readmission rate in the DMC-ODS increased from the prior year to 8.89 percent and is now similar to the statewide readmission rate of 8.79 percent.

IMPACT OF TIMELINESS FINDINGS

- Of those members who step down post residential treatment, only one in ten experiences such transition within San Diego's own standard of seven days.
- Eight out of every ten members who discharge from residential care receive no subsequent SUD system of care transitions at all, posing an elevated risk for these members for relapse.
- There is a high rate of no-shows for intake appointments at the outpatient LOC, the service most utilized by members, representing an opportunity for improving member engagement and access.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the Plan members 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 members. 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, principal responsibility for QI is shared among these five departmental units: population health, data science, quality assurance, management information systems, and health plan administration. The following four entities are additional components of the QI structure of the DMC-ODS: executive QI team, QRC, quality improvement committees (QICs), and outcomes and metrics committee.

The model adopted by San Diego is one of continuous QI within key service and clinical areas and encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key systems, service, and administrative functions. The QRC is scheduled to meet quarterly and the DMC-ODS QIP meets monthly. It is comprised of coordinators, directors, health officers, and supervisors. Of the 12 identified FY 2022-23 QAPI workplan goals, the DMC-ODS met four and did not meet eight.

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 Plan members. 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 Members 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:

- MAT services are a relative strength of San Diego, whose ten partner OTPs deliver both methadone and non-methadone forms of MAT to over 5,000 members.
- CalOMS discharge data indicates a high level of functional improvement for those who do complete treatment, (see Figures 7 and 8 below), with homeless status decreasing from 45 percent at admission vs just 24 percent at discharge. Improvements were also seen in the various statuses of employment, including a large rise in full-time employment or job seeking.
- Communication with contract providers is noted to require additional attention by San Diego, and agency partners express a desire for more transparency and greater levels of collaboration in their interactions. The Network Quality and Planning team presents at both the Mental Health Contractors Association and Alcohol and Drug Services Provider Association executive committees to discuss the data analysis completed in response to the EQRO recommendations.
- The access line does not conduct ASAM screenings but refers to programs where full ASAM assessments occur, and so initial ASAM screening data is only available for 7.5 percent of members, making it difficult to analyze the fidelity of initial LOC determinations.

QUALITY PERFORMANCE MEASURES

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

- Members served by Diagnostic Category
- Non-methadone MAT services

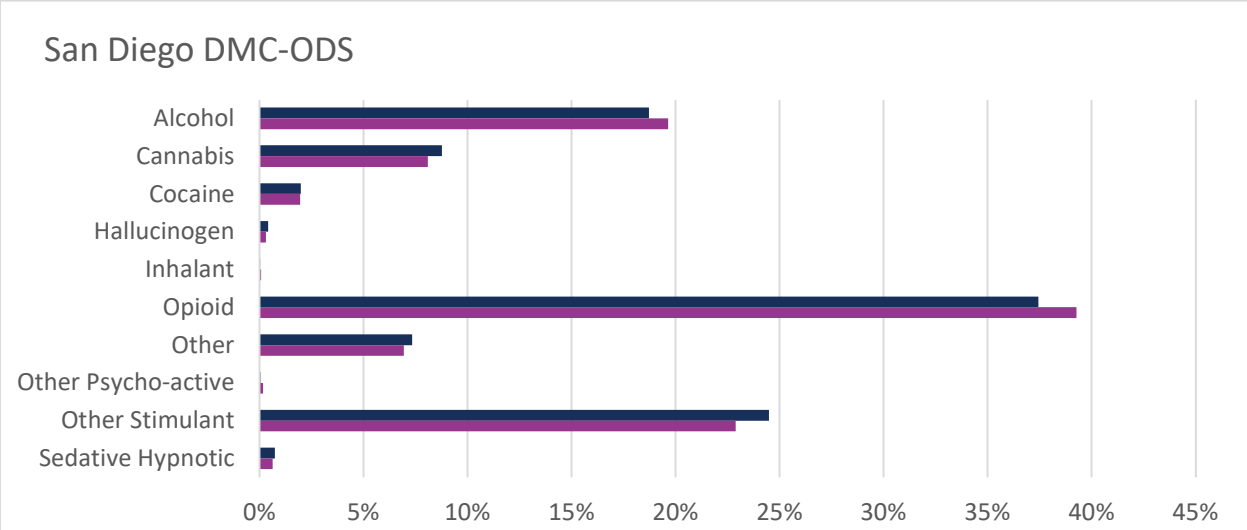
- Residential WM with no other treatment
- High-Cost Members (HCM)
- ASAM congruence
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS admission versus discharge for employment and housing status
- CalOMS Legal Status at Admission
- CalOMS Discharge Status Ratings

DIAGNOSIS DATA

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

Initial assessment and services provided during the assessment process, except for residential treatment, may be provided without an established diagnosis for DHCS-defined periods of time. These deferred diagnoses are included in "Other."

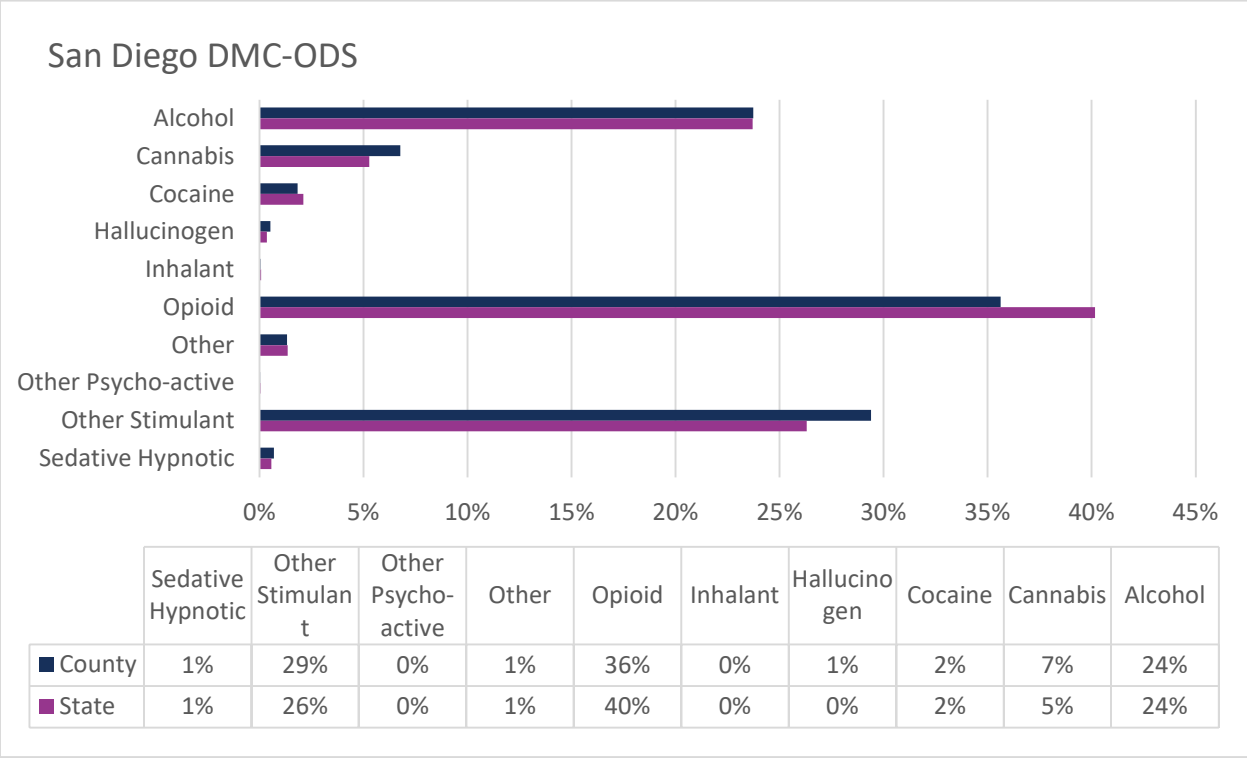
Figure 5: Percentage of Plan Members by Diagnosis Code, CY 2022



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	1%	24%	0%	7%	37%	0%	0%	2%	9%	19%
State	1%	23%	0%	7%	39%	0%	0%	2%	8%	20%

- In the DMC-ODS, 37 percent of members receiving services were diagnosed with an opioid use disorder (OUD), followed by other stimulant as the next most common diagnosis (24 percent).
- The primary diagnostic pattern in the DMC-ODS was comparable to the statewide diagnostic pattern.

Figure 6: Percentage of Approved Claims by Diagnosis Code, CY 2022



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	1%	29%	0%	1%	36%	0%	1%	2%	7%	24%
State	1%	26%	0%	1%	40%	0%	0%	2%	5%	24%

- OUD was the dominant diagnostic category and accounts for 36 percent of claims.
- The proportion of approved claims decreased from the prior year for members with OUD (from 39 to 36 percent) and remains below the statewide rate (40 percent). The percentage of claims slightly increased for members with an other stimulant use diagnosis (from 28 to 29 percent), and claims increased slightly for members with an alcohol use diagnosis (from 23 to 24 percent) of overall claims.

NON-METHADONE MAT SERVICES

Table 15: San Diego DMC-ODS Non-Methadone MAT Services by Age, CY 2022

	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	-	0	0.00%	24	0.56%	13	0.30%
Ages 18-64	1,256	12.55%	612	6.12%	7,473	7.96%	3,881	4.13%
Ages 65+	-	-	17	2.37%	428	5.78%	173	2.34%
Total	**1,318**	**11.73%**	**629**	**5.60%**	**7,925**	**7.13%**	**4,051**	**3.66%**

- The DMC-ODS had a higher rate of members receiving non-methadone MAT compared to the statewide rates.

RESIDENTIAL WITHDRAWAL MANAGEMENT WITH NO OTHER TREATMENT

Table 16: San Diego DMC-ODS 3+ Episodes of Residential WM and No Other Treatment, CY 2022

	# Members with 3+ Episodes WM & No Other Services	% Members with 3+ Episodes WM & No Other Services
County	15	1.34%
Statewide	205	2.00%

- The DMC-ODS had 15 members receiving three or more WM services with no other treatment, 1.34 percent compared to 2.00 percent statewide.

HIGH-COST MEMBERS

Tracking the HCMs provides another indicator of quality of care. In SUD treatment, this may reflect multiple admissions to residential treatment or residential WM. HCMs may be receiving services at a LOC not appropriate to their needs. HCMs for the purposes of this report are defined as those who incur SUD treatment costs higher than two standard deviations above the mean, which for CY 2022 equates to claims of $17,188 or more.

Table 17: San Diego DMC-ODS and Statewide High-Cost Members, CY 2022

	Total Members Served	HCM Count	HCM % by Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
County	11,240	1,276	11.35%	$23,263	$29,683,408	34.63%
Statewide	105,657	5,724	5.42%	$24,551	$140,532,204	21.84%

- 1,276 HCMs served by the DMC-ODS accounted for 34.63 percent of total claims for CY 2022.
- The DMC-ODS proportion of members considered to be HCMs (11.35 percent), was more than twice the statewide proportion (5.42 percent).

ASAM LEVEL OF CARE CONGRUENCE

Table 18: San Diego DMC-ODS Congruence of Level of Care Referrals with ASAM Findings, CY 2022 – Reason for Lack of Congruence

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable /No Difference	666	98.09%	8,886	94.02%	10,870	90.48%
Patient Preference	<11	-	304	3.22%	556	4.63%
Level of Care Not Available	0	0.00%	22	0.23%	32	0.27%
Clinical Judgement	<11	-	41	0.43%	84	0.70%
Geographic Accessibility	0	0.00%	27	0.29%	25	0.21%
Family Responsibility	0	0.00%	<11	-	0	0.00%
Legal Issues	0	0.00%	34	0.36%	81	0.67%
Lack of Insurance/Payment	<11	-	<11	-	11	0.09%
Other	<11	-	93	0.98%	325	2.71%
Actual Level of Care Missing	0	0.00%	35	0.37%	30	0.25%
Total	679	100.00%	9,451	100.00%	12,014	100.00%

- The DMC-ODS reported a congruence rate for LOC referrals with ASAM findings at 94.02 percent at initial assessment, and 90.48 percent for follow-up assessment.
- Initial screening LOC congruence with ASAM was reported for 7.5 percent of members with a reported initial assessment. Members calling into the ACL were more frequently referred to programs where assessment would occur.
- The patient preference category was the primary reason the ASAM-indicated LOC differed from referral.

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 19 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 Plan members who initiate treatment begins with identifying the initial visit in which the member's SUD is identified. Based on claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a member 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 14th and 34th day following initial DMC-ODS service.

Table 19: Initiating and Engaging in San Diego DMC-ODS Services, CY 2022

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Members with an initial DMC-ODS service	9,961		469		99,855		4,026	
	#	%	#	%	#	%	#	%
Members who then initiated DMC-ODS services	8,813	88%	428	91%	83,830	84%	3,286	82%
Members who then engaged in DMC-ODS services	6,843	78%	331	77%	63,753	76%	2,202	67%

- The DMC-ODS had initiation and engagement rates higher than statewide for both youth and adults.

LENGTH OF STAY

Examining Plan members' LOS in services provides another look at engagement in services and completion of treatment. Table 20 presents the number of members who discharged from treatment in CY 2022, defined as having zero claims for any DMC-ODS services for 30+ days, the average and median LOS for members, and results indicating what proportions of members had accessed services for at least 90, 180, and 270 days, as well as statewide comparisons for reference.

Table 20: Cumulative LOS in San Diego DMC-ODS – DMC-ODS Services, CY 2022

	County		Statewide	
Members discharged from care (no treatment for 30+ days)	15,017		139,688	
LOS for members across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	164	95	158	90
	#	%	#	%
Members with at least a 90-day LOS	7,849	52%	69,919	50%
Members with at least a 180-day LOS	4,889	33%	43,096	31%
Members with at least a 270-day LOS	3,186	21%	27,677	20%

- The average (mean) LOS for DMC-ODS members was 164 days (median of 95 days), which was longer than the statewide average of 158 days (median was 90 days).

- 52 percent of members had at least a 90-day LOS, 33 percent had at least a 180-day stay, and 21 percent had at least a 270-day LOS. The proportions of members retained for each measured period were higher than statewide.

CALOMS DATA

CalOMS is one of the few national datasets that asks SUD service users about psychosocial information at both admission and discharge. These are critical outcomes that reflect areas of life functioning expected to be positively influenced by SUD treatment. The measures provided below allow for system evaluation and determine the efficacy of care provided. Additionally, the types of discharges and their ratings reflect the degree to which treatment episodes were considered successful.

Table 21: San Diego DMC-ODS CalOMS Legal Status at Admission, CY 2022

	County		Statewide	
Admission Legal Status	**#**	**%**	**#**	**%**
No Criminal Justice Involvement	6,599	54.07%	57,878	65.62%
Under Parole Supervision by California Department of Corrections and Rehabilitation	366	3.00%	1,675	1.90%
On Parole from any other jurisdiction	151	1.24%	1,465	1.66%
Post release supervision - AB 109	4,373	35.83%	20,314	23.03%
Court Diversion CA Penal Code 1000	-	-	1,326	1.50%
Incarcerated	<11	-	460	0.52%
Awaiting Trial	573	4.70%	5,078	5.76%
Total	**12,204**	**100.00%**	**88,196**	**100.00%**

- Within the DMC-ODS, 54.07 percent were reported to have no criminal justice involvement, lower than the statewide rate of 65.62 percent.

Table 22: San Diego DMC-ODS CalOMS Discharge Status Ratings, CY 2022

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment – Referred	3,559	22.11%	22,790	20.50%
Completed Treatment - Not Referred	1,046	6.50%	7,636	7.53%
Left Before Completion with Satisfactory Progress - Standard Questions	2,059	12.79%	13,465	13.28%
Left Before Completion with Satisfactory Progress – Administrative Questions	998	6.20%	8,322	8.20%
Subtotal	*7,662*	*47.59%*	*50,213*	*49.51%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	2,695	16.74%	17,832	17.58%
Left Before Completion with Unsatisfactory Progress - Administrative	5,532	34.36%	32,329	31.87%
Death	31	0.19%	200	0.20%
Incarceration	179	1.11%	856	0.84%
Subtotal	*8,437*	*52.41%*	*51,217*	*50.49%*
Total	**16,099**	**100.00%**	**101,430**	**100.00%**

- 47.59 percent of discharges in the DMC-ODS were considered satisfactory discharges, with the plurality of members having been rated "completed treatment – referred." A slightly greater proportion of DMC-ODS members were discharged with that rating compared to statewide (22.11 percent vs. 20.50 percent statewide).
- More members (34.36 percent) discharged were rated "left before completion with unsatisfactory progress – administrative," compared to the statewide proportion (31.87 percent).

Table 23: San Diego DMC-ODS CalOMS Types of Discharges, CY 2022

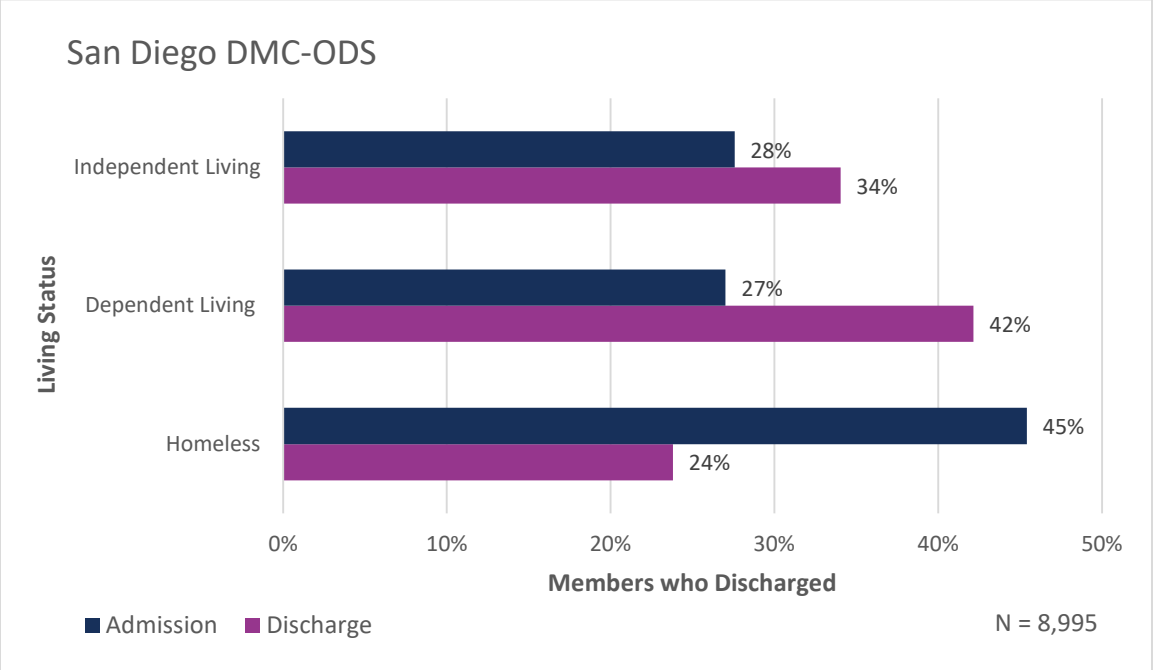
Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	8,013	49.77%	52,677	49.81%
Administrative Adult Discharges	6,740	41.87%	41,707	40.74%
Detox Discharges	982	6.10%	7,233	7.95%
Youth Discharges	364	2.26%	1,813	1.50%
Total	**16,099**	**100.00%**	**103,430**	**100.00%**

- The DMC-ODS experienced a 3 percent increase in total discharges since the prior EQR.

- Standard adult discharges were the primary discharge type at 49.77 percent, and increased from the prior year, while the administrative adult discharge rate decreased from 45.4 to 41.87 percent and remains slightly above the statewide rate of 40.74 percent.

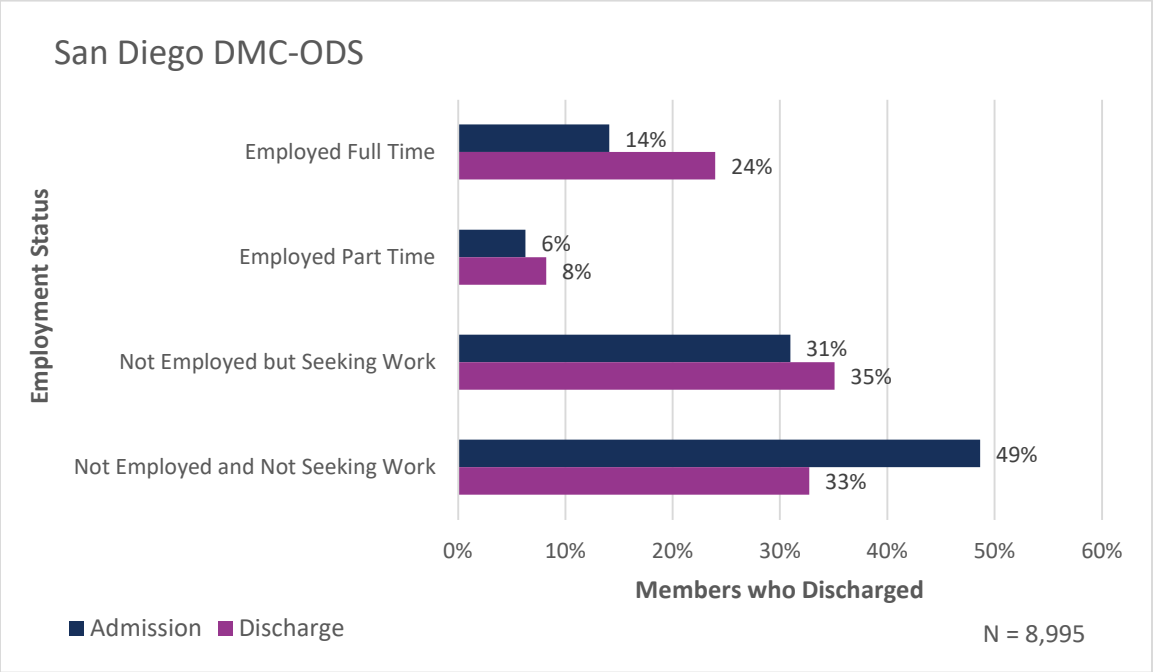
The data presented in Figures 7 and 8 reflect percent change at discharge from admission for both living status and employment status. Both questions are asked in relation to the prior 30 days.

Figure 7: CalOMS Living Status at Admission versus Discharge, CY 2022



- The plurality of DMC-ODS members (45 percent) were homeless at admission, which was an increase from the CY 2021 CalOMS data (36 percent for that CY).
- There was a positive change in living status between admission and discharge for many members, showing improvement in housing stability at the time of discharge.

Figure 8: CalOMS Employment Status at Admission versus Discharge, CY 2022



- In CY 2022, there was an increase for members employed full time between admission and discharge (from 14 to 24 percent). There was also a substantial decrease in members unemployed but not seeking work (from 49 to 33 percent).

IMPACT OF QUALITY FINDINGS

- High rates in the use of MAT including for non-methadone forms indicates MAT is accepted and available on a widespread basis within the DMC-ODS.
- For the members who complete treatment, there is a marked improvement in functioning evidenced by improved employment and housing status indicating the efficacy of care provided for those who remain in care.

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 Plan member satisfaction. They should have a direct Plan member 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.caleqro.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: 07/2022

Date Completed: 03/2024

Aim Statement: "This POD PIP aimed to increase the proportion of OUD pharmacotherapy treatment events among members aged 16 years and older served at the OTPs that continue for at least 180 days (six months) by five percent by March 2024. BHS worked towards this goal by aiming to increase knowledge of the benefits of MAT among members."

Target Population: The member population is individuals aged 16 years or older with OUD and a new pharmacotherapy event for OUD. The PIP Advisory group agreed to narrow the scope of the POD PIP to focus on this population served at the OTPs in the

[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

DMC-ODS with the intent of scaling the project out to the entire DMC-ODS if appropriate.

Status of PIP: Implementation Phase

SUMMARY

As part of CalAIM, the POD Behavioral Health QIP efforts in San Diego County aimed to increase the proportion of members aged 16 and older with an OUD and a new pharmacotherapy treatment event for OUD that continued for at least 180 days (six months) by 5 percent.

Based on the information gleaned from the stakeholder workgroups and the member survey, the evaluation team designed educational interventions aimed at increasing knowledge about the benefits of MAT among those with OUD. They developed a MAT pamphlet and a MAT toolkit. Production of an educational video is being considered as a potential third intervention should the POD PIP be extended for an additional year.

While 180 days since the first member received an intervention have not yet elapsed and any changes which may have occurred as a result of the PIP interventions cannot yet be assessed, it can be reported that as of February 12, 2024, 150 unique members received at least intervention #1 and/or intervention #2.

TA AND RECOMMENDATIONS

As submitted, this clinical PIP was found to have moderate confidence, as while data collection was initially sporadic at one of the pilot sites and data quality concerns identified during routine checks by the PIP evaluation team were deemed to have potentially threatened the validity of the findings, the DMC-ODS reports that both data entry and data quality concerns have since been remedied.

During the review, CalEQRO provided TA to the DMC-ODS as follows:

- Extending the PIP, when coupled with a recently added third pilot site, would provide additional baseline data spanning an additional year.

NON-CLINICAL PIP

GENERAL INFORMATION

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

Date Started: 06/2022

Date Completed: 03/2024

Aim Statement: “By March 1, 2024, this project aims to increase the percent of adult, Medi-Cal-eligible members from pilot EDs referred to peer navigation services connected to the County of San Diego DMC-ODS services within seven and 30 days after an ED visit by 5 percent.”

Target Population: The member population for the FUA Healthcare Effectiveness Data and Information Set (HEDIS) measure is individuals aged 18 years or older with an ED visit at a participating pilot hospital who have a principal diagnosis of Alcohol or Other Drug (AOD) abuse or dependence. This intervention is limited to adults because children are typically seen at a hospital which is not currently one of the pilot EDs.

Status of PIP: Implementation Phase

SUMMARY

In collaboration with the National Alliance on Mental Illness (NAMI) of San Diego and Imperial Counties, the DMC-ODS will integrate PeerLINKS program staff into pilot EDs. PeerLINKS program staff are comprised of certified peers that offer system navigation and support for a variety of needs (e.g., transportation, Medi-Cal eligibility, etc.) to Plan members in the ED for future BH treatment, both during their visit and post-discharge. PeerLINKS program staff or other care team members then endeavor to connect members to experienced BHS navigation staff to be linked with appropriate treatment services as quickly as possible. If member entry into treatment is not achieved, then a desired endpoint is the distribution of a concise, business card-sized information resource, which emphasizes the ACL and the NAMI PeerLINKS program.

TA AND RECOMMENDATIONS

As submitted, this non-clinical PIP was found to have low confidence due to numerous factors that affected the methodology of the study. For example, the length of time to get a data sharing agreement and referral process in place between PeerLINKS and the pilot EDs impacted the low rate of referrals to date. Also, development of the resource cards included a lengthy review and approval process by both NAMI and BHS prior to printing and disseminating to members. This process delayed the roll-out of the resource cards significantly. Moreover, Title 42, Part 2, within the Code of Federal Regulations (Confidentiality of Substance Use Disorder Patient Records), makes it very difficult for any information sharing between the various stakeholders to communicate and work to improve the connection to services for members once discharged from the ED. Finally, San Diego targeted specific hospitals with this intervention, aware that the unhoused population are not connected after discharge. The challenges inherent in contacting unhoused members led to difficulties for PeerLINKS and managed care plans (MCP) with post-ED discharge follow-up efforts.

During the review, CalEQRO provided TA to the DMC-ODS in the form of feedback on this non-clinical PIP, including discussion of data aggregation issues, population selection criteria, and challenges related to intervention roll-out.

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 SanWITS, which has been in use for 17 years. Currently, the DMC-ODS is actively implementing a new system (SmartCare), as part of the CalMHSA semi-statewide EHR initiative. This implementation requires heavy staff involvement to fully develop, with the goal to go-live September 2024.

Approximately 4 percent of the DMC-ODS budget is dedicated to supporting 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 San Diego Health and Human Services Agency and Budget Offices.

The DMC-ODS has 848 named users with log-on authority to the EHR, including approximately 155 county staff and 693 contractor staff. Support for the users is provided by 23.12 full-time equivalent (FTE) IS technology positions. Currently there is a 0.5 FTE vacant position, and there was an increase of 7.37 FTE positions due to increased vendor and contracted IS support.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the DMC-ODS' EHR. While all contract providers enter service data directly into the DMC-ODS EHR, not all providers utilize the ability to directly enter clinical documentation and maintain a separate EHR for clinical data. 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 members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 24: San Diego DMC-ODS Contract Provider Transmission of Information to DMC-ODS EHR

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%

PLAN MEMBER PERSONAL HEALTH RECORD

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The DMC-ODS does not currently have a functioning PHR, though it anticipates one will be implemented in the next year under the new SmartCare system.

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. The DMC-ODS does not currently provide access to the EHR to any external agencies.

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 Plan member 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 25: 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:

- The DMC-ODS places a high value on IT infrastructure and data analytics. IS and data analytics resources were increased from the prior EQR to support the DMC-ODS system of care. A new IS Principal position was created to support EHR development, which will be a vital role as the DMC-ODS transitions to the SmartCare EHR. Budgeted support for the DMC-ODS IS infrastructure is 4 percent of the overall department budget.
- The Medi-Cal claims process meets all of the stated metrics of fiscal and billing training, consistent claiming volume, and formal claiming procedures, with the DMC-ODS claim denial rate (1.48 percent) at less than half the statewide average of 3.64 percent.
- Regarding the integrity of data collection and processing, while other metrics were in place, the absence of a data warehouse is the only missing component, leading to a rating of partially met for this key component.
- In assessing interoperability, there is currently no DMC-ODS participation within an HIE and a no reported electronic data exchange with external stakeholders, leading to a rating of partially met for this key component. Data exchange and interoperability is especially notable in the system of care with 100 percent of services delivered by contracted providers.

INFORMATION SYSTEMS PERFORMANCE MEASURES

MEDI-CAL CLAIMING

Table 26 shows the amount of denied claims by denial reason, and Table 27 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 2022.

Tables 26 and 27 appear to reflect a substantially complete claims data set for the time frame represented.

The DMC-ODS reports that their claiming is current through January 2024; however, it was also reported that no Medi-Cal reimbursement has been received for FY 2023-24 claims at the time of the review.

Table 26: Summary of San Diego DMC-ODS Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Member not eligible	4,924	$792,235	60.41%
Other Healthcare coverage must be billed first	8,329	$330,455	25.20%
Duplicate/same day service without modifier or other info needed for adjudication	1,199	$162,217	12.37%
Other	99	$16,822	1.28%
Late claim submission	24	$4,963	0.38%
Service location not eligible	27	$4,735	0.36%
Total Denied Claims	**14,602**	**$1,311,427**	**100.00%**
Denied Claims Rate	**1.48%**		
Statewide Denied Claims Rate	**3.64%**		

- The top three denial reasons account for $1.2 million, and almost 98 percent of the denied claims amount.
- The DMC-ODS denied claims rate is less than half the statewide denial rate.

Table 27: San Diego DMC-ODS Claims by Month, CY 2022

Month	# Claim Lines	Total Approved Claims
Jan-22	61,189	$6,108,299
Feb-22	72,515	$5,977,046
Mar-22	84,407	$7,346,976
Apr-22	82,753	$7,198,681
May-22	84,996	$7,500,230
Jun-22	81,504	$7,057,773
Jul-22	81,974	$7,495,825
Aug-22	85,457	$8,085,883
Sep-22	81,411	$7,564,339
Oct-22	84,547	$7,773,184
Nov-22	81,919	$7,577,191
Dec-22	83,910	$7,793,749
Total	**966,582**	**$87,479,178**

- The DMC-ODS had a relatively stable volume of claim lines across CY 2022.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The DMC-ODS has decided to transition from the SanWITS EHR to the SmartCare system under the multi-county EHR initiative coordinated by CalMHSA. San Diego already began a transition to SmartCare for the MHP, so this alignment under a single EHR is anticipated to provide efficiencies in future development, data collection and analytics, and interoperability efforts, as all resources will be focused on a single system.
- The decision to align both the MHP and DMC-ODS services under a single EHR does offer potential long-term efficiencies, however multiple DMC-ODS development projects will be delayed or require reassessment under the new EHR including but not limited to: PHR functionality, a contract/invoice management system, interoperability with contract provider EHRs, and billing updates tied to CalAIM. Due to these delays and the transition targeted for September 2024, many of these initiatives and related functionality may not be in place prior to the next EQR.
- While the DMC-ODS has updated Medi-Cal claiming under CalAIM payment reform, the lack of reimbursement for the submitted FY 2023-24 claims impacts cash flow and resources needed to support the system of care.

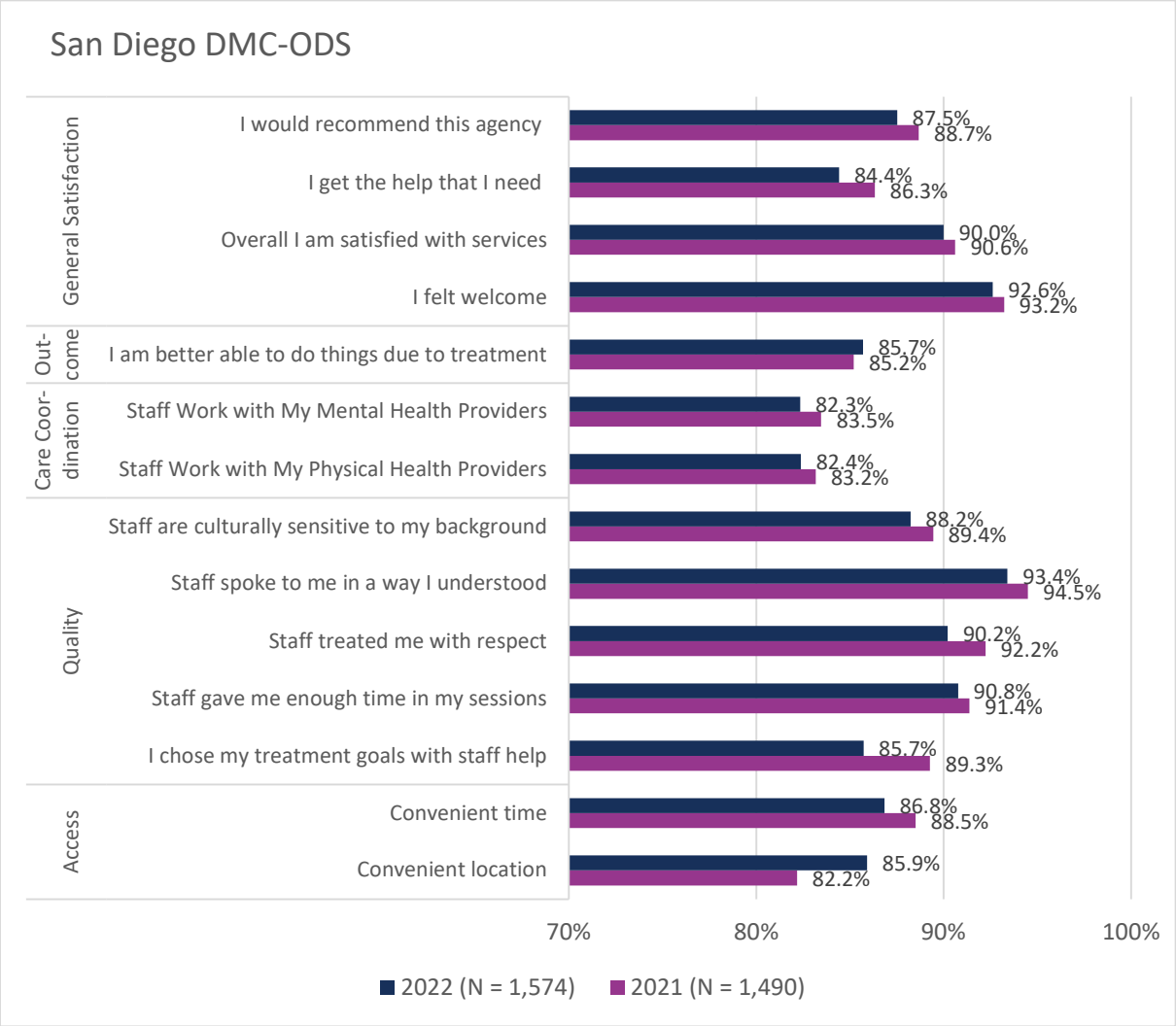
VALIDATION OF PLAN MEMBER PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

The TPS consists of ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. DMC-ODSs administer these surveys to members 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 had a six percent increase in participants from the prior year TPS with ratings lower in most domains. The DMC-ODS received highest ratings in the Quality and General Satisfaction domains, and the lowest ratings were seen in the Care Coordination domain.

Figure 9: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA



** Note that the horizontal axis begins at 70% in order to display small differences in responses from year to year.*

- The largest increase in rating from the prior TPS was for convenient location, and the largest decrease in a rating was members in agreement that they chose treatment goals with staff help.

PLAN MEMBER/FAMILY FOCUS GROUPS

Plan member and family (PMF) 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 PMF 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 Plan members, containing 10 to 12 participants each.

PLAN MEMBER/FAMILY FOCUS GROUP ONE SUMMARY

CalEQRO requested a diverse group of adult Plan members who initiated services in the preceding 12 months. This focus group was held virtually and included eight participants; a language interpreter was not needed for this focus group. All Plan members participating in the session receive clinical services from the DMC-ODS.

All eight participants had initiated services in the past 12 months. Intake processes were felt to be swift and relatively easy, with strong care coordination with external agencies (probation, courts, etc.) as well as with members' medical and MH providers, including ensuring that members are made aware of the potential benefits of MAT. Community integration activities such as Alcoholics Anonymous and Narcotics Anonymous (AA/NA) meetings, sponsor visits, etc., are provided by program staff, some of whom are peer providers with lived experience. Personalized care planning is evident and extends to the individualized manner in which on-site relapses are handled by program staff, whom members feel to be extremely approachable, supportive, and culturally sensitive.

Recommendations from focus group participants included:

- Reduce redundancy of intake and admission questions, many of which are often asked multiple times at different system touch points, such as during initial telephone screening by the ACL and then again by the accepting treatment provider, who seldom seem to have been provided with any information obtained by ACL during their screening.
- Earned day-pass privileges would be appreciated by participants as a good way to safely begin their sober community reintegration while still remaining in residential treatment.

PLAN MEMBER/FAMILY FOCUS GROUP TWO SUMMARY

CalEQRO requested a diverse group of adult Plan members who initiated services in the preceding 12 months. The focus group was held virtually and included three participants; a language interpreter was not needed for this focus group. All members participating receive residential treatment services from the DMC-ODS.

All three participants had initiated services in the past 12 months. Intake processes were generally seen as both swift and efficient. Culturally aware services are provided in members' preferred language and bilingual staff are present on site. Crisis and access telephone numbers have been shared with participants, as has information regarding the potential benefits of MAT. Care coordination activities are robust and include assisting members with scheduling/attending medical and/or MH appointments, as well as

supporting members in their interactions with external agencies Child Protective Services, probation, and the courts. The program's community integration activities such as AA/NA meetings, obtaining/meeting with sponsors, etc., are praised by session participants. Person-centered treatment and discharge planning activities were mentioned, and the program's individualized handling of on-site relapses was also praised.

Recommendations from focus group participants for improving care included:

- Allowing family to visit on site to receive education on the disease of addiction and to provide support.
- Participants would welcome the incorporation of their family members in their respective future outpatient treatment.
- Groups could be more structured, with more hands-on resources provided by the program.
- Participants want greater access to recovery residences and transitional housing, and more job seeking assistance.

SUMMARY OF MEMBER FEEDBACK FINDINGS

- Intake assessments as well as the overall admission process itself were noted to be convenient and timely by the majority of participants within each residential program.
- Good coordination between both treatment programs and participants' external physical and MH providers is evident.
- Community integration is a vital aspect of addiction treatment and both programs provide meaningful relevant activities (i.e., alumni meetings, AA/NA panels, etc.)
- Both treatment programs discussed demonstrate a commitment to providing individualized care (i.e., not automatically discharging a member from care who has relapsed while in treatment).

CONCLUSIONS

During the FY 2023-24 annual review, CalEQRO found strengths in the DMC-ODS' programs, practices, and IS that have a significant impact on member 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. San Diego's MAT service delivery system exhibits an impressive degree of collaboration between its 10 OTPs, which provide methadone and buprenorphine to over 5,000 members. They adopted flexible take-home dosing models without requiring daily visits to obtain doses based on program progress. Moreover, MAT services are expanding to outpatient clinics within the DMC-ODS, some of which have begun launching integrated MAT services with grant funding and increased partnerships. (Access, Quality)
2. The DMC-ODS' system of care for youth evidences a robust and well-integrated network of alliances and partnerships spanning across outpatient teen recovery centers, school-based services, justice system partnerships and strong coordination with allied MH and physical health providers. (Access, Quality)
3. Exceptional levels of inter-agency coordination with allied partners, such as courts and probation, vital for assuring access to substance use services for members involved with the criminal justice system, is evident in San Diego. (Access, Quality)
4. The decision to align the DMC-ODS EHR with the current MHP EHR transition has the potential to provide substantial efficiencies in system administration efforts as well as providing a framework for integration of data collection, reporting, and interoperability development moving forward. (IS)
5. The continued investment in county IS and Data Analytic resources speaks to the effort being made in improving the quality and availability of data to inform the system of care. Notable progress is seen since the prior EQR tied to prior recommendations, including the addition of the IT Principal position. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The DMC-ODS has a small number of WM beds (77) relative to the need of a large county that provided SUD services to more than 11,000 members in CY 2022. Expanded access to WM services, whether standalone, embedded within residential treatment settings or provided elsewhere within the healthcare system, would expedite an increased number of members entering into treatment. (Access, Timeliness, Quality)

2. Feedback obtained during focus groups with providers revealed a need for expanded bed capacities in both residential treatment and recovery residences. (Access, Timeliness, Quality)
3. The lack of a formal referral management process and care coordination with the DMC-ODS' ACL appears to be impacting the timeliness of transitions between LOCs. (Access, Timeliness)
4. While San Diego has taken steps at improving bi-directional communication with contract providers since the last EQR cycle, providers expressed a need for greater transparency and sense of collaboration in their interactions with the DMC-ODS. (Quality, IS)
5. The recent decision to transition from the SanWITS EHR to the SmartCare EHR impacts many high-priority system development projects that have been in process. The timeline for system functionality will now be delayed due to the shift to a new system. (IS)

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 member outcomes:

1. San Diego should strive to increase system capacity for member access to WM services; it may wish to research evidence for the pairing of ambulatory WM services with residential treatment and identify strategies to resolve billing system barriers such as the "same day billing matrix lock outs" that currently prevent such coupling. An innovative approach that the DMC-ODS should continue to explore is the integration of recuperative care facilities with its health plan partners. This could serve as a bridge between hospitals and SUD treatment programs for members experiencing severe withdrawal symptoms who need of a greater degree of medical support than can be provided in residential settings but are not sufficiently infirm to warrant acute hospitalization. (Access, Quality)
2. The DMC-ODS should continue its efforts to build more system capacity in both residential treatment and recovery residences. As it did with identifying an overdose "hot spot" in the South Bay and adding treatment slots targeting that region, San Diego should consider harnessing the power of its epidemiology and public health teams in prioritizing the location(s) of such expanded access to residential treatment and recovery residence beds. (Access, Quality, IS)
3. The DMC-ODS should seek to revise the structure and processes of the ACL in order to provide referral management and the ability to provide initial ASAM assessment for member callers seeking services in lieu of simply providing program referral information. If this is not feasible within the ACL program structure, a referral management team would assist members in having timely access into care, and support transitioning between LOCs. (Access, Timeliness)

4. The DMC-ODS should develop improved and more transparent communication pathways with its providers while continuing to engage with them to improve data tracking, analysis, and integrity via groups such as the SUD provider association. Expanding the presence and availability of workgroups and tip sheets designed to address provider confusion on billing matters and taking a leadership role in clarifying complex fiscal and payment concerns would be well received by San Diego's contracted agencies. (Quality, IS)

   (This recommendation is a carry-over from FY 2022-23.)

5. San Diego should be proactive in exploring SmartCare functionality to fully implement available system options upon transition. Collaboration with other counties implementing SmartCare may provide information on current system limitations to enable the DMC-ODS to prepare for future projects or identify alternative solutions. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

The DMC-ODS identified no barriers to this FY 2023-24 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 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, and 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 Member Satisfaction
Plan Member/Family Focus Group(s)
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 supervisors group interview – county and contracted
Clinical line staff group interview – county and contracted
Recovery support services group interview including staff with lived experience – county and contracted
Site visits such as residential treatment (youth, perinatal, or general adult), WM, access center, MAT induction center, and/or innovative program
Key stakeholders and community-based service agencies group interview
Closing session: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Eric McMullen, Lead Quality Reviewer
Anita Catapusan, Quality Reviewer
Joel Chain, Information Systems Reviewer
Katie Faires, 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
Adams	Theresa	Assistant Sheriff	San Diego County She
Amacher	Carlie	Utilization Review QI Supervisor	SDCBHS – Network Qu Planning
Ascencio	Ozcar	Program Manager	Vista Hill Foundation
Bauers	Brian	Executive Director	The Way Back
Bergmann	Luke	Director	SDCBHS
Blanchard	Michael	Behavioral Health Program Coordinator	SDCBHS - Quality Management - SUD
Biondi	Mindy	Manager	Optum - ACL
Boatman	Courtney	Director of Addiction Programming	Union of Pan Asian Co
Booker	Sheila	Behavioral Health Intake Counselor	Optum - ACL
Bowman	Shellie	Director	Interfaith
Briones	Melanie	Program Coordinator	SDCBHS – Local Opioi Authority
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum
Cacho	Janet	Behavioral Health Program Coordinator	SDCBHS – Healthcare
Ceballos	Patricia	Reentry Services Manager	San Diego County She
Ceja	Ramon	Program Manager	McAlister Inc. – Teen R Center East
David	Nora	Assistant Medical Services Administrator	SDCBHS – QI
Emerson	Cynthia	Principal Administrative Analyst	SDCBHS – Manageme Systems
Esposito	Nicole	Chief Population Health Officer	SDCBHS – Population
Evans Murray	Cara	Deputy Director	SDCBHS – Programs a
Eftehkari	Alisha	Assistant Medical Services Administrator	SDCBHS – Programs a

Last Name	First Name	Position	County or Contracted Agency
Felix	Delia	Administrative Analyst II	SDCBHS – Data Sciences
Gallacher	Veronica	Assistant Medical Services Administrator	SDCBHS – QI
Gaspar	Mayra	SUD Counselor	TURN BHS - North Inland Teen Recovery Center
Garcia	Piedad	Deputy Director	SDCBHS – Programs and Services
Gomez	Olivia	Program Director	El Dorado (OTP)
Gonzaga	Alfie	Program Coordinator	SDCBHS – Health Plan Administration
Guevara	Christopher	Program Coordinator	SDCBHS – Data Sciences
Hardge	Carly	Program Manager	McAlister Inc. - South Teen Recovery Center
Hayes	Skylar	Reporting and Application Development Manager	Optum
Higgins	Alan	Data Analytics Manager	Optum
Houghton	Catherine	Utilization Review Quality Improvement Specialist	SDCBHS – Network Quality and Planning
Jackson	Shannon	Behavioral Health Program Coordinator	SDCBHS – Programs and Services
Johnson	Judith	Program Manager	TURN BHS – North County Center for Change
Kang	Teresa	Behavioral Health Program Coordinator	SDCBHS – Programs and Services
Kattan	Jessica	Medical Consultant	SDCBHS – Inpatient Health Services
Kelly	Channa	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Kemble	Derek	Program Coordinator	SDCBHS – Data Science
Kiviat Nudd	Aurora	Assistant Director and Chief Operations Officer	SDCBHS
Kneeshaw	Stacey	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Koenig	Yael	Deputy Director	SDCBHS – Programs and Services

Last Name	First Name	Position	County or Contracted Agency
Kort	Marie	Utilization Review Quality Improvement Specialist	SDCBHS – Network Quality and Planning
Krelstein	Michael	Chief Medical Officer	SDCBHS – Clinical Director's Office
Lang	Tabatha	Operations Administrator	SDCBHS - Health Plan Operations Unit
Lao	Shentelyn	Program Manager	Interfaith
Lao	Stephanie	Agency Programs and Operations Manager	SDCBHS – Population Health
Loberia	Ana	Program Director	McAlister Inc – South Bay Women's Recovery Center
Loyo-Rodriguez	Raul	Department Budget Manager	SDCBHS – Strategy and Finance Unit
Luu	Peter	Contractor – Data Analyst	Rady
Madden	Matthew	Program Manager	El Dorado Community Services
Marquez	Samantha	Administrative Analyst I	SDCBHS – Health Plan Administration
Martinez	Olivia	Utilization Review Quality Improvement Specialist	SDCBHS – Network Quality and Planning
Matsuda	Mariko	Program Manager	TURN BHS
McNamara	Amanda	Research Associate	UCSD - Health Services Research Center
Medrano	Francisco	Behavioral Health Program Coordinator	SDCBHS – Healthcare Oversight
Mendoza	Thomas	Administrative Analyst I	SDCBHS – Data Science
Miles	Liz	Program Coordinator	SDCBHS – Population Health, QI
Mockus-Valenzuela	Danyte	Health Planning and Program Specialist	SDCBHS – Prevention and Community Engagement
Morgan	Maria	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Morgan	Tiffany	Manager	Optum ACL

Last Name	First Name	Position	County or Contracted Agency
Nambo	Cynthia	Program Coordinator	San Diego County Medical Care Services
Nwabueze	Conscilla	Utilization Review Quality Improvement Specialist	SDCBHS – Network Quality and Planning
Nishihara	Emi	Administrative Analyst II	SDCBHS - Data Science
Nunez	Francisco	Program Manager	TURN BHS
Panczakiewicz	Amy	Senior Evaluation Research Associate	UCSD - Health Services Research Center
Pauly	Kimberly	Deputy Director	SDCBHS – Programs and Services
Pearson	Luisa	Case Manager	McAlister Inc – North Coastal Women's Recovery Center
Post	Dave	Administrative Analyst III	SDCBHS - Data Science
Preston	Kristie	Director	Optum ACL
Privara	Nadia	Assistant Director	SDCBHS
Quach	Phuong	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Quijas	Stephanie	Licensed Practitioner of the Healing Arts (LPHA)	McAlister Inc - Southbay Women's Recovery Center
Quiroz	Melissa	Mental Health Director	San Diego County Sheriff's – Medical Services Division
Ralph	Christina	Commander	San Diego County Sheriffs
Ramos	Nilanie	Chief, Agency Operations	SDCBHS – Clinical Director's Office
Rheuby	Vanessa	Program Manager	Interfaith
Riley	Claire	Behavioral Health Program Coordinator	SDCBHS – Programs and Services
Romo	Isabella	LPHA	Vista Hill – Bridges Teen Recovery Center
Salazer	Lisa	Program Director	HealthRIGHT 360
Sarabia	Brenda	Deputy Director	SDCBHS – Programs and Services

Last Name	First Name	Position	County or Contracted Agency
Shapira	Erin	Program Coordinator	SDCBHS - Quality Management
Shucart	Mason	Data Analyst I	Optum
Soto-Meza	Gloria	Captain – Detentions	SD County Sheriffs
Spain	Shannah	QA Specialist	Vista Hill ParentCare- East
Sternberg	Joseph	SUD Counselor	The Way Back
Stone	Danny	Vice President	TURN Behavioral Health Services
Tally	Steve	Assistant Director of Evaluation Research	UCSD - Health Services Research Center
Thihalolipavan	Sayone	Public Health Medical Officer	San Diego County Medical Care Services
Thorpe	Mychele	Behavioral Health Intake Counselor	Optum – Access and Crisis Line
Thornton-Stearns	Cecily	Assistant Director	SDCBHS
Tomic	Tatjana	Chief, Agency Operations	SDCBHS - Data Science
Tomimatzu	Ashley	Administrative Analyst I	SDCBHS - Data Science
Tran	Phuong	Administrative Analyst III	SDCBHS - Data Science
Valdez	Alfie	Behavioral Health Program Coordinator	SDCBHS – Programs and Services
Vargas	Angel	Behavioral Health Program Coordinator	SDCBHS – Programs and Services
Varond	Marisa	Executive Director	McAlister Inc.
Wan	Katherine (Katie)	Senior Evaluation Research Associate	UCSD - Health Services Research Center
White-Voth	Charity	Deputy Director	SDCBHS – Programs and Services
Williams	Seth	Behavioral Health Program Coordinator	SDCBHS – Population Health
Wilson	Samantha	Utilization Review Quality Improvement Specialist	SDCBHS – Network Quality and Planning
Wood	Katie	Director	Family Health Centers of San Diego

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	As submitted, this clinical PIP was found to have moderate confidence, as while data collection was initially sporadic at one of the pilot sites and data quality concerns identified during routine checks by the PIP evaluation team were deemed to have potentially threatened the validity of the findings, the DMC-ODS reports that both data entry and data quality concerns have since been remedied.
General PIP Information	
MHP/DMC-ODS Name: San Diego	
PIP Title: Pharmacotherapy for Opioid Use Disorder (POD)	
PIP Aim Statement: "This POD PIP aimed to increase the proportion of OUD pharmacotherapy treatment events among members aged 16 years and older served at the OTPs that continue for at least 180 days (six months) by five percent by March 2024. BHS worked towards this goal by aiming to increase knowledge of the benefits of MAT among members."	
Date Started: 07/2022	
Date Completed: 03/2024	
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: Members aged 16 and older
Target population description, such as specific diagnosis (please specify): The member population is individuals aged 16 years or older with OUD and a new pharmacotherapy event for OUD. The PIP Advisory group agreed to narrow the scope of the POD PIP to focus on this population served at the OTPs in the DMC-ODS with the intent of scaling the project out to the entire DMC-ODS if appropriate.
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): Based on the information gleaned from the stakeholder workgroups and the member survey, the evaluation team designed educational interventions aimed at increasing knowledge about the benefits of MAT among those with OUD.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Programs participating in the pilot were instructed to offer both educational materials to all new members with OUD and were given the option to also provide the materials to existing members if they felt that the members would benefit from the information.
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 member registries or data tools): Dissemination of the educational materials were logged via a web-based Qualtrics form.

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. A greater proportion of members aged 16 years and older with a new Medications for Opioid Use Disorder (MOUD) event will continue to receive MOUD for at least 180 days	2022	n=2,660 22%	☒ Not applicable — PIP is in planning or implementation phase, results not available	*n/a: 180 days since the first member received the intervention has not elapsed*	*n/a: 180 days since the first member received the intervention has not elapsed*	☐ 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: San Diego reports that it resolved the initial data quality concerns that emerged from pilot ED sites in February 2024. Moreover, as part of routine monitoring of the PIP, the DMC-ODS asserts that its evaluation team intends to conduct ongoing data quality checks quarterly, with the next quality review scheduled to occur in May 2024.

NON-CLINICAL PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	As submitted, this non-clinical PIP was found to have low confidence, due to numerous factors affecting the methodology of the study. Firstly, the length of time to get a data sharing agreement and referral process in place between PeerLINKS and the pilot EDs impacted the low rate of referrals to date. Secondly, the 42 CFR law makes it very difficult for any information sharing between the various stakeholders. Lastly, San Diego has had to grapple with the myriad challenges inherent in contacting unhoused members, leading to difficulties for PeerLINKS and MCPs with post-ED discharge follow-up efforts for this member subset.
General PIP Information	
MHP/DMC-ODS Name: San Diego	
PIP Title: Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	
PIP Aim Statement: By March 1, 2024, this project aims to increase the percent of adult, Medi Cal eligible members from pilot EDs referred to peer navigation services connected to the County of San Diego DMC-ODS services within seven and 30 days after an ED visit by five percent.	
Date Started: 06/2022	
Date Completed: 03/2024	
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 member population for the FUA HEDIS measure is individuals aged 18 years or older with an ED visit at a participating pilot hospital who have a principal diagnosis of AOD abuse or dependence. The reason this intervention is limited to adults is because within the system of care, children are typically seen at a hospital which is not currently one of the pilot EDs.
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): Members will use the information handout post discharge to obtain information about the range of substance use services available to them.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): ED staff will provide members visiting the ED for a substance use-related condition with an informational handout.
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 member registries or data tools): The DMC-ODS will integrate PeerLINKS program staff into pilot EDs. They will oversee the project data collection, reporting and analysis.

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. The proportion of members with an ED visit with a principal diagnosis of AOD abuse or dependence that were referred to peer navigator services and/or received a resource card will be connected to BHS DMC-ODS within seven days of the ED visit.	October 2023 (PeerLINKS) January 2024 (Resource Card)	TBD – not enough date to analyze	TBD	TBD	TBD	TBD
PM 2. The proportion of members with an ED visit with a principal diagnosis of AOD abuse or dependence that were referred to peer navigator services and/or received a resource card will be connected to BHS DMC-ODS within 30 days of the ED visit.	October 2023 (PeerLINKS) January 2024 (Resource Card)	TBD – not enough date to analyze	TBD	TBD	TBD	TBD

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 ☒ Implementation phase ☐ Planning 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: San Diego should in future performance improvement projects, have a more realistic understanding of the length of time it will be necessary to get data sharing agreements and referral processes in place between external agencies. Also, in future PIP's, the DMC-ODS should better anticipate the often lengthy review and approval processes needed by stakeholder agencies prior to rolling out system-wide changes. Similarly, San Diego should now be better able to more deftly plan for the myriad follow-up challenges associated with any future interventions targeting the unhoused population.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, ATA form, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the CalEQRO website: www.caleqro.com

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

A letter from the DMC-ODS Director was not required for this report.