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FY 2018-19
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

SANTA CLARA COUNTY DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
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SANTA CLARA COUNTY DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Calendar Year 2017 — 2404 Medi-Cal beneficiaries in DMC-ODS
Santa Clara Threshold Language(s) — Spanish, Vietnamese, Mandarin, Tagalog, Chinese, Farsi
Santa Clara Size — 1,938,153 population (US Census)
Santa Clara Region — Bay Area
Santa Clara Location — South of San Mateo County, west of Santa Cruz County
Santa Clara County Seat — San Jose
Site Review Process Barriers— none

Introduction

Santa Clara County officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in June 2017 for Medi-Cal recipients as part of California's 1115 Drug Medi-Cal Waiver. Santa Clara County was the third to launch in California's Bay Area Region and fourth statewide. In this report, "Santa Clara" shall be used to identify the Santa Clara County DMC-ODS program unless otherwise indicated. Santa Clara is part of an integrated care model with mental health, which began in the past year to provide more comprehensive treatment to those with behavioral health disorders.

Santa Clara County, according to US Census Bureau, is the sixth most populous county in California and has been considered the "hub" of the technology industry in the US. The population is almost 2 million individuals, and there are many major technology businesses such as Apple, Google, Hewlett-Packard, and others. The county also has very high housing costs with current estimates by the San Jose Mercury News (June 2018) listing the median price as $935,000. Santa Clara County has a large area stretching from Gilroy in the south to Palo Alto in the north and is primarily urban and suburban. There are many prominent colleges as well, including Stanford and Santa Clara Universities, and Cal State University, San Jose.

The population is 22.2 youth and 13.1 percent older adult with a significant amount of diversity including a large Latino population of 25.6 percent and a diverse Asian population of 37.5 percent. This is reflected in the number of threshold languages including Spanish, Vietnamese, Mandarin, Tagalog, Cantonese, and Farsi. Documents were available in threshold languages at the program sites.

The Santa Clara Alcohol and Drug Program Administrator and division staff began developing a system of care for substance use services several years before the DMC-ODS Waiver and were active in committees to formulate the waiver. They had historically used the American Society of Addiction Medicine (ASAM) criteria for assessments and determining optimal treatment, and they had established an Access

Call Center (referred to as Gateway by Santa Clara) years before the waiver began to coordinate access to services. They began very early to acculturate county staff and network provider programs to a managed system of care orientation that incorporated matching clients to appropriate level of care placements and promoting client-centered treatment planning. Nonetheless, with staff turnover and program changes additional training was provided to prepare for the waiver launch and continues to be provided including by Dr. Mee-Lee, who is one of the physician architects of the ASAM treatment system.

During the fiscal year 2018-19 (FY 2018-19) Santa Clara review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to Drug Medi-Cal access, timeliness, quality, and outcomes related to the first- year implementation of Santa Clara DMC-ODS services. The FY 2018-19 review utilizes 2017-18 data for the review and Santa Clara DMC-ODS activities for the same period. EQRO reviews are retrospective reviews.

Access

Santa Clara County Medi-Cal beneficiaries may access services in a variety of ways within the DMC-ODS, including by contacting the Access Call Center's 800 number for a screening and referral, or through direct referrals from the Santa Clara County hospital or specific outside agencies. The Access Call Center Line is a county-operated service that is operated by trained staff who provide a brief ASAM screening and then refer to a provider for a full ASAM assessment at the indicated level of care (LOC). The Access Call Center is also used for significant SUD information and referral activities. If a client comes directly to a community program, the provider insures the client is called in to be screened and log the first request for services. The Access Call Center, called Gateway, is not an integrated service with mental health. The Access Call Center received an average of 2,301 calls per month from July 2017 to June 2018.

The staff are well trained in the use of ASAM Criteria to screen and refer clients into appropriate treatment. ASAM Criteria are evidence-based and well-established internationally for matching clients to treatments and form the clinical core of the 1115 DMC-ODS Waiver Standard Terms and Conditions (STCs). The Access staff training in ASAM Criteria began in October 2014, well in advance of the county's implementation of the DMC-ODS Waiver. Santa Clara also checks the accuracy of the screening tool and processes used by their staff and have found it to match the outcomes of the full ASAM assessments by over 90 percent.

The Access Call Center Line is especially useful for prospective clients who are unfamiliar with the provider network or unable to determine what treatment might be best to address their situation. Access Line staff will provide a prospective client with a brief clinical screening based upon ASAM Criteria and make a referral for the prospective client based primarily upon the ASAM Criteria findings from the screening and considering any strong preferences the prospective client may have. The treatment

program to which the person is referred will provide a full ASAM assessment and make a more definitive determination of the appropriate level of care. If the determination is for a different level of care, then the program will initiate a transfer. If the program to which the person is to be admitted is residential treatment, then Quality Improvement Coordinators authorize the residential treatment.

The county uses state of the art call center software through Cisco for monitoring the accessibility of the SUD services to callers. Reports are produced that monitor: the percentage congruence between the suggested level of care based upon ASAM Criteria findings and the actual referral made by the ACCESS (Gateway) screeners. Approximately 20% receive a direct placement to outpatient providers who do not have open access. Clients who are sent directly to an open access agency do not have a specific appointment time, so the interval between screening and appointment cannot be computed at this time. Open access agencies generally process clients on the same day for their assessment.

The primary issue for resolution in the Access Call Center Line (Gateway) was related to clients who called for services. If the capacity was not present at the time the prospective client called in requesting services, then the prospective client was instructed to call back the next day. These clients must be called back to ask them about their desire for treatment or other supports even if they do not call back and to arrange access to address their requests and continued need. Many counties have walk-in services at specific sites to address timely access for offered appointments. Santa Clara also has a number of outpatient agencies that offer walk in appointments for assessments and referrals to treatment. As reflected above, these clients are referred by Gateway.

Santa Clara added withdrawal management (WM) services into the Medi-Cal continuum of care, but additional capacity was identified as a need, and thus new beds are being added as part of residential programs specifically for WM. They also added a contract with a Narcotic Treatment Program (NTP) in San Mateo County to serve north county residents.

Santa Clara also set up a direct referral process for persons coming out of the county hospital with SUD needs who can be assessed and directed into appropriate treatment. Tracking data from these urgent requests into an urgent request timeliness report should be a goal for year two.

Santa Clara added outpatient capacity as the number of calls into the Access Call Center exceeded capacity for the service. Santa Clara plans to add more outpatient slots in the immediate future.

Santa Clara expanded MAT mobile services to residential treatment centers and Partial Hospitalization and next year plans to expand into detention centers for maintenance and initiation of MAT.

The waiver provided opportunities for expanded service capacity and the range of services for Drug Medi-Cal beneficiaries, and the county used geo-mapping and analysis of demand data to guide the expansion, so they could be confident that there would be services within close mileage and drive time to all beneficiaries. Network providers already operating services under other funding were able to obtain Drug Medi-Cal certification for those services, which included residential withdrawal management and residential treatment. These providers also became eligible to bill Medi-Cal for new services including case management, recovery support, and physician consultation.

For nearly two decades, residential treatment has been used for stabilization in Santa Clara County. The length of stay is generally short for residential and is focused on individualized treatment needs. Since the population being served are often homeless or living in environments with active drug use, it became more critical that stepdown care from residential treatment include both outpatient and sober living environments (SLEs, referred to in this report as Recovery Residences). Santa Clara continues to work on homeless issues and expanded Recovery Residences. They are created a new sobering center approximately one year ago for local residents with drug and alcohol issues for law enforcement and others to use to provide a safe place for withdrawal from alcohol and other drugs. They also created an educational video for law enforcement on this service.

Santa Clara has plans for year two of the waiver to expand the continuum to include ASAM 3.3 residential and 3.5 residential for Clinically Managed High-Intensity services per the ASAM requirements.

Timeliness

As part of the preparation for the waiver implementation, Santa Clara refined its capabilities to track timeliness data. Staff worked with contract providers and county programs, discussed with them the reasons for timeliness tracking, and incorporated the new responsibilities into their provider contracts. Existing SUD programs and systems were thoroughly reviewed six months after the launch of the waiver (June 2017) and the results were documented in a report called the “180 Scan” provided to the review staff to show system metrics including access and timeliness, as well as key quality measures that were part of their quality improvement plan and evaluation. This effort showed capacity to use data to identify system problems and challenges as well as successes, and where they needed to take corrective action. It was a strong indication of the commitment to quality of care linked to ASAM principles.

Santa Clara uses Access Call Center data in combination with ProFiler data to track timely access to care. At the time of the review, Santa Clara had just decided for the SUD programs to have their clinical documentation system be AVATAR by Netsmart and not go on to a system linked to EPIC Care because of confidentiality restrictions and the risks associated with a breach in confidentiality. Therefore, the AVATAR system can be modified to provide timeliness data linked to clinical documentation and events using the scheduling module, as well as the claims tracking system. Because of

this recent decision, some of the desired functionality was not yet in place, but the staff had designed the desired workflows and data points in preparation for a new electronic health record.

The current system can track requests for services by phone, but not walk-in requests or external referrals except the hospital requests. The operational definition used for urgent by Santa Clara includes WM services. The Gateway Call Center currently offers scheduled appointments at different provider sites and can monitor the success of these referrals by monitoring Profiler admission data (the Santa Clara EHR) for those events.

The new AVATAR system functionality should allow for the tracking of referrals and first appointments in a streamlined manner as well as the outcomes of these referrals via clinical documentation.

Santa Clara also tracks timely access to NTP services and readmissions to WM within 30 days as well as follow-up care post-residential treatment with a goal of achieving access within seven days of discharge to another LOC.

The average length of time from the first request for services to first offered appointment was reported as 11.59 days as a mean for both adults and youth. The mean for adults was 13 days and for youth was 1.76 days with a standard of 14 days for a first offered appointment. Overall, this standard was met by 79.8 percent with clients requesting services. The mean from initial request to the first face-to-face appointment was 13 days for all services and was achieved within the standard of 14 days 52.2 percent of the time. To increase the percentage seen within the standard, Santa Clara is adding 250 more adult outpatient slots. It was reported that as many as 15 prospective clients per day could not be offered appointments at the time of the request, and this added capacity was intended to address the resulting delays in timely access. This will also reduce the need to have clients call back for appointments.

Santa Clara also tracked access to first NTP assessment and dosing. The goal for NTP is three days, and 32 percent of the appointments met this standard. Significant expansion in this area was planned as well. Santa Clara County directly operates the NTPs to provide both methadone and other MAT medications. There are north and south county program locations, and they deliver medications and assessments at residential and other sites. As previously noted, there are also efforts underway to expand access to county detention facilities including initiation and maintenance treatment.

Santa Clara SUTS does not track no shows to initial appointment directly, but can estimate the attrition based on absence of an admission for the referral. Santa Clara is aware of this lack of data and a developing a mechanism to track this type of event. Clients can call for appointments or walk in after hours to WM. These were considered urgent appointments and could be accommodated within one day 92.8 percent of the time, though providers and clients expressed the need for more WM capacity so that referrals to and from the emergency department could be reduced. Residential

providers reported need for immediate access after a relapse and had difficulty with achieving this as the system currently has 20 beds of WM and capacity was usually unavailable.

Authorization of residential treatment is a new and central component of the waiver's blueprint for an organized delivery system. It has the potential to add quality to the system of care, and to create barriers to access. Per the DMC-ODS Standard Terms and Conditions (STCs), the response time to requests for treatment authorizations should be no longer than 24 hours. Santa Clara can review requests within the 24-hour period, which includes using assistance from a 24-hour provider with after hour assessments, and requests. Focus groups did confirm smooth access to care at multiple levels except some WM, which many felt were difficult. Issues of transfer of out-of-county Medi-Cal for new county residents were seen as causing delays in access, except pregnant women who were immediately admitted to services regardless of coverage status.

Quality

Santa Clara acted to promote quality in the last year. There are three distinct committees involved in implementation and quality activities: the monthly Innovative Partnership meeting with the county and contract staff; the Waiver Advisory and Coordination Committee which meets weekly and is a county focused meeting; and the Quality Assurance and Performance Improvement meeting which is a monthly joint county and contract provider meeting. These communication and problem solving activities were appreciated by providers as supporting them in their efforts to ensure best practices, using data to improve care, and compliance with Medi-Cal requirements in charting and in the individualized philosophy of care that is central to ASAM SUD treatment.

For line staff, they created a DMC-ODS compliance-training schedule and updated the beneficiary handbook and published it in all six threshold languages. They disseminated the grievance policy and created an equitable procedure for uninsured constituents. As part of provider contracts, they also implemented quarterly performance measures that align with DMC-ODS metrics and held individual sessions with each contracted provider to assess their metrics and discuss improvements, if needed. They conducted a clinical chart audit review following requirements in the standard terms and conditions (STCs) for the waiver and provided clinical staff and programs feedback.

One of the major quality improvement efforts was the "180 Scan," which was a thorough assessment and evaluation of the programs at the six-month mark post-implementation. This was followed by workshops across the county to discuss the launch of the DMC-ODS, areas needing improvement, capacity needs, systemic challenges linked to new structures and requirements, and many issues linked to the quality of care similar to the key components.

They negotiated MOUs with their two health plans that are being implemented in November 2018 after the Board of Supervisors approves and signs these agreements. They also have worked closely with mental health and physical health to offer treatment rapidly to their high-risk populations and set up special systems with the Santa Clara County Hospital and other health providers. Santa Clara also implemented a direct phone line for primary care referrals for direct coordination of residential referrals.

To address needs of north county residents, they added a contract with an NTP on the north county border in San Mateo County for NTP services. In addition, they added MAT coordination with the County medical center's emergency room with the first dose of MAT being given before patient release and coordination of follow up care post-discharge from the emergency department.

For year two of the waiver, Santa Clara is engaging in several special studies to improve care. They are studying withdrawal management services and the high utilizers for better access and utilization management including the interface with the acute care system. They are also establishing a workgroup to study duplication in paperwork processes from assessments, ALOC (an authorization and assessment for level of care (LOC)form), treatment plans and CalOMS. The goal is to streamline these processes and to have clinical documentation follow the client and be updated where needed instead of having the client "tell their story" and review repetitive questions repeatedly, whenever possible. Many clinical standards will be studied, and the option of having an electronic health record using AVATAR with notes and treatment planning and histories could play a positive role in this process. In addition, many clinical staff expressed frustration and concern that this burden of administrative and clinical documentation was interfering with client engagement and building important rapport and an effective therapeutic alliance with clients.

Another important quality goal for year two is working with health care providers to add ASAM levels of care 3.7 Medically Monitored Intensive Inpatient Services and 4.0 Medically Managed Intensive Inpatient Care. Both of these services are currently not available and high-risk complex clients would benefit from access to this treatment.

Another important goal for year two is to add 250 additional adult outpatient slots to support the goal of treatment on demand when the individual is ready and motivated to engage in treatment for their SUD disorder.

Additional residential capacity was identified by Santa Clara as program needs for year two. The crisis residential center allocated to Mental Health is called Muriel Wright Center and would also help persons with co-occurring disorders needing stabilization before entering an ASAM residential 3.1 or 3.5 setting.

Outcomes

Santa Clara utilized the TPS data to evaluate client satisfaction and therapeutic alliance. They developed a performance improvement project (PIP) to enhance engagement and

reduce dropouts by using the TPS. This is in addition to the regular annual process of using the TPS survey. The administrative PIP focused on enhanced engagement of clients in participation in the TPS and understanding of the importance of the goals.

The CalOMS data is also used to track improvements but it is seen as less reliable because of the structure of the data tool and the process for repeatedly administering it with each change in the program, level of care, or legal entity. This was particularly true when there was a rapid cycle through these levels of care or different programs within a single legal entity.

ASAM data was still being collected and analyzed, and the goal was to enhance and optimize good care by using the assessment to drive placements. Preliminary data showed a 90 percent or more match with the recommended ASAM treatment. The primary reasons for not matching included client preference or issues based on individual family needs and locations.

Client Family Impressions and Feedback

There were three formal focus groups and two informal groups conducted on the review. These included a youth group, women's group, NTP group, and two adult groups, with one in Spanish. Clients of all ages and ethnicities saw the program staff in a very positive way. They frequently described them as truly kind and caring about each individual and their long-term wellness and recovery. There were program suggestions about making the Access Call Center process easier to navigate, getting more individual time with their counselors, and doing more family groups to make the transitions and stresses at home easier. Overall, the clients felt they were well treated by the content and focus of the treatment services and, unlike some other counties, did not feel negativity toward them if they were using MAT to support their recovery. They were concerned about finding affordable housing after their residential programs and others were stressed about needs for better paying jobs to keep the housing and stay in recovery. There were also many smaller suggestions about improvements to the physical plans of the sites, adding more physical activity spaces to relieve stress, hours of services, requests for more home visits, and case management. Overall, clients felt the system was accessible and of high quality.

Preliminary Recommendations

1. Revised Call Center Procedures to offer services to all Medi-Cal clients requesting access to care, regardless if they call back. Per Medi-Cal requirements, the client can be encouraged to call back to speed up access to care but cannot be required to do so to access needed and requested treatment. Several approaches are used to achieve this in other early adopter counties with similar Access Call Centers. Technical assistance is available on this area. All requests for care should be tracked and provided follow-up to offer ASAM screening for services, even if it is beyond the 14-day standard. Document these efforts and the outcomes of the follow-up efforts.

2. Utilize the process of implementing AVATAR clinical tools to identify ways to streamline paperwork processes and support efforts at client engagement and forming effective therapeutic alliances to support retention in treatment, particularly in the first 30 days.

3. Work with health partners, particularly hospitals, for access to medical withdrawal management as well as medically managed inpatient care. This will enhance outcomes and appropriately stabilize clients prior to transfer into community DMC-ODS settings.

4. Develop a plan for enhancing functionality and infrastructure for contract providers to coordinate with the DMC-ODS to coordinate care, reduce duplicative paperwork where possible, and double data entry.

5. Add WM capacity to reduce “churn/recycling” through acute care systems and more effective stabilization, prior to transfer into community settings, both residential, outpatient, and other treatments.

6. Address, as planned, the capacity issues with outpatient assessments by adding outpatient slots and enhancing timely access to care in outpatient for all persons requesting services.

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has received and approved 40 plans for Medi-Cal DMC-ODSs to provide Medi-Cal covered specialty Drug Medi-Cal Organized Delivery System services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. DHCS may contract with up to 40 DMC-ODSs if all requirements including readiness standards and a contract agreement are approved.

This report presents the FY 2018-19 findings of an EQR of Santa Clara by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

Both a statewide annual report and this DMC-ODS-specific report present the results of CalEQRO's validation of twelve performance measures (PMs) for year one of the DMC-ODS Waiver as defined by DHCS. The 12 PMs include:

- Total beneficiaries served by each county DMC-ODS;
- Number of days to first face-to-face DMC-ODS service after referral;
- Total costs per beneficiary served by each county DMC-ODS;
- Cultural competency of DMC-ODS services to beneficiaries;

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

- Penetration rates for clients, including ethnic groups, age, language, and risk factors are validated for access;
- Coordination of Care with physical health and mental health;
- Timely access to medication for narcotic treatment program (NTP) services;
- Timely access and numbers of beneficiaries accessing non-methadone MAT;
- Timely transitions in levels of care (LOC) after residential treatment in year one of the waiver;
- 24-hour access call center line availability to link clients to ASAM assessments and treatment;
- Identification and coordination of the special needs of high-cost beneficiaries (HCB);
- Percentage of clients with three or more withdrawal management episodes and no other treatment to improve engagement.

Performance Improvement Projects[2]

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

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

DMC-ODS Information System Capabilities[3]

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

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

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

Validation of State and County Client/Consumer Satisfaction Surveys

CalEQRO examined the TPS results compiled and analyzed by the University of California, Los Angeles (UCLA) which all DMC-ODS programs administer at least annually in October to current clients, and how they are being utilized as well as any local client/consumer satisfaction surveys. DHCS Information Notice 17-026 (describes the TPS process in detail) and can be found on the DHCS website for DMC-ODS. The results each year include analysis by UCLA for the key questions organized by domain. The survey is administered at least annually after a County has begun services. Counties can use the survey more frequently to monitor these key quality measures. Domains include questions linked to ease of access, timeliness of services, cultural competence of services, therapeutic alliance with treatment staff, satisfaction with services, and outcome of services. Surveys are confidential and linked to the specific SUD program that administered the survey so that quality activities can follow the survey results for services at that site. CalEQRO reviews the UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

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

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

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

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

This means looking at the research-linked programs and standard terms and conditions of the waiver as they relate to best practices, enhancing access to MAT, developing and supervising a competent and skills workforce with ASAM training and skills. The DMC-

ODS should also be able to establish and further refine an ASAM Continuum of Care modeled after research and optimal services for individual clients based upon their unique needs. Thus, each review includes a review of the Continuum of Care, program models linked to ASAM fidelity, MAT models, use of evidence-based practices, use of outcomes and treatment informed care, and many other components defined by CalEQRO in the Key Components section of this report that are based on CMS guidelines and the STCs of the DMC-ODS Waiver.

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

During the last year, Santa Clara began a major re-organization that involved integration of Mental Health and Substance Use treatment programs. In the first phase, the Quality Improvement Departments were merged and a new person was promoted to the lead position overseeing Quality Improvement (QI) programs. In addition, children's programs included co-locations and some integrated access functions that appeared to be working well for DMC-ODS services. Other steps in the integration process will occur over time in a phased process including the Access Call Center Line and some of the crisis and acute services programs.

Past Year Accomplishments and Initiatives

- Santa Clara developed systems and processes to track and report on network adequacy and complete and submit to DHCS the Network Adequacy Certification Tool. Having adequate capacity in the provider network is critical for clients to access care in a timely and appropriate manner.
- In preparation for "going live" with the DMC-ODS on June 15, 2017, new and existing facilities representing most ASAM programs/modalities of service became Drug/Medi-Cal certified and prepared for billing and clinical documentation requirements.
- In quality activities, they disseminated the grievance policy and client handbooks in all six threshold languages and developed guidelines for uninsured clients and those transferring from other counties.
- Santa Clara established a DMC-ODS compliance-training schedule and conducted a clinical chart audit review following DMC-ODS regulatory and IA compliance statutes.
- In addition, updates were completed on the County Health website related to existing and expanded services as well as adding beneficiary documentation on grievances and other processes.
- Santa Clara also created a leadership Waiver Advisory Committee within Substance Use Treatment Services (SUTS) to meet weekly on performance improvement and efforts to insure quality assurance.
- SUTS Physician team involved in MAT and NTP services expanded services in both NTP sites and adding MAT to services including perinatal and planning to expand in the jail and criminal justice system programs. They had also begun delivering medication to residential sites and doing services at those sites. Clients and programs appreciated the mobile MAT services very much, as reflected in client focus groups.
- An additional NTP contract had been developed for a program in San Mateo County to improve easy access for north county residents. They were serving close to 100 Santa Clara county residents.

- Santa Clara also conducted a major review of their DMC-ODS system after six months of operation. This major review was called the “180 scan” and was used to study the functioning and key performance measures for the programs and set new goals for improvement.
- Santa Clara was working actively with the mental health program on coordinated efforts on the Final Rule with new policies and procedures and efforts at addressing any gaps or capacity issues in the system.
- There were also new systems instituted to make referrals from the emergency departments and hospital-based outpatient clinics, easier to accomplish with a direct line to priority service access.
- Santa Clara administered TPS and tracks various outcomes measures linked to specific providers and their performance. They are using as their primary sources the electronic health record ProFiler. Santa Clara also uses the CalOMS data, Gateway Referral system, and the TPS as well as ASAM LOC System as their important data sources. They have used the results to create data dashboards and other reports they use for quality improvement purposes, and for outcomes reporting. For more information about CalOMS and about the two new measurement tools, go to:
- CalOMS Treatment Data Collection Guide: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf
- TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf
- ASAM Level of Care Data Referral System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

Year Two Initiatives and Goals: July 1, 2018 to June 30, 2019

- Year two includes a goal of expanding to add two new residential levels of care including ASAM 3.3 Residential Treatment and ASAM 3.5 Clinically Managed High Intensity Residential services.
- Goals include refining the systems used for quality metrics in monitoring programs and enhance capacity for monitoring of care.
- Santa Clara developed and implemented new contract templates and requirements for all DMC-ODS providers that reflect the DMC-ODS STCs and 42CFR 438 Managed Care requirements. The findings from the 180 Scan informed the county of measures that were most valuable to tracking outcomes and identifying problems; the findings were used to inform year-two contracts as well.
- Santa Clara has created an Evidence Based Practices (EBP) requirement for direct services to expand the appropriate implementation and use of EBPs across all behavioral health programs, as well as assist contracted providers. There are continued trainings and efforts in assessing fidelity to their EBPs for system providers, both county and contract.

- One of the most significant new efforts is expanding MAT beyond residential and partial hospitalization to initiation and maintenance within the county detention facilities. This effort to bring MAT into the detention settings has proved difficult in many counties. There is still significant stigma within criminal justice facilities in many communities related to opioid replacement therapies and other MATs which reduce cravings.
- Santa Clara is adding 30 beds of residential treatment, including a crisis residential center, which could treat clients with co-occurring disorders in a more acute state and needing stabilization.
- To serve clients with highly acute conditions and with medical complexity, the goal of Santa Clara is to establish with hospitals ASAM levels of care 3.7 Inpatient Services and 4.0 Medically Managed Intensive Inpatient Services. Focus groups with staff serving clients indicated a need for these levels of care to be available.

:

PERFORMANCE MEASUREMENT

The purpose of performance measures (PMs) is to foster access to treatment and quality of care by measuring indicators with solid scientific links to health and wellness. CalEQRO conducted an extensive search of potential measures focused on SUD treatment, and then proceeded to vet them through a clinical committee of over 60 experts including medical directors and clinicians from local behavioral health programs. Through this thorough process, CalEQRO identified 12 performance measures to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, CalOMS, and the ASAM level of care data for these measures.

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

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

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries;
- Number of days to first DMC-ODS service after client assessment and referral;
- Total costs per beneficiary served by each county DMC-ODS by ethnic group;
- Cultural competency of DMC-ODS services to beneficiaries;
- Penetration rates for clients, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes);
- Coordination of Care with physical health and mental health;
- Timely access to medication for NTP services;
- Access to non-methadone MAT focused upon beneficiaries with 3 or more MAT services in the year being measured;
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after residential treatment;
- Availability of the 24-hour access call center line to link clients to full ASAM-based assessments and treatment (with description of call center metrics);
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs);
- Percentage of clients with three or more withdrawal management episodes and no other treatment to improve engagement.

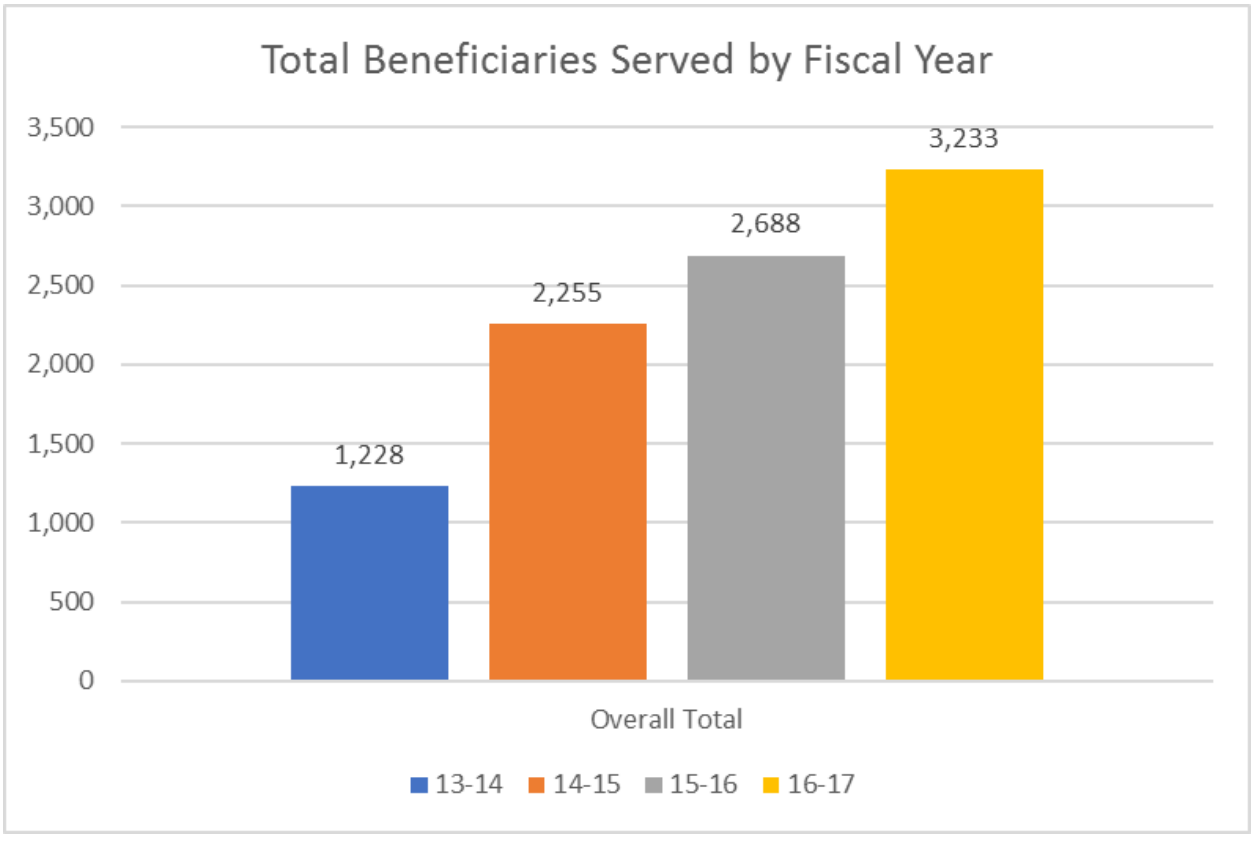
HIPAA Guidelines for Suppression Disclosure:

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

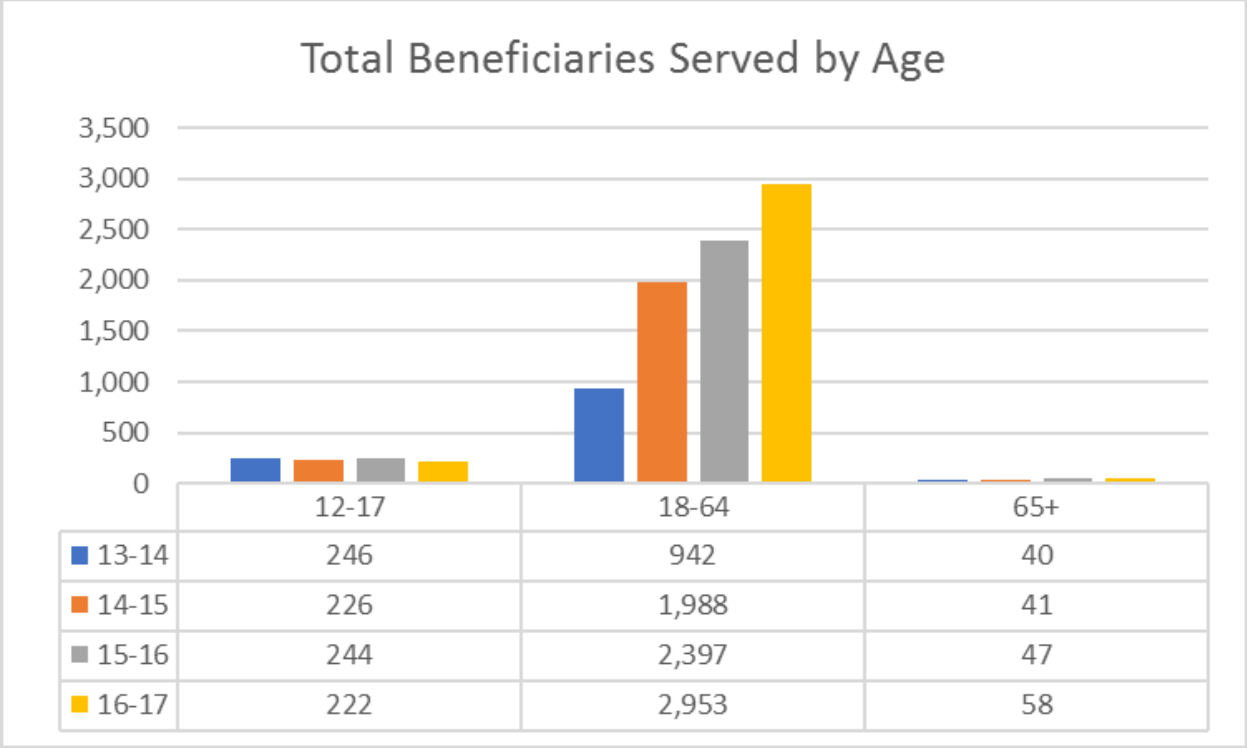
Baseline PM Data for Santa Clara Prior to the DMC-ODS Waiver

To evaluate the impact of the DMC-ODS Program and Waiver, baseline data for four prior FYs were analyzed both statewide and for each DMC-ODS County.

B Table 1-Total Beneficiaries Served

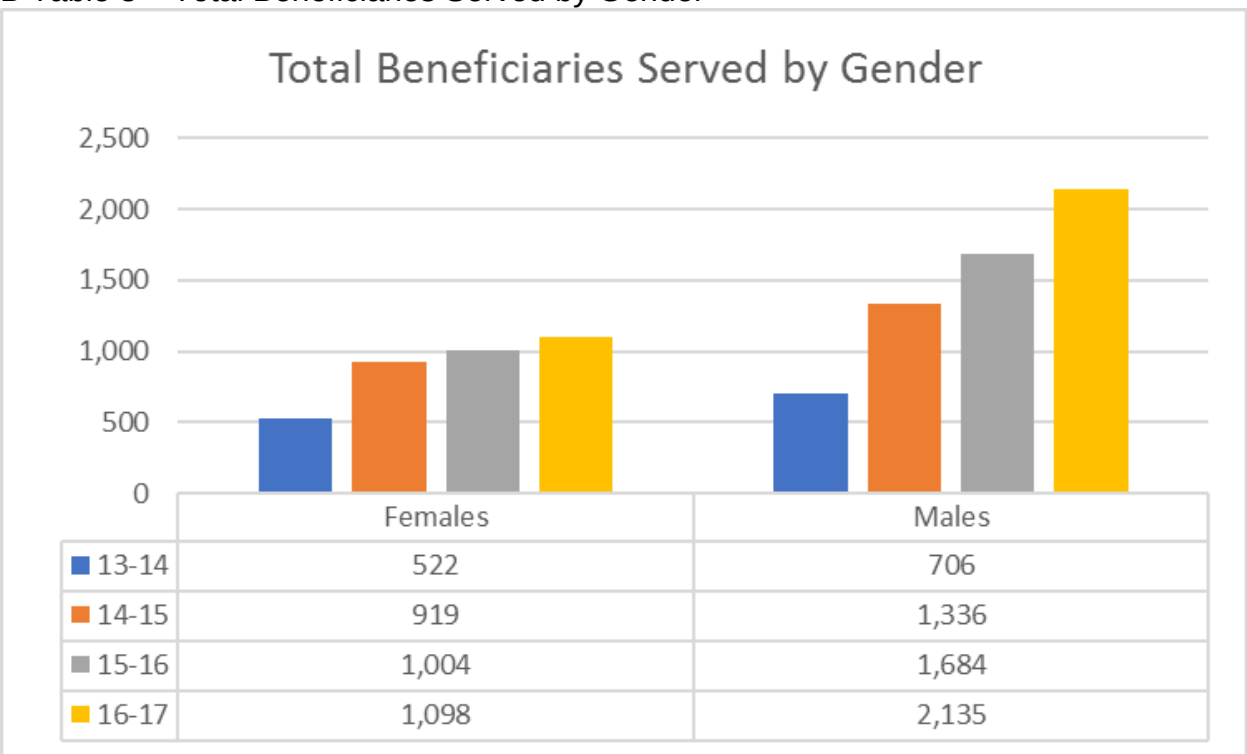


B Table 2 – Total Beneficiaries Served by Age



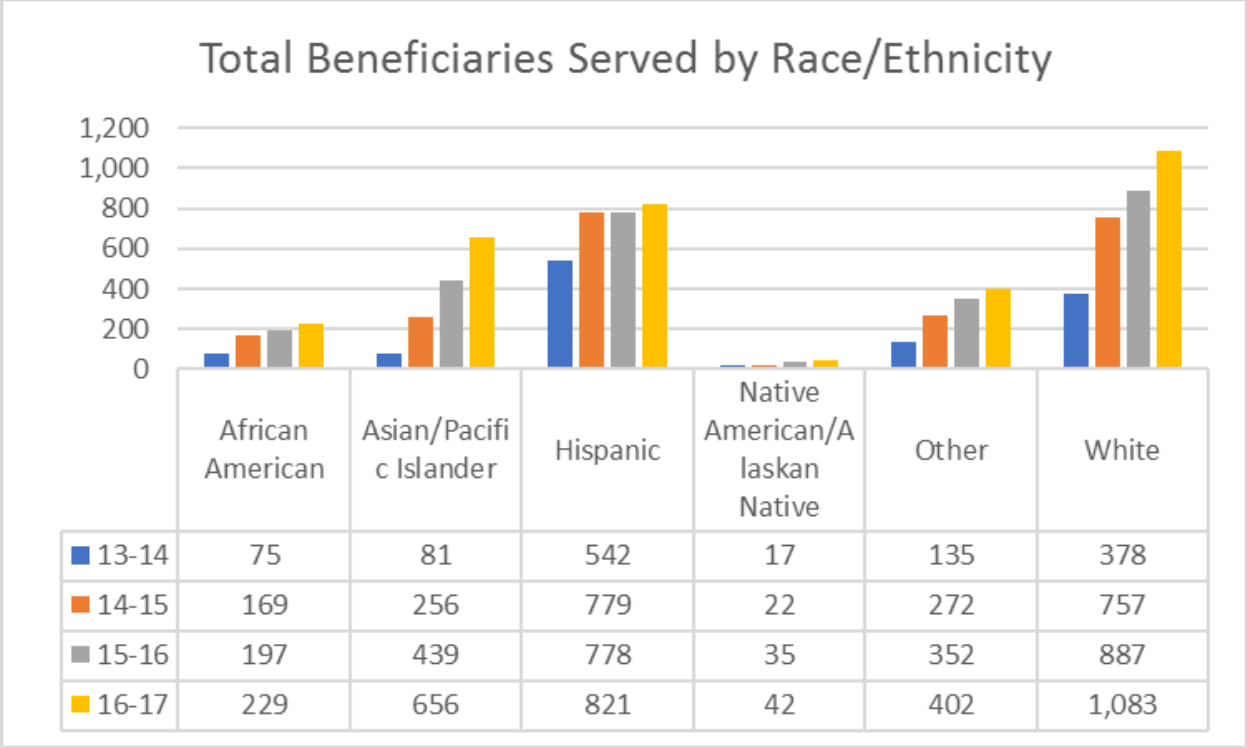
	12-17	18-64	65+
13-14	246	942	40
14-15	226	1,988	41
15-16	244	2,397	47
16-17	222	2,953	58

B Table 3 – Total Beneficiaries Served by Gender



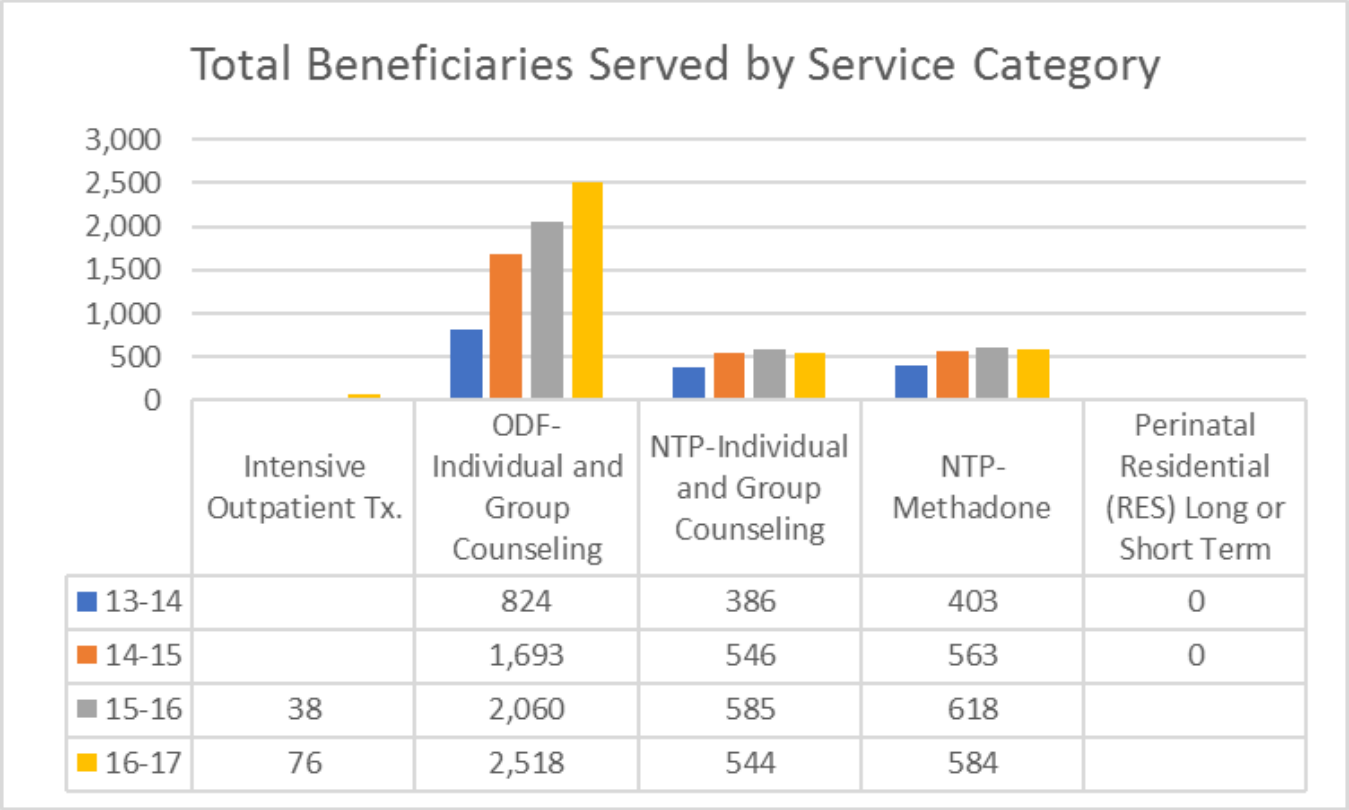
	Females	Males
13-14	522	706
14-15	919	1,336
15-16	1,004	1,684
16-17	1,098	2,135

B Table 4 – Total Beneficiaries Served by Race/Ethnicity



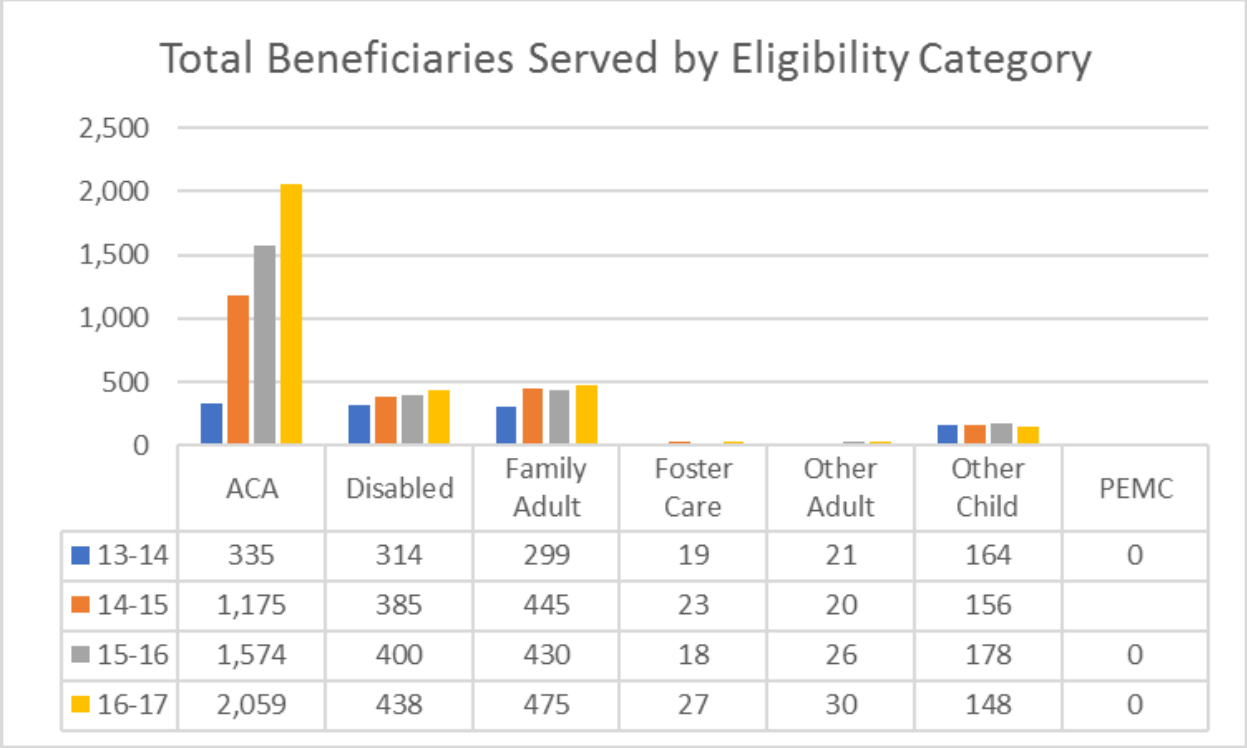
	African American	Asian/Pacific Islander	Hispanic	Native American/Alaskan Native	Other	White
13-14	75	81	542	17	135	378
14-15	169	256	779	22	272	757
15-16	197	439	778	35	352	887
16-17	229	656	821	42	402	1,083

B Table 5 – Total Beneficiaries Served by Service Category



	Intensive Outpatient Tx.	ODF-Individual and Group Counseling	NTP-Individual and Group Counseling	NTP-Methadone	Perinatal Residential (RES) Long or Short Term
13-14		824	386	403	0
14-15		1,693	546	563	0
15-16	38	2,060	585	618	
16-17	76	2,518	544	584	

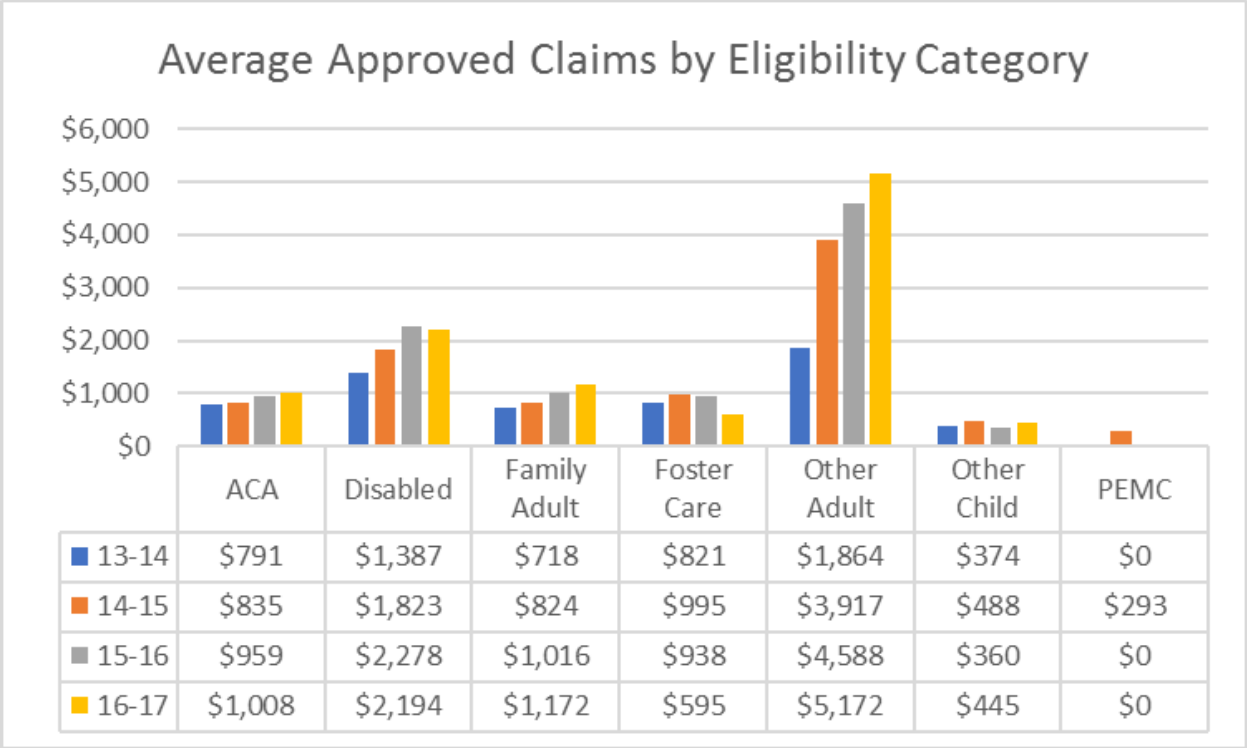
B Table 6 – Total Beneficiaries Served by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	Other Adult	Other Child	PEMC
13-14	335	314	299	19	21	164	0
14-15	1,175	385	445	23	20	156	
15-16	1,574	400	430	18	26	178	0
16-17	2,059	438	475	27	30	148	0

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

B Table 7 – Average Approved Claims by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	Other Adult	Other Child	PEMC
13-14	$791	$1,387	$718	$821	$1,864	$374	$0
14-15	$835	$1,823	$824	$995	$3,917	$488	$293
15-16	$959	$2,278	$1,016	$938	$4,588	$360	$0
16-17	$1,008	$2,194	$1,172	$595	$5,172	$445	$0

Discussion of Baseline Data Trends and Implications

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

Prior to the waiver, SUD treatment services covered by Drug Medi-Cal were limited to a narrow range of services, including narcotic replacement therapy with counseling, outpatient group counseling, intensive outpatient treatment, and perinatal residential and outpatient treatment. No case management, recovery support, residential treatment, or withdrawal management were covered under the state Medicaid plan.

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

The age group with the least utilization of care depicted in Baseline Table 7 was youth, and this will be a focus for expansion through the waiver in many counties.

Costs per beneficiary were highest for the elderly population, even though there were low numbers served. The elderly population have many complicated SUD needs as well as health and mental health issues. The average cost per beneficiary across all age groups in FY 2016-17 was $4,866.

Calendar Year 2017 – Year 1 of the Waiver

Santa Clara services began in mid-June 2017 and CalEQRO obtained PM data from DHCS for claims, eligibility, the provider file, and from UCLA for Treatment Perception Surveys (TPS) for the six-month period from mid-June through December 2017. The results of each PM will be discussed for that period, followed by highlights of the overall results from that same period. DMC-ODS Counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there is a claims lag for many services in the data available at the time of the review. For the CY 2017 claims download available for the report, there were limited claims for the end of the Calendar Year (November and December). For this reason, the data will be refreshed before the FY 18-19 annual report is done to insure as complete a data set as possible. In addition, many DMC-ODS Counties phased in new and expanded services for billing, and thus there is not a stable set of services for the complete duration of the Calendar Year after launch.

DMC–ODS Beneficiaries Served in Calendar Year 2017

CY 2017 Table 1 – Beneficiaries Served

Table 1: Santa Clara DMC-ODS Enrollees and Beneficiaries Served in 2017, by Race/Ethnicity				
Race/Ethnicity	**Unduplicated Average Monthly Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of DMC Beneficiaries Served**	**% Served**
White	50,498	13%	815	34%
Latino/Hispanic	163,372	42%	887	37%
African-American	12,932	3%	161	7%
Asian/Pacific Islander	117,152	30%	177	7%
Native American	1,390	<1%	31	1%
Other	47,015	12%	333	14%
Total	392,359	**100%**	2,404	**100%**

The totals in the bottom row indicate a decrease in beneficiaries served as compared to FY16-17—2,404 compared to 3,233. However, the data for CY17 shown above is incomplete, with some of the claims data yet to be processed, and the new DMC-ODS data was from a six-month period in CY 2017 compared to a twelve-month period for FY 16-17.

The race/ethnicity results in this table can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS.

Penetration Rates and Approved Claim Dollars per Beneficiary for CY 2017

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

Regarding calculation of penetration rates, Santa Clara uses the same method used by CalEQRO.

CY2017 Table 2 and 3A show CY 2017 of the DMC-ODS's overall penetration rates and approved claims by age compared to current statewide averages.

CY 2017 Table 2 – Penetration Rates

	Santa Clara			Statewide
Age Groups	Average Number of Enrollees per Month	Number of Beneficiaries Served CY 2017	Penetration Rate	Penetration Rate
Total	392,358	2,404	0.61%	0.25%
Age Group 12-17	96,600	120	0.12%	0.04%
Age Group 18-64	213,396	2,127	1.0%	0.36%
Age Group +65	82,362	157	0.19%	0.19%

CY 2017 Table 3A – Penetration Rates and Average Approved Claims

	Santa Clara		Statewide
Age Groups	Total Approved Claims	Approved Claims per Beneficiary Served per Year	Approved Claims per Beneficiary Served per Year
Total	$5,490,322	$2,284	$2,662
Age Group 12-17	$202,735	$1,689	$1,483
Age Group 18-64	$4,807,455	$2,260	$2,721
Age Group +65	$480,131	$3,058	$2,640

CY 2017 Table 3B and 4 show Santa Clara's approved claims per beneficiary by eligibility category and penetration rates, compared to the statewide average.

CY 2017 Table 3B –Beneficiaries Served and Penetration Rates by Eligibility Category

	Santa Clara			Statewide
Eligibility Categories	**Average Number of Enrollees per Month**	**Number of Beneficiaries Served CY 2017**	**Penetration Rate**	**Penetration Rate**
Disabled	30,292	371	1.22%	0.60%
Foster Care	1,217	13	1.07%	0.49%
Other Child	54,149	79	0.15%	0.03%
Family Adult	49,873	404	0.81%	0.25%
Other Adult	78,830	31	0.04%	0.03%
MCHIP	42,678	51	0.12%	0.03%
ACA	135,597	1,527	1.13%	0.43%

CY 2017 Table 4 – Approved Claims by Eligibility Category

	Santa Clara			Statewide
Eligibility Categories	**Average Number of Enrollees per Month**	**Number of Beneficiaries Served CY 2017**	**Approved Claims per Beneficiary Served per Year**	**Approved Claims per Beneficiary Served per Year**
Disabled	$1,029,658	371	$2,775	$2,495
Foster Care	$11,822	13	$909	$1,110
Other Child	$129,659	79	$1,641	$1,472
Family Adult	$743,196	404	$1,840	$2,459
Other Adult	$99,063	31	$3,196	$2,561
MCHIP	$69,460	51	$1,362	$1,551
ACA	$3,407,463	1,527	$2,231	$2,768

Children 12 and under rarely need treatment for SUD. Foster care, other child and Maternal and Child Health Integrated Program (MCHIP) include children of all ages. As with many counties, there is a low penetration rate. Expansion of services to youth is an important focus of Santa Clara with their expanded residential and outpatient services.

ACA, family adult, and disabled members constituted the major groups using SUD services. The most expensive group were "other adults" which includes low-income seniors.

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

Average Days from First Contact to First Dose at NTP is a measure in the Access to Care Domain.

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

Persons seeking methadone medication are likely to have been unable to stop using through non-MAT approaches and are likely to have mixed feelings about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they are likely to go back to opiate use that can be life threatening. For these reasons, NTPs regard the request to begin treatment with methadone as urgent and requiring a timely response. Tables 5 and 6 show the average number of days from triage/assessment contact to the first dose of NTP services for opioid use disorder (OUD) diagnoses, first by age groups and then by race/ethnicity.

Average times indicated below for Santa Clara clients indicate they access care in a timely manner, on average within 1.2 days of diagnosis/assessment. The African-American population average is slightly higher, at 3.2 days.

CY 2017 Table 5 – Number of Days to First Dose of NTP Services by Age

Age Groups	Santa Clara			Statewide		
	Clients	%	Avg. Days	Clients	%	Avg. Days
Total Count	488	100%	1.2	13,867	100%	<1
Age Group 12-17	*	n/a	n/a	*	n/a	<1
Age Group 18-64	375	77%	1.4	10,831	78%	<1
Age Group 65+	113	23%	<1	*	n/a	<1

CY 2017 Table 6 – Number of Days to First Dose of NTP Services by Ethnicity

Race/Ethnicity	Santa Clara			Statewide		
	Clients	%	Avg. Days	Clients	%	Avg. Days
Total Count	488	100%	1.23	13,867	100%	<1
White	227	47%	<1	5,992	43%	<1
Hispanic/Latino	152	31%	1.7	3,753	27%	<1
African-American	22	5%	3.2	1,815	13%	<1
Asian Pacific Islander	*	n/a	<1	173	1%	<1
Native American	*	n/a	<1	93	<1%	<1
Other	75	15%	1.6	2,041	15%	<1

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

Santa Clara Services for Non-Methadone Medication-Assisted Treatment

Some people with opiate addictions have become interested in newer-generation addiction medicines that have increasing evidence of effectiveness. These include longer-acting medications such as buprenorphine and naltrexone that need not be taken in as rigorous a daily regimen as methadone. While these medications can be administered through NTPs, they can also be prescribed and administered by physicians through other settings such as primary care clinics, hospital-based clinics, and private physician practices. For those who may not find methadone as helpful, these other MATs have the advantages of being available in more types of settings, involving less stigma, and requiring far fewer appointments for regular dosing. The DMC-ODS Waiver encourages MATs for these reasons, and because of the evidence supporting their effectiveness. However, physicians are required to receive specialized training before they prescribe some of these medications, and many feel the need for further consultation backup once they begin prescribing. Consequently, physician uptake throughout most of the country tends to be slow. Santa Clara County operates its own NTP and does administration of a range of MAT out of its geographically distributed sites.

Access to Medication-Assisted Treatment

This measure is associated with the Access and Quality Outcomes Domain.

Tables 7 and 8 display the number and percentage of clients receiving three or more MAT visits per year provided through Santa Clara providers, comparing the county level for Santa Clara and statewide. Three or more visits were selected to identify clients who were getting regular MAT treatment versus a single dose. This include NTP/OTP non-methadone medications billed to the DMC-ODS.

CY 2017 Table 7 – Three or more DMC-ODS MAT Billed Visits, by Age

	Santa Clara					Statewide				
	# of Total Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits	# of Total Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits
Total	2,404	47	2%	28	1.2%	29,266	154	0.5%	80	0.3%
Age Group 12-17	120	0	n/a	0	n/a	1,183	0	n/a	0	n/a
Age Group 18-64	2,127	40	1.9%	24	1.1%	24,304	141	0.6	75	0.3%
Age Group +65	157	*	n/a	*	n/a	3,349	12	0.4%	*	0.2%

CY 2017 Table 8 - Three or more DMC-ODS MAT Billed Visits, by Ethnicity

	Santa Clara					Statewide				
	# of Total Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits	# of Total Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits
Total	2,404	47	2%	28	1.2%	29,266	154	0.5%	80	0.3%
White	815	22	2.7%	16	2%	10,596	91	0.9%	52	0.5%
Hispanic/Latino	887	*	*	*	n/a	10,401	31	0.3%	13	0.1%
African-American	161	*	n/a	*	n/a	3,659	*	n/a	*	n/a
Asian Pacific Islander	177	*	n/a	*	n/a	593	*	n/a	*	n/a
Native American	31	*	n/a	*	n/a	190	*	n/a	*	n/a
Other	333	*	n/a	16	2%	3,409	20	0.6%	*	n/a

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

The numbers in Table 8 are limited due to incomplete data and to initial challenges with hiring providers who can prescribe and are trained for SUD treatment. Nonetheless, the non- methadone MAT services in Santa Clara is higher than others counties statewide in the DMC-ODS as reflected by the total percentages.

Transitions in Care Post Residential Treatment – CY 2017

The DMC-ODS Waiver emphasizes client-centered care, one element of which is the expectation that treatment intensity should change over time to match the client's changing condition and treatment needs. This treatment philosophy is in marked

contrast to a program-driven approach in which treatment would be standardized for clients according to their time in treatment (e.g. week one, week two, etc.).

Table 9 and Table 10 show two aspects of this expectation— (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment to a non-residential service. Table 10 shows similar information from the perspective of statewide data for DMC-ODS counties. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days after discharge from residential treatment, and clients who had no follow-up within the DMC-ODS system during CY 2017.

Follow-up services that are counted in this measure are based entirely on DMC-ODS claims data and include the following services: outpatient, intensive outpatient, partial hospital, MAT, NTP, WM, case management, recovery supports, and physician consultation. CalEQRO does not count re-admission to residential treatment in this measure or transition to a lower level of residential care. In addition, CalEQRO was not able to obtain and calculate Fee-for-Service (FFS)/Health Plan Medi-Cal claims data at this time. CalEQRO also cannot county service elements funded by SAPT, which are not billed.

CY 2017 Table 9 Timely Transitions in Care Post-Residential Treatment DMC-ODS, Santa Clara

	Santa Clara								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Follow Up	Cumulative %	Total Clients	Follow Up	Cumulative %	Total Clients	Follow Up	Cumulative %
Days 1-7	0	n/a	n/a	369	42	11%	0	n/a	n/a
Days 8-14	0	n/a	n/a	369	57	16%	0	n/a	n/a
Days 15-30	0	n/a	n/a	369	70	20%	0	n/a	n/a
Any days	0	n/a	n/a	369	80	23%	*	n/a	n/a
Total Follow Up, Post Residential	0	n/a	n/a	369	80	23%	*	n/a	n/a

Eighty clients received follow-up treatment in a non-residential Santa Clara program that resulted in an approved claim. This includes all ages and because of low numbers of seniors and youth, the numbers are suppressed. (Note: the asterisked data were suppressed according to HIPAA guidelines).

This measure, while constituting valuable information, is relatively new and without much in the research literature enabling comparison. To help provide for comparisons, the table below indicates the same type of performance data statewide across all counties already implementing a DMC-ODS. As with other Santa Clara claims data, the approved claims data upon which the table is based are only partially complete CY 17 data at the time of this report. NIDA is also using this as a new measure and it is hoped that national comparisons will be available over time.

CY 2017 Table 10 Timely Transitions in Care Post-Residential Treatment DMC-ODS, Statewide

	Statewide								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%
Within 7 days	105	*	n/a	5,133	388	8%	106	*	n/a
Within 14 days	105	*	n/a	5,133	516	10%	106	*	n/a
Within 30 days	105	*	n/a	5,133	641	13%	106	*	n/a
Any Days	105	*	n/a	5,133	817	16%	106	*	n/a
Total Transfer Admits, Post Residential	105	*	n/a	5,133	817	16%	106	*	n/a

Asterisks and N/A indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). Youth and seniors' follow-up care reflected small numbers in residential.

The statewide numbers of youth clients in residential treatment are low relative to their statewide numbers of Medi-Cal enrollees. DHCS and county DMC-ODSs, including Santa Clara, are making efforts to increase the number of youth treated in residential and other levels of care through outreach and early identification in partnership with schools and other agencies.

Regarding post-residential follow-up, the statewide statistics indicate similar percentages of clients across all age groups receiving timely follow-up care after discharge from residential treatment. Year One is seen as a baseline year for this new measure. Santa Clara and other counties are putting tracking mechanisms in place to evaluate the smooth transitions in care within the ASAM continuum.

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment of a person's reaching out for help to address a SUD represents a critical crossroad in that person's life, and the opportunity may pass quickly if barriers to access treatment are high. A DMC-ODS has the responsibility to make initial access easy for prospective clients to the most appropriate treatment for their particular needs. For some people, an Access Line may be enormously helpful to help the person find the

best treatment match in a system that can otherwise be confusing to navigate. For others, an Access Line may be experienced as impersonal or otherwise off-putting because of long telephone wait times. For these reasons, it is critical that all county DMC-ODSs monitor their Access Lines for performance using critical indicators. CalEQRO requires a site visit for each review of the Access Call Centers and a focus group with staff doing the access functions.

Table 11 shows Access Line critical indicators from July 1, 2017 through May 31, 2018. For the Access Line Key Indicator form, please refer to Attachment F.

CY 2017 Table 11 – Access Line Critical Indicators

Santa Clara Access Line Critical Indicators 7/1/17 through 5/31/2018	
Average Volume	2320 calls per month
% Dropped Calls	9.2%
Time to answer calls	40 seconds
QA authorizations for residential treatment (monthly averages)	137 access indicators document
% of calls referred to a treatment program for care, including residential authorizations	30% of callers are linked to treatment through the Access Call Center
Non-English capacity	The CISCO Automatic Call Distribution (ACD) gives clients a choice of one of the threshold languages which are currently English, Spanish, Vietnamese, Farsi, Chinese and Tagalog. The call will then be transferred to one of the bilingual staff for that threshold language.
Software	Cisco

Timeliness for residential authorizations exceeded the state standard for DMC-ODS, with 98% of Santa Clara's responses within 24 hours of receipt of request.

High-Cost Beneficiaries

Table 12 provides several types of information on the clients who use a substantial amount of DMC-ODS services. These persons, labeled in this table as HCBs, are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $5,668 in approved claims per year. The table lists the average approved claims costs for the year for Santa Clara HCBs compared with the statewide average. The intent of reporting this information is to help DMC-ODSs identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes. Many have co-occurring complex medical and mental health conditions making treatment more complex and challenging. Others are

homeless and environmental stability is playing a role in successful treatment and outcomes.

CY 2017 Table 12 – HCBs at 90th percentile or higher

	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	33,923	2,539	7.5%	$11,215	$28,475,794	37%
Santa Clara	2,816	170	6%	$11,307	$1,922,209	35%

Overall, Santa Clara had a lower percentage of HCB clients than statewide data; however, this data is also preliminary due to claims lag and other factors.

Withdrawal Management with No Other Treatment

This PM intends to measure engagement after WM for beneficiaries with no other DMC-ODS treatment services for their SUDs. The goal is to track levels of engagement for a high-risk group of clients using only WM and overtime bring this number down with enhanced outreach and engagement. Santa Clara's numbers were too low to share given HIPAA requirements. The numbers are very low in Santa Clara so this is a rare event and clients are being linked into treatment.

CY 2017 Table 13 – Withdrawal Management by Age

	Santa Clara		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	0	n/a	966	0.62%
Age Group 12-17	0	n/a	*	n/a
Age Group 18-64	0	n/a	933	0.64%
Age Group 65+	0	n/a	*	n/a

CY 2017 Table 14 – Withdrawal Management by Ethnicity

	Santa Clara		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	0	n/a	966	0.62%
White	0	n/a	515	0.39%
Hispanic/Latino	0	n/a	298	0.67%
African-American	0	n/a	62	1.61%
Asian Pacific Islander	0	n/a	*	0%
Native American	0	n/a	*	0%
Other	0	n/a	85	1.18%

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

Santa Clara did not fully implement and begin claiming their residential WM services until later in their first implementation year. Thus, the above tables are not an accurate reflection of the total numbers of clients served in residential WM. A data refresh in the annual report will include more data on treatment engagement after a withdrawal management episode.

Diagnostic Categories

Table 15 summarizes the diagnostic billing codes used statewide by DMC-ODS counties to identify diagnostic groups with SUDs.

Table 16 compares the breakdown by diagnostic category of the statewide, DMC-ODS number of beneficiaries served, and total approved claims amount, respectively, for CY 2017. Opioids, alcohol, and stimulants were the most prominent types of SUDs addressed by Santa Clara's DMC-ODS treatment providers.

CY 2017 Table 15 – Diagnosis Codes

Diagnosis Category – ICD 10	Diagnosis Codes (for dates of service on or after October 1, 2015)
Alcohol Use Disorder	F1010, F10120, F10129, F1020, F1021, F10220, F10229, F10230, F10239, F10920, F10929
Cannabis Use	F1210, F12120, F12129, F1220, F1221, F12220, F12229, F1290, F12920, F12929
Cocaine Abuse or Dependence	F1410, F14120, F14129, F1420, F1421, F14220, F14229, F1423, F1490, F14920, F14929
Hallucinogen Dependence or Unspecified	F1610, F16120, F16129, F1620, F1621, F16220, F16229, F1690, F16920, F16929
Inhalant Abuse/Dependence/Unspecified	F1821, F1810, F18120, F18129, F1820, F18220, F18229, F1890, F18920, F18929
Opioid	F1110, F11120, F11129, F1120, F1121, F11220, F11229, F1123, F1190, F11920, F11929, F1193
Other Stimulant Abuse/Dependence	F1510, F15120, F15129, F1520, F1521, F15220, F15229, F1523, F1590, F15920, F15929, F1593
Other Psychoactive Substance	F1910, F19120, F19129, F1920, F1921, F19220, F19229, F19230, F19239, F1990, F19920, F19929
Sedative, Hypnotic Abuse/Dependence	F1310, F13120, F13129, F1320, F1321, F13220, F13229, F13230, F13239, F1390, F13920, F13921, F13929, F13930, F13939

CY 2017 Table 16 – Percentage Served and Average Cost by Diagnosis Code

Diagnosis Codes	Santa Clara		Statewide	
	% Served	Average Cost	% Served	Average Cost
Total	100%	$2,372	100%	$2,888
Alcohol Use Disorder	21%	$2,085	11.2%	$2,648
Cannabis Use	10%	$1,316	6.4%	$1,543
Cocaine Abuse or Dependence	2%	$1,813	1.7%	$2,705
Hallucinogen Dependence	0.5%	$2,152	n/a	$2,388
Inhalant Abuse	0.0%	$1,808	n/a	$739
Opioid	29%	$3,412	58.6%	$3,221
Other Stimulant Abuse	37.7%	$2,033	20.3%	$2,521
Other Psychoactive Substance	0.1%	$6,780	1.1%	$2,684
Sedative, Hypnotic Abuse	0.2%	$3,083	0.3%	$2,831

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

Performance Measures Findings—Impact and Implications

Overview

Data in many sectors showed robust launch of SUD programs, but claims lag resulted in partial year data at the time of the review. WM only became integrated into the continuum of care in May 2018, so data is incomplete for this modality. In addition, DMC-ODS claims for MAT were also subject to claims lag and need refresh for the annual report.

Access to Care PM Issues

- Claims data from baseline to calendar year 2017 reflect a steady expansion of services for Medi-Cal DMC-ODS with 3233 beneficiaries served in FY16-17. From mid-June 2017 until December 2017 (approximately six months), DMC-ODS beneficiaries served were 2,404. Thus, the anticipated beneficiaries served for FY17-18 will exceed FY16-17 results given the current trend.

- Santa Clara achieved a higher penetration rate than the Statewide average in beneficiaries served, and this is reflected in most of the race/ethnicity, age group and gender analyses. Comparing subgroups within Santa Clara County, the Caucasian and African-American enrollees had a relatively higher rate of access to services than did the Asian/Pacific Islander enrollees. Latino/Hispanics accessed services at a slightly lower than expected rate given the percentage of enrollees (37 percent of served beneficiaries, compared to 42 percent of enrollees).

- Across age groups, the 18-64 age group had the highest penetration rate for age groups (1.0 percent). The average approved claims for the 65+ age group was higher at $3,058 than the 18-64 group at $2,260, reflecting that the older age group, as a result of their more complex medical conditions, need more intensive and lengthier substance use treatment in addition to more physical health care.

Timeliness of Services PM Issues

- Santa Clara's clients who receive methadone from an NTP received timely dosing following their first request for NTP treatment. The average time to first dose at NTP is 1.4 days for the 18-64 age group overall; however, the average time for African-American consumers is 3.2 days compared to Caucasian consumers at 0.68 days. Santa Clara was going to do additional research on this data related to a number of variables such as a medical issues or other factors.

- DMC-ODS is tracking the timeliness of transitions from residential treatment to non-residential treatment in the community. In this first year of the DMC-ODS

implementation, Santa Clara indicated that, approximately 6 percent of discharged clients from residential (80) treatment were admitted into a non-residential treatment for follow-up. Those not receiving non-residential treatment after residential treatment may be continuing with some form of non-claimable services or Fee-for-service billable care, but that is speculation because CalEQRO cannot track client progress outside of DMC-ODS claims data. Santa Clara indicated that using Profiler 34% of residential clients were transferred to another level of care within 14 days. Santa Clara stated their data was based on 1151 residential episodes and it is know that claims data if delayed due to billing processes for up to 6 months for submission.

- The Access Line is tracking key indicators with call center software that provides dashboards on a daily and monthly basis for staff to monitor performance and identify performance improvement areas. Santa Clara provided a monthly report for the CalEQRO Review that showed performance within Santa Clara's system of care, and relevant standards, including a low call abandonment rate.

Quality of Care PM Issues

- California has a longstanding legacy of social model abstinence-oriented approaches to SUD treatment. Santa Clara SUTS also used harm reduction treatment approaches, which is more client-centered and reduces sigma. This approach has helped many clients who are prone to addiction and cannot use alcohol or other drugs responsibly. However, this approach does not work for everyone. Santa Clara has strongly supported access to MAT and focus groups indicated less stigma associated with methadone and other MAT than in some other counties.

  Santa Clara uses CalOMS to track services, measure outcomes, and create data dashboards. They train all individual providers in how to complete the CalOMS forms so that inter-rater reliability is high.

- The DMC-ODS uses the TPS to measure several domains, including clients' perception of the quality of care they received. Santa Clara administered the TPS, received results from UCLA, and actively reviewed them. Clients were not only diligent in completing the survey, but also in writing comments. Santa Clara's non-clinical PIP is focused on the administration of the TPS early in outpatient treatment by the fourth session. The purpose of early administration is to capture any issues that may arise early in treatment that might cause the client to leave treatment prematurely. Santa Clara is seeking to identify and prevent early drop-outs due to problems in client experience.

Client/Consumer Outcomes PM Issues

- Santa Clara uses CalOMS data to measure treatment success by time of discharge, and housing and employment status at time of discharge. They also measure the pre-treatment to post-treatment change in use of drug-free social support activities, criminal justice involvement, and number of psychiatric and general medical hospitalizations. They also use client self-report data from the TPS as an additional type of general outcome measure.

- Santa Clara has implemented a 180 Scan that examines clinical processes, client outcomes, system performance, and system efficiency. The 180 Scan was conducted 6 months' post-implementation of the waiver to assess performance on these selected elements. Additional information about the results of the 180 Scan can be found in the Appendix under County Highlights.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the DMC-ODS

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

ISCA Table 1 shows the percentage of services provided by type of service provider.

Table 1: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	25%
Contract providers	75%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff: 8%

The budget determination process for information system operations is:

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

DMC-ODS currently provides services to client/consumers using a telehealth application:

☐ Yes ☒ No ☐ In pilot phase

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in ISCA Table 2.
ISCA Table 2 – Summary of Technology Staff Changes

Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
3	0	1	1

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

ISCA Table 3 – Summary of Data and Analytical Staff Changes

Table 3: Summary of Data and Analytical Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
9	0	0	2

Current Operations

DMC-ODS utilizes Pro-Filer information system, implemented in 2005, as well as AVATAR for dosing records. Santa Clara migration to Avatar is pending the completion of a contract with Netsmart. At this point, the actual go-live date is not available.

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

ISCA Table 4 – Primary EHR Systems/Applications

Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Pro-Filer	Service recording, State reporting, billing, capacity management, assessment, referral, and managed care	Co-Centrix	13	BHS IS Team
AVATAR	Dosing records	Netsmart	4	BHS IS Team

Priorities for the Coming Year

- Transition to new clinical and practice management system for Behavioral Health Services SUTS.
- Migrate from Pro-Filer to AVATAR.

Major Changes since Prior Year

- County completion of MH practice management implementation of the Netsmart system with AVATAR and EPIC. This accomplishment is the precursor to the SUTS practice management implementation to Netsmart. When SUTS migrates to Netsmart, it will include the clinical module as well as practice management.

Other Significant Issues

- Santa Clara implemented the DMC-ODS waiver and is in the second year of services. Pro-Filer may not have the full functionality required to support expanded pieces of the waiver; however, Santa Clara is developing a contract with Netsmart to provide this functionality and capacity that aligns with regulatory obligations.
- Contract Providers only have access to performance management functionality. To function as full partners in the continuum of care, they will need to have access to AVATAR expanded functionality.
  The plan for this year is to get all providers, directly operated and contracted, entering data into AVATAR, but contractor roles and duties will be negotiated with Netsmart and where possible double data entry will be avoided per Santa Clara.

Plans for Information Systems Change

- The most significant change for Santa Clara occurred when the county decided that EPIC was not going to work for DMC-ODS because of 42 CFR,

Part 2-related confidentiality concerns. Santa Clara decided to work with Netsmart on building out AVATAR for their EHR instead.

Current Electronic Health Record Status

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

Table 5: EHR Functionality

		Rating			
Function	**System/ Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts				x	
Assessments	Pro-Filer	x			
Care Coordination	Pro-Filer		x		
Document imaging/storage				x	
Electronic signature—client/consumer				x	
Laboratory results (eLab)	EPIC	x			
Level of Care/Level of Service	Pro-Filer	x			
Outcomes	Pro-Filer	x			
Prescriptions (eRx)				x	
Progress notes			x		
Referral Management	Pro-Filer	x			
Treatment plans				x	
Summary Totals for EHR Functionality:		**5**	**1**	**6**	**0**

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- There have been no EHR enhancements over the past year.

Client/consumer's Chart of Record for county-operated programs (self-reported by DMC-ODS):

☐ Paper ☐ Electronic ☒ Combination

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

Summary of Findings	Yes	No	%
ASAM is being administered to clients in all DMC-ODS Medi-Cal Programs.	x		
ASAM being used to improve care.	x		
CalOMS being administered on admission, discharge and annual updates.	x		
CalOMS being used to improve care. Track discharge status. Outcomes.	x		
Percent of treatment discharges that are administrative discharges.			25%
TPS being administered in all Medi-Cal Programs.	x		

Highlights of use of outcome tools above or challenges:

- Santa Clara has been using CalOMS data as part of their Quality Management evaluation plan for some time, including tracking outcomes such as housing and vocational status.
- TPSs have been administered to all levels of care and average scores for each domain calculated showing positive results in the system overall. Santa Clara added four additional questions to the TPS to track outcomes related to housing, income, daily activities of living, and legal situation. This is very positive from a quality and leadership perspective as many clients are engaging in the TPS processes.
- ASAM is administered for clients and metrics such as concordance of actual level of care to assessed level is being tracked. Only one month of data was available for CalEQRO, but 90 percent of clients were being referred for recommended ASAM levels of care.

Drug Medi-Cal Claims Processing

- Santa Clara has successfully submitted claims for NTP services, residential treatment, intensive outpatient and outpatient treatment services during CY 2017. MAT and WM services were just starting to bill.

Special Issues Related to Contract Agencies

- Contract provider access to Pro-Filer is largely limited to practice management functionality.
- As many contract providers have local EHR systems, the electronic transfer of practice management and clinical data to AVATAR should be a priority. Strategies to use HL7 and X12 standard transactions to exchange data

between provider and ODS systems should be a short-term goal to eliminate double-data entry.

- Contract providers use their own EHRs for progress notes. Some County providers use Pro-filer and the QI staff who facilitate care coordination enter progress notes into Pro-Filer. Progress notes can be entered into Pro-filer.

Overview and Key Findings

Access to Care

- Access Call Center software was of high quality and allowed tracking of calls, wait times, disposition, and other key data.

Timeliness of Services

- Santa Clara tracks the timeliness of first appointments, responsiveness to authorization requests, and timeliness of follow-up appointments after discharge from residential treatment.

Quality of Care

- Contract providers' access to Pro-Filer is largely limited to its practice management functionality; some contract providers use its clinical functionality for entering progress notes.
- Staff prioritize review of data and services using their 180 Scan for quality.

Client/Consumer Outcomes

- Santa Clara tracks encounters and outcomes with CalOMS.
- Santa Clara administers TPS to all clients who were close to discharge. Data collection was continuous in 2018. In addition to this regular administration of TPS, Santa Clara also participates in the annual event once per year which is analyzed by UCLA for use in quality improvement.
- Santa Clara SUTS began to submit ASAM LOC data for ASAM assessments and referrals to DHCS when the county launched in June 2017 and will be monitoring this for ASAM fidelity. The internal ALOC system tracks this data as well. CalEQRO has had difficulty accessing downloads of this data and is working with DHCS and UCLA.

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PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Santa Clara PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated two PIPs submitted by Santa Clara, as shown below.

PIP Table 1 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

PIP Table 1

Table 1: PIPs Submitted by Santa Clara County		
PIPs for Validation	**# of PIPs**	**PIP Titles**
Clinical PIP	1	Clinical PIP Engagement Four Visits in 30 days
Non-clinical PIP	1	Client Experience of Care – TPS survey enhancements

PIP Table 2, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially M, Not Applicable (NA), and Unable to Determine (UTD), or Not Rated (NR).

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

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

PIP Table 3 provides a summary of the PIP validation review.

Table 3: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	10	13
Number Partially Met	7	3
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**54%**	**58%**

Clinical PIP— Four Visits in Thirty Days Engagement

The DMC-ODS presented its study question for the clinical PIP as follows:

"Will a primary clinician's phone call to a client between the first and second session of a client's outpatient treatment increase the likelihood the client will continue treatment and have four treatment visits within thirty days?"

Date PIP began: June 2018

Status of PIP: Active and ongoing

Pilot study of a single outpatient (OP) provider's delivery of a simple, convenient treatment service. The intervention service is a clinical phone call between the beneficiary and their primary clinician that occurs between the first and typically second session. This is designed as a new engagement intervention to improve patient experience and satisfaction with care resulting in enhanced engagement as evidenced by four sessions within 30 days. Four visits in 30 days is tracked as a standard for engagement in the SUD care system. Goal is to increase by significant level the percentage of clients who have four visits in 30 days.

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

The technical assistance provided to the DMC-ODS by CalEQRO consisted of early feedback on concept, indicators and interventions.

Non-Clinical PIP— Boosting Outpatient Beneficiary TPS Response Rate for Improving Retention in SUD Treatment

The DMC-ODS presented its study question for the non-clinical PIP as follows:

(i) "Is there a systematic difference in client treatment perception between clients who drop out early and those that complete treatment?
(ii) Are there differences in dropout rates by gender, age, ethnicity/race, criminal justice status and other variables?
(iii) Are there systematic differences by outpatient programs?

The purpose of investigating these questions is to identify factors/indicators that are amenable to intervention by programs to reduce dropouts and enhance retention in care. Retention in care is considered in SUD research as one of the key indicators or sustained abstinence and recovery. The UCLA TPS tool will be used to evaluate the difference between those that drop out and those that continue in treatment."

Date PIP began: Not Started

Status of PIP: Concept only, not yet active (not rated)

In addition to the annual point-in-time administration of the Client Feedback Survey, SUTS OP beneficiaries will be asked to complete the survey *prior to their fourth appointment* in the treatment episode in support of SUTS's. Normally the TPS is done annually in October of each year.

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

The technical assistance provided to the DMC-ODS by CalEQRO consisted of providing input on additional data necessary for program background and clarity. The PIP launch was delayed because UCLA had announced potential changes to the TPS that were not yet finalized to be announced.

PIP Findings—Impact and Implications

Access to Care

- The Clinical PIP addresses access to care with a plan to enhance engagement and reduce premature discharges that can result in increased readmissions to treatment

- The Non-Clinical PIP seeks to gain input from persons who discharge prematurely to develop additional strategies that would address these specific

issues. Readmission to treatment can improve treatment success and outcomes.

Timeliness of Services

- The Clinical PIP is piloting an intervention to increase engagement after the first clinician appointment. Early engagement and timely access has been determined to be effective at successful outcomes thereby reducing the impact of readmissions into the system and enhancing client outcomes.

- The Non-Clinical PIP seeks data to answer the question of what barriers or common issues are identified by persons who have unplanned exits in the first month. This population may affect system access with increased readmissions and more potential for relapse. Clients who stay engaged have significantly better treatment outcomes based on length of stay per the research on SUD treatment measures associated with sustained recovery.

Quality of Care

- System wide data was reviewed after the first six months of implementation. This data identified issues with early exits from treatment. The PIPs were developed with this data to consider interventions that would potentially increase the number of persons staying engaged in treatment. This six-month comprehensive review was called the “180 Scan” and is referenced in county highlights in the attachments to this report.

- Providers, client members of the committee and other stakeholders participated in the development of these PIPs. The Clinical PIP provider was selected using specific criteria necessary for a pilot program, and the intervention expectations were clear and precise.

- The Non-Clinical PIP seeks to gain data from persons with premature exits from treatment that will be effective in developing new interventions that can keep this population engaged and improve outcomes.

Consumer Outcomes

- The Clinical PIP intervention was designed to support the client with increased engagement and ease of appointment designing a phone call that would be both convenient and deepen the engagement process.

- The clinical PIP was based in research showing that four sessions in 30 days’ increases positive consumer outcomes.

- Treatment Perception Surveys are taken seriously, and the Non-Clinical PIP adds a third time this instrument in administered in the Santa Clara system providing additional data that can be compared across system wide utilization data with the goal to improve the client experience of treatment.

CLIENT/CONSUMER FOCUS GROUPS

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

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

Input in summary includes two extra informal groups at a residential center and a perinatal group where the input forms were not completed, but the comments from these groups are in the summary.

Focus Group One: Adult Re-Entry Group

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

The group met on August 2, 2018 at one of the meeting rooms in the Re-entry center, in San Jose, CA. The participants included eight adults, all of which were adults 25 years of age or over who were SUD clients. Most were admitted into treatment within the previous 12 months. They all spoke English, so no interpreter was needed. Most were Caucasian, and some were African American/Black and Hispanic/Latino. Most were male, and some were female.

Number of participants: eight

Participants are first facilitated through a group process to rate each of eight (8) items on a survey, and discussion is encouraged. The facilitator asks each participant to rate each item on a five (5)-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there are no wrong answers, and that feelings are important. The group facilitators explain that the information sharing is regarded as confidential and reflects the participating group members' own experiences and feelings about the program. The facilitators further explain that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools.

Participants described their experience as the following:

Question	Mean	Range
1. I easily found the treatment services I needed.	4.25	1-5
2. I got my assessment appointment at a time and date I wanted.	4.38	3-5
3. It did not take long to begin treatment soon after my first appointment.	4.5	3-5
4. I feel comfortable calling my program for help with an urgent problem.	3.6	2-5
5. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	2.8	1-5
6. I found it helpful to work with my counselor(s) on solving problems in my life.	4.5	2-5
7. Because of the services I am receiving, I am better able to do things that I want.	4.2	3.5
8. I feel like I can recommend my counselor(s) to friends and family if they need support and help	3.8	3-4

The eight participants who entered services within the past year described their experiences as the following:

- Good but want more individual confidential one on one time.

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

- Need more counselors especially in crisis if yours in not available.
- Clients need help with transitioning from residential treatment.

Recommendations for improving care included the following:

- Need night and weekend hours for those who are trying to work.
- Sober living or transitional housing needs to be available and not just for people on probation.
- More recovery skills and role models
- Like 12 step format and seeking safety.
- Have residential programs that accept people with mental health issues.
- Include exercise and activity programs for depression (in place of pills).
- More family work with spouse and kids, parents

Interpreter used for focus group 1: No

Focus Group Two: Youth Group

CalEQRO requested a culturally diverse group of youth client beneficiaries including a

mix of existing and new clients who have initiated/utilized services within the past 12 months.

Number of participants: five

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

Participants described their experience as the following:

Question	Mean	Range
1. I easily found the treatment services that I needed.	4.0	3-5
2. I got an assessment appointment at a time and date we wanted.	4.1	3-5
3. It did not take long to begin treatment after their assessment appointment.	3.6	3-4
4. I feel comfortable calling the program for help with an urgent problem.	3.0	2-4
5. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.0	2-4
6. I respond in the following way to learning it is time to go to see my counselor again:	4.0	3-5
7. Because of the services I am receiving, I am better able to do things I want.	3.7	3-5
8. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.1	4-5

The three participants who entered services within the past year described their experiences as the following:

- Counselor helpful with understanding my problems but have difficulty with PO.

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

- Want more recreational activities and ways to earn money and become independent.

- Would benefit from more individual therapy and help with school and peer pressures
- Help needed to talk to girls and persons who you want as friends.

Recommendations for improving care included the following:

- Sport and recreation
- Help with jobs and goals
- More program flexibility and help with POs
- Communication couching

Interpreter used for focus group 2: No

Focus Group Three: NTP MAT Group

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

Number of participants: three

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

Participants described their experience as the following:

Question	Mean	Range
1. I easily found the treatment services that I needed.	4.0	3-5
2. I got an assessment appointment at a time and date we wanted.	4.1	3-5
3. It did not take long to begin treatment after their assessment appointment.	4.6	3-5
4. I feel comfortable calling the program for help with an urgent problem.	3.0	2-4
5. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.0	2-4
6. I respond in the following way to learning it is time to go to see my counselor again:	4.0	3-5

Question	Mean	Range
7. Because of the services I am receiving, I am better able to do things I want.	3.3	3-5
8. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.1	4-5

The three participants who entered services within the past year described their experiences as the following:

- MAT was very helpful but still feel embarrassed with family about taking the meds so keep to myself.
- Staff helpful and solid especially counselors.
- Reception could use customer service training.

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

- Want more drop-in hours for counseling and transportation to the facility is helpful such as bus vouchers
- Would benefit from more individual therapy and help with job and family pressures
- Want to know more about alternative treatments that do not require daily attendance.

Recommendations for improving care included the following:

- More flexible hours and counseling times
- Easier intake processes
- Family therapy times and activities

Interpreter used for focus group 3: No

Client Focus Group Findings and Experience of Care

Overview

Adult focus groups were at residential facilities and the NTP program. The youth focus group was at the youth clinic and included a diverse group of youth most of which were involved in the criminal justice system.

Access Feedback from Client Focus Groups

- Adults discussed frustration with daily call requirements for the Access Call Center and said it was not always possible but got into treatment in most cases within 2-3 weeks. Adults reported need for local Medi-Cal and it was a long eligibility process for those with out-of-county Medi-Cal.
- The participants perceive the SLEs to be highly selective and exclusionary, particularly toward clients receiving MATs and clients with co-occurring mental health disorders. Participants shared that they need more options for after residential to still stay in treatment.
- Participants wanted more individual and group help with dealing with families and help finding sponsors who understood their issues and needs.
- Participants also wanted to see more access to withdrawal management if they relapse reported calling but not getting in until they had coped with withdrawal themselves.

Timeliness of Services Feedback from Client Focus Groups

- They agreed that for most substance use treatment services access to treatment is relatively easy, usually taking less than two weeks to see someone especially if you have local Medi-Cal.
- Participants felt the timely access was working for most services except withdrawal management and outpatient (sometimes).

Quality of Care Issues from Client Focus Groups

- Participants liked NTP programs and help with medication when in residential treatment. In addition, they liked the support from counselors who they said were excellent and committed to helping them.
- Participants thought it was easy to call counselor when feeling bad and at risk of relapse. They did not feel emergency room was very helpful but talking to their own counselors was best for them.

Client/Consumer Outcomes Feedback from Client Focus Groups

- The adult client participants agreed that case managers employed or contracted by the county are very helpful to their recovery and appreciate that they are available.
- Participants in youth group wanted more help with life planning for school, jobs, and friends not in the SUD or criminal justice systems. They felt that improvements were based on consistent support and keeping the communication good with POs and others.
- Participants like MAT alternatives and felt they were getting more independent.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1

Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	M
Strong CLAS plan with documented efforts and training. Verified in client focus group that they felt respected in their cultures and had language access when needed.		
1B	Manages and Adapts its Capacity to Meet SUD Client Service Needs	M
Completed a thorough ASAM Program assessment and network capacity adjustments to meet the requirements of the 1115 Waiver and Managed Care Final Rule. Continuing to track network requests for service, back-ups in key areas and develops action plans to address them.		
1C	Integration and/or Collaboration with Community-Based Services to Improve Access & Care	M
Positive relations and planning evident in work with community-based non-profits and partners including courts, Probation, schools and child welfare. They are working to sign and implement MOUs with Health Plans.		

Timeliness of Services

As shown in KC Table 2, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to Drug Medi-Cal Organized Delivery System services. This ensures successful engagement with client/consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

KC Table 2

Table 2: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Face to Face Appointment	PM
Access Call Center tracks calls and provides screening and then an assessment appointment. There are two challenges with the system, not enough appointments for intake for all the callers who need outpatient, and the requirement the people call back daily to obtain an appointment for services. All clients must be offered access regardless if they call back or not. Services should be offered to all clients requesting treatment. DMC-ODS adding 250 outpatient assessments to address current back up in service appointments.		
2B	Tracks and Trends Access Data from Initial Contact to First MAT/NTP Appointment	PM
NTP services were being tracked for timely access to first dose, but no data provided for MAT other than methadone.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	PM
Urgent appointments from hospital are tracked and have special phone line. Specific data on hospital timeliness not available but rapid direct line is helpful per staff. Withdrawal management also considered urgent, but data on timeliness not available. Clients are required to call back every 2 hours if WM beds are full and this delays access. Some reported they could not call back. Similar to Access Call Center client requests need to be followed up even without call back, when there is capacity.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential	M
Santa Clara does track transitions in care from residential and withdrawal management programs.		
2E	Tracks and Trends Data on Re-Admissions to Residential Treatment and WM	M
Re-admissions within 30 days are monitored as measure.		
2F	Tracks and Trends No Shows	PM
Not met this first year. SUTS getting new software system including electronic health record and scheduling module so should be able to track doctor and counselor no		

shows after this functionality is in place. Admissions to programs based on Gateway referrals are tracked.

Quality of Care

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

KC Table 3

Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality Management and Performance Improvement are Organizational Priorities	M
The QI Plan for the DMC-ODS is separate from the one for the MHP. The Plan is well written, with meaningful and clearly stated goals and objectives. The QIC meetings are structured in part to monitor progress in meeting the QI Plan objectives. The evaluation addresses the end of year results for each of the objectives and action plans. This is a particularly strong QI plan for Drug Medi-Cal with many measurable goals and systems to improve care. The CalEQRO used it as an example when training other counties.		
3B	Data is Used to Inform Management and Guide Decisions	M
Santa Clara has many excellent examples of use of data to improve care. The 180 scan, which is in the County Highlight section, is a good example. (See Attachment D – County Highlights).		
3C	Evidence of Effective Communication from DMC-ODS Administration and SUD Stakeholder Input and Involvement on System Planning and Implementation	M
Contract providers praised Santa Clara SUTS and staff related to regular and complete communication and problem solving. The Innovative Partnership meeting is an example of this excellent communication. The only area of concern was from contractors. There was concern that the leadership and consultants involved in directing the integration with Mental Health needed to communicate more with them about system strengths and challenges, which need to be both preserved and revised.		
3D	Evidence of an ASAM Continuum of Care	M
Santa Clara had taken to heart the use of ASAM Criteria for individualized placement and treatment planning many years ago. They did so through specialized training,		

Table 3: Quality of Care Components		
Component		**Quality Rating**
contract management, SUD treatment planning, and some data tracking. Their data tracking is limited by the launch of their new data system AVATAR that is not operational yet for notes, treatment plans, etc. The billing system is functioning, and they are planning to build out the other components of the product to meet the needs of SUD treatment and coordination of care.		
3E	MAT Services both outpatient and NTP exist to Enhance Wellness and Recovery:	M
Santa Clara has excellent medical leadership with 3 key physicians who staff the county run NTP and MAT outpatient services. They are working with others on expansion of MAT and have already made it a mobile service with visits and medications for residential settings and partial hospital programs. Expansion into detention is expected next year.		
3F	ASAM Training and fidelity to core principles is evident in programs within the Continuum of Care	M
As stated previously, Santa Clara was an early adopter to the ASAM philosophy and culture of individualized treatment within a full range of treatment options and levels of care. The goal is to enhance the levels of care with new residential capacity, a crisis residential, and inpatient levels 3.7 and 4.0. To do the later will require a hospital to work with the DMC-ODS on this component of care. The core of ASAM Criteria are the principles of client-centered care—treatment is to be individually tailored to address the changing needs of each client. Santa Clara actively encouraged providers to admit into treatment clients who were being treated with Methadone and other MATs rather than insisting they use no medications. These early efforts made the transition to a DMC-ODS easier in many ways for the provider network.		
3G	Measures Clinical and/or Functional Outcomes of Clients Served	M
Clients who leave treatment without an exit interview make it difficult for the treatment program to accurately rate the client's status at discharge. Santa Clara also uses client self-report ratings on the TPS outcome-related items to determine treatment effectiveness. One of the PIPs expands use of the TPS to measure the client's experience of care and administer it at the 4th visit to measure therapeutic alliance, whether the client feels culturally respects, and the services are having a positive impact. Ideally as a best practice but rarely as a common practice, some clinical programs throughout the country might use brief outcome and therapeutic alliance measures regularly in treatment to continually adjust treatment as needed and improve outcomes. It is noteworthy that Santa Clara has prioritized client feedback to enhance the quality of care and positive engagement practices.		
3H	Utilizes Information from Client Perception of Care Surveys to improve care	M

Table 3: Quality of Care Components	
Component	**Quality Rating**
Santa Clara administers the TPS to clients as required, and the results measure several important domains in clients' experience of care: Access, Quality, Outcomes Care Coordination, and Satisfaction. Clients seem to be particularly engaged by the instrument, adding many handwritten comments in addition to rating the items. UCLA scored the instruments and reported to the counties on their results. Overall, the ratings were 80% or higher on the rating scale. Treatment programs also reported the results separately. This allows the SUD administrator to focus in on any outlier organizations and work on corrective action plans. With regular use of the TPS survey for all outpatient clients at the fourth visit, you will be able to have more system wide feedback from the TPS and make it a core part of tracking quality of care.	

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- During the first year of its DMC-ODS Waiver implementation, Santa Clara increased the number of Medi-Cal beneficiaries for CY 2017 from June 2017 through December 2017 compared with the FY 16-17 data. Santa Clara's overall penetration rate for treating Medi-Cal beneficiaries with substance use disorders was 1.4 percent-more than double the Statewide average of 0.64 percent. The same positive comparisons were demonstrated in analyses that are more detailed by age, gender, race/ethnicity, and levels of care. Furthermore, the CY 2017 numbers are based upon incomplete data; claims data for October-December 2017 is not yet available.

  Santa Clara had established a centralized call center called the Gateway Phone Line. The service screens 2320 calls per month. Qualified staff are cross-trained to do an ASAM brief screening, refer for substance use disorders, and arrange appointments at appropriate settings. Clients who presented to community SUD sites were directed to call in and register their service request and participate in the brief phone screening. This allows for a "no wrong door" approach but also allows tracking of requests and timely access to care. The average call wait time is three minutes and the average monthly call abandonment rate is 9.2 percent. The call center has eight FTE staff and serves solely SUD treatment requests. These rates do need to be a goal for improvement as many clients could be lost with the wait time and almost double digit abandonment rates.

- Santa Clara expanded service capacity and the range of services for Drug Medi-Cal beneficiaries. They used geo-mapping information to guide the expansion to ensure that there would be services within mileage and driving time expectations for all beneficiaries. Network providers were required to become Drug Medi-Cal certified. Santa Clara expanded Drug Medi-Cal services including residential WM, residential treatment, partial hospitalization, case management, MAT, and recovery support services.

Opportunities:

- While the Access Call Center is in many ways a state-of-the-art system with sophisticated Cisco software and the ability to track calls and dispositions, the call-back requirement for access to a DMC-ODS assessment for care may be creating an unneeded obstacle to treatment. Clients can be encouraged to call back to speed up placement opportunities, but everyone who calls and requests service should be contacted with some options for assessment and treatment even if they do not call back. Other counties refer clients to walk-in

assessment centers to allow for timely access. To address timely outpatient capacity, the Santa Clara leadership is adding capacity for 250 outpatient slots to the Gateway resources. All beneficiaries have a right to an assessment regardless which level of care they enter, therefore numbers of assessment could be much greater than the 250 added to the call center inventory. This system change for service requests is very important to honor the intent of the Drug Medi-Cal access requirements.

- Staff from both contract agencies and county programs shared their view that the paperwork burden was excessive and duplicative, distracting from the important work of forming an effective therapeutic alliance with clients, especially at the beginning of the care process. Some of the requirements are from contract agencies and not the county. For the county review purposes, only county paperwork standards can be addressed. Some of the general concern areas included full psychosocial assessments at each change in level of care or legal entity. In addition, when the client has a series of short treatment episodes, the client history and goals had changed very little, but full reports versus updates were still required. Some of the state requirements with CalOMS added to paperwork burden with long questionnaires with every program or location change. It was reported that cases were closed and reopened for every level of care change, and a required closing of the case after 30 days of no activity requiring extensive admission paperwork when they returned. Leadership staff was interested in forming a work group on this topic and using the new AVATAR electronic health record to improve use of staff time and reduce duplication of effort.

- Access to additional withdrawal management beds is needed to allow for timely placement. Leadership staff shared the year-two goal of adding more withdrawal management capacity as well as adding a crisis residential program to assist persons with co-occurring disorders.

- Add ASAM levels that are hospital based for those with complex medical conditions needing withdrawal and treatment. These are levels 3.7 and 4.0 in the ASAM continuum of care. Without these treatment options for persons with complex medical needs, it is likely they will become inpatient medical admissions for medical conditions secondary to chronic SUD. It is important to note that the requirement in the Inter-Governmental Agreement (IGA) is for managed care plans (MCPs) to develop mechanisms to refer clients to levels 3.7 and 4.0. So these levels would be added to the MCP network, not the specialty DMC-ODS system.

- Explore possibilities for obtaining fee-for-service MAT data from the Health Plan and FQHCs to track utilization and timeliness measures if local primary care begins to embrace more MAT as part of their delivery system. HRSA is providing funding for these efforts.

Timeliness of DMC-ODS Services

Strengths:

- As part of the preparation for the waiver implementation, Santa Clara began enhancing its capabilities to track timeliness data. They explained to their county and contracted providers the new data tracking responsibilities that would be required, discussed with them the reasons, and incorporated the new responsibilities into their DMC-ODS provider contracts along with various performance measures.

- Santa Clara tracks a variety of timeliness indicators. The time from initial request to first DMC-ODS service averages 11.59 days for outpatient and 1.2 days for NTP methadone dosing as documented in the Timeliness Self-Assessment form and in Performance data.

- Authorization of residential treatment is a new and central component of the Waiver's blueprint for an organized delivery system. Santa Clara set a timeliness standard of 24 hours for the authorization process to help clients access residential treatment as quickly as possible. Santa Clara reports that 88 percent of all authorizations met the standard. The authorization process does not appear to create barriers to access.

Opportunities:

- Santa Clara has just begun systematic tracking of timeliness measures, including no shows and timeliness from first request to first session for urgent conditions (WM and Hospital referrals). Data dashboards were not available at the time of the review. For these measures and others, the data analytics staff levels were low compared to counties of similar size and some enhanced staffing would benefit the system, especially as they begin the full implementation of AVATAR for clinical functionality and practice management.
- Time from initial MAT request to first MAT appointment was 18 days and the goal is to lower this time from request to first MAT appointment. Goal is to get to within the network adequacy standard of 14 days for routine access.

Quality of Care in DMC-ODS

Strengths:

A fundamental premise of the waiver is that quality treatment is founded on a client-centered approach that includes matching level of care and treatment plan to a client's situation. One of the many ways that Santa Clara applies this principle is to screen and assess prospective clients using ASAM Criteria and use the findings to guide referrals into treatment. Screeners and assessors are trained to enter data for later analysis on the concordance between the ASAM Criteria-indicated Level of Care, what referral was made, and the reasons for lack of concordance if that was the case. Santa Clara tracks this data, as does UCLA. One month of ASAM assessment data was available for CalEQRO review from UCLA and the concordance level was 89 percent for referrals for March 2018.

- Santa Clara assigns to their Utilization Review Specialists in SUTS the responsibility for chart reviews as part of assurance that quality care is being delivered as defined by Drug Medi-Cal for billing and by the Waiver for client-centered ASAM-based care. The chart reviews include intensive technical assistance so that providers learn how to document linkages between the ASAM-based assessment findings, the treatment plan to address the findings, and the progress notes to indicate how the treatment plan is being implemented and how the client is responding to the services. UR staff work as part of the Quality Improvement Team to provide a structured training program for staff, both new and those who need a refresh on core elements of ASAM based treatment.

- In congruence with DMC Waiver principles, Santa Clara encourages coordination of care between substance use, physical health, and mental health services. Because the organizational structure in Santa Clara, includes the hospital, outpatient clinics, and county public health, there are easy-to-access treatment options for physical health care and mental health care. Santa Clara is doing training and outreach for the physical health providers to encourage MAT as well as counseling in the outpatient clinics. They indicated during this review that 75 percent of clients with SUDs report on the TPS that they are satisfied with coordination of their care across substance use, primary care and mental health care.

  Santa Clara, with its early adoption of ASAM principles and strong and visible support for MAT, has reduced any lingering stigma associated with non-abstinence treatment approaches. Only a few clients shared that some family members were still negative about using MAT, but it was rare and, with community education on this issue, decreasing. Counselors and treatment staff saw the value and were supportive. The MAT program under medical leadership had expanded to offer services in residential settings and was planning expansion of MAT in criminal justice settings as well.

- Santa Clara began nearly a decade ago to encourage providers to keep clients who relapse and work with them through their relapses. Santa Clara has regular training with Dr. Mee-Lee on management of relapse issues and in addition has requirements in contracts related to this issue.

- Santa Clara programs also showed evidence of a wide variety of evidence-based practices (EBPs) in their outpatient, residential, case management, and WM programs.

Opportunities:

- Clinical line staff in both contract agencies and county programs showed high levels of commitment to positive outcomes to clients but felt that current paperwork was compromising the ability to focus on the development of strong therapeutic alliances in the first 45 days of services. Administration expressed a willingness to review this issue and look for streamlining solutions.

- Hospital-based WM and residential (?) treatment is needed to fill the gap for high-need, medically complex cases. Without these levels of care, clients will progress to acute levels of medical need with SUD linked complications requiring inpatient care. Prevention of hospitalizations by having these additional levels of care would benefit both the health and SUD care systems and many clients.

- Many primary care clinics nationwide are beginning to deliver MAT and outpatient withdrawal within the primary care delivery system. Outreach, training, and consultation to encourage MAT expansion in the primary care system has begun in Santa Clara and they are training physicians in the hospitals and in primary care. This approach is particularly germane in the context of new HRSA federal funding announced in June 2018 for FQHCs to combat the opioid crisis (see https://www.hhs.gov/about/news/2018/06/15/hhs-makes-350-million-available-to-fight-opioid-crisis-community-health-centers.html).

- Three FTEs in Santa Clara's information systems unit will almost certainly be inadequate to implement and maintain its AVATAR system.

Client/Consumer Outcomes for DMC-ODS

Strengths:

- Santa Clara participates actively in use of the TPS and receives analyses of their results from UCLA. The overall ratings were high, averaging about 4.0, and these remained consistent across each of the survey domains that included access, outcomes, care coordination, quality of care, and

satisfaction. A few providers were outliers with lower ratings. Santa Clara uses clinical feedback such as TPS to improve care and is integrating TPS into one of their Performance Improvement Projects for all clients at their fourth treatment visit. This will provide important feedback in the early stages of engagement in the care process and has the potential to reduce dropouts.

- Santa Clara also uses CalOMS to track pre and post-treatment measures related to drug use, family issues, arrests, and other metrics. They shared the desire to participate in the State revision of CalOMS to reduce unnecessary questions and link it more effectively to ASAM levels of care.

- Santa Clara has one active PIP, and the second will be started as soon as they know UCLA is not making changes to the TPS. Other PIPs have potential to contribute to learning in the SUD field overall, and in particular some aspects of the waiver.

Opportunities:

- Utilize the implementation of AVATAR to strengthen tracking systems for timeliness and outcomes throughout the system of care and include an interface with the Access Call Center Software. Several AVATAR counties have embedded the ASAM LOC Referral questions into their intake/assessment workflow documents, enhancing accuracy and saving staff time.

Recommendations for DMC-ODS for FY 2018-19

1. Santa Clara should initiate one or more task forces to identify opportunities to reduce duplicative paperwork, streamline documentation processes, and enhance reporting in needed areas. The task forces should include contract providers and line staff along with county managers. As part of this effort, consider participation in a proposed State committee to re-write CalOMS.

2. Revise Call Center Procedures to eliminate the requirement for clients to call back to get intake appointments for services. Per Medi-Cal requirements, this procedure creates a barrier to access. Counties have approached this issue in a variety of ways, including walk-in assessment hours at clinic sites. Systems with drop-in intake hours have fewer challenges with intake timeliness and no-shows. Technical assistance is available to discuss these options.

3. Collaborate with hospital representatives and health plan leadership to expand access to two ASAM levels of hospital-based care - withdrawal management and inpatient SUD care for those with medical complexity and risks of serious medical complications.

4. Develop a plan to electronically exchange client case management, billing, and clinical information between Santa Clara's AVATAR system and its contract provider's EHR systems using standards-based transactions.

5. Enhance systems linked to withdrawal management services to reduce "churn/recycling" through acute care systems and enhance capacity and effective stabilization prior to transfer into community settings, both residential and outpatient.

6. Address, as planned by management of SUTS, need for addition of 250 slots for outpatient assessments and services in the next year. This will allow for timely access to these services and reduce potential wait times.

7. Evaluate the realistic information systems staffing required to implement, optimize, and maintain Santa Clara's AVATAR system.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: County Highlights
- 180 Scan Reference

Attachment E: Client Family Focus Group Forms

Attachment F: Access Call Center Key Indicators

Attachment G: Continuum of Care Form

Attachment H: Acronym List Drug Medi-Cal EQRO

Attachment A—On-site Review Agenda

The following sessions were held during the DMC-ODS on-site review, either individually or in combination with other sessions.

Table A1—CalEQRO Review Sessions – Santa Clara DMC-ODS
Opening session – Changes in the past year; current initiatives; baseline data trends and comparisons, and dialogue on performance measures for access, timeliness and quality
Quality management activities, diversity, access and timeliness
Adult SUD client focus groups - 4
Information systems and fiscal/billing
General data use
ASAM – related data use
Youth site visit and focus group-1
Access Line site visit and staff focus group
Performance improvement projects -2
Medication in addiction treatments (MATs)
Clinical line staff focus group for both contracted with county
Contract provider executives to discuss waiver challenges in administration, operations and quality management
Youth service stakeholders focus group
Coordination with other systems of care, especially physical health plan and FQHCs
Exit interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Rama Khalsa, Lead Reviewer and Deputy Director, Drug Medi-Cal EQRO
Maureen Bauman, Second Quality Reviewer
Karen Baylor, Quality Reviewer
Melissa Martin, Information Systems Reviewer
Anita Shoemaker, Child/Client and Family Member Reviewer

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

Sites for Santa Clara's DMC-ODS Review

DMC-ODS Sites

Outpatient Clinic
Gardner/Proyecto Primavera
614 Tully Rd #304
San Jose, CA. 95111

Central Treatment and Recovery
976 Lenzen Ave suite 1900
San Jose, CA. 95126

Children, Family Community Services
2101 Alexian Drive
San Jose, CA. 95116

Pathway House
102 South 11th St
San Jose, CA. 95113

Central Valley Clinic
2525 Enborg Lane
San Jose, CA. 95128

Horizon South
650 South Bascom Ave #C
San Jose, CA. 95122
Santa Clara County
1075 E Santa Clara St.
San Jose, CA.

Access Call Center
Gateway Call Center
1867 Senter Road
San Jose, Ca. 95112

Table B1 - Participants Representing Santa Clara DMC-ODS			
Last Name	**First Name**	**Position**	**Agency**
Acaccia	Richard	Quality Assurance	Family Children Services, Caminar
Acevedo	Domingo	Compliance Manager	BHSD
Adams	Catherine	Marriage and Family Therapist	Pathway Society
Arciaga	Adeline	Revenue Control Analyst	Health and Hospital
Awbry	Aylin	Residential Care Worker	Advent Group Ministries
Banerjee	Kakoli	Division Director of Research and Outcomes Measurement	BHSD SUTS Administration
Bolding	Karen	Management Information Services Manager III	Health and Hospital
Bourdon	Chevelle	Clinical Supervisor of WM	Pathway Society
Brown	Renee	Chief Clinical Officer	Advent Group Ministries
Bui	Long	Sr. Management Information System Analyst	BHSD SUTS Quality Improvement & Data Support
Canfield	Lisa	Alcohol and Drug Counselor	Horizon South Inc.
Casper	Pauline	Quality Improvement Coordinator II	BHSD SUTS Quality Improvement & Data Support
Chaudhry	Hafsa	Health Care Program Analyst Associate	BHSD SUTS Administration
Cherukuri	Sudhakar	Sr. Staff Physician	Addiction Medicine Treatment
Chesnakova	Olena	Sr. Management Information System Analyst	BHSD SUTS Quality Improvement & Data Support
Choksy	Irem	Clinical Supervisor	Horizon South
Christian	Katherine	Sr. Health Care Program Analyst	BHSD SUTS Quality Improvement & Data Support
Copley	Bruce	Director of Alcohol, Drug, and Access Services	BHSD SUTS Administration
Crocker Cook	Mary	Program Coordinator	San Jose City College and Pathway Society

Table B1 - Participants Representing Santa Clara DMC-ODS			
Last Name	**First Name**	**Position**	**Agency**
Daly	Paul	Marriage and Family Therapist	BHSD Central Treatment and Recovery
Davis	Deahna	Addictions Counselor	Advent Group Ministries
Do	David	Sr. Staff Physician	Addiction Medicine Treatment
D'Zatko	Kimberly	Sr. Research & Evaluation Specialist	BHSD SUTS Administration
Guinn	John	Program Manager	Horizon South
Guida	Richele	Alcohol and Drug Counselor	Horizon South Inc.
Gissible	Loren	Program Coordinator	Gardner Family Corporation
Gutierrez	Isaac	Associate Social Worker	BHSD Children, Family, & Community Services
Gutierrez	Patrick	Alcohol and Drug Counselor	Gardner Family Corporation
Harnish	Mary	Clinical Risk Manager	BHSD
Hatanaka	Yukiko	Associate Marriage and Family Therapist	Asian Americans for Community Involvement, Inc.
Hernandez	Angelina	Director of Mariposa	Pathway Society
Hill	Satsuki	Alcohol and Drug Counselor	Horizon South Inc.
Hong	Linh	Quality Improvement Coordinator II	BHSD SUTS Quality Improvement & Data Support
Hsiao	Theresa	Quality Improvement Coordinator II	BHSD SUTS Quality Improvement & Data Support
Jaurigue	Mia	Rehabilitation Counselor	BHSD SUTS Offender Treatment Program
Kahn	Dana	Office Specialist III	BHSD SUTS ROM
Kebede	Sehene	Alcohol and Drug Counselor	Horizon South Inc.
Kim	Sujung	Health Care Program Analyst Associate	BHSD SUTS Administration
Lamdin	Martha	Alcohol and Drug Counselor	Horizon South Inc.

Table B1 - Participants Representing Santa Clara DMC-ODS			
Last Name	**First Name**	**Position**	**Agency**
Liang	ShuNing	Quality Improvement Coordinator II	BHSD SUTS Quality Improvement & Data Support
Lipschultz	Marla	Marriage and Family Therapist	Addiction Medicine Treatment
Lownsbery	Steve	Clinical Standards Coordinator	BHSD SUTS Quality Improvement & Data Support
Lozada	Neidy	Associate Director or Programs	Pathway Society
Ma	Roberto	Associate Director of Outpatient Services	Advent Group Ministries
Martinez	Martha	Sr. Health Care Program Analyst	BHSD SUTS Administration
Miller	Mindy	Rehabilitation Counselor	BHSD SUTS NTP/OTP
Montrezza	Gary	Chief Executive Officer	Pathway Society
Nelson	Sue	Division Director Children, Family & Community Services	BHSD SUTS
Nelson	Tianna	Division Director of Quality Improvement and Data Support	BHSD SUTS
Newlin	Dennis	Marriage & Family Therapist II	BHSD Central Treatment & Recovery
Nguyen	Annie	Marriage and Family Therapist	BHSD Children, Family, & Community Services
Nguyen	Hung	Sr. Mental Health Program Specialist	BHSD
Panlilio	Noel	Sr. Health Care Program Manager/ Compliance Officer	BHSD SUTS Gateway Call Center
Parwiz	Mira	Division Director Addiction Medicine & Treatment Services (AMT)	Addiction Medicine Treatment
Pham	Hang	Quality Improvement Coordinator II	BHSD SUTS Quality Improvement & Data Support
Phan	Victoria	Compliance Officer	Compliance
Piazza	Jim	Information Systems Manager III	Health and Hospital

Table B1 - Participants Representing Santa Clara DMC-ODS			
Last Name	**First Name**	**Position**	**Agency**
Picchi	Carol	Management Info Systems Analyst	BHSD SUTS Quality Improvement & Data Support
Ramsey	Tammy	Sr. Health Care Program Analyst	BHSD SUTS Administration
Rice	Amy	Clinical Supervisor	Gardner Family Corporation
Rubio-Corona	Patricia	Health Care Program Analyst Associate	BHSD SUTS Administration
Saunders	Nicole	Health Care Compliance Analyst	Compliance
Sentner	Tina	Program Director	Mission Street Sobering Center Horizon South
Singh	Suma	Sr. Staff Physician	Addiction Medicine Treatment
Sona	Edith	Health Care Program Manager II	BHSD SUTS Parolee Re-Entry Resource Center
Stone	Samara	Clinical Supervisor	HealthRIGHT 360
Styner	Deborah	Health Care Program Manager II	BHSD SUTS Central Treatment & Recovery
Tai	Sydney	Alcohol and Drug Counselor	HealthRIGHT360
Taylor	Nancy	Quality Improvement Coordinator II	BHSD SUTS Quality Improvement & Data Support
Toprak	Ahmet	Management Info Systems Analyst II	BHSD SUTS Administration
Tsai	Dan-Wen	Nurse Manager	Addiction Treatment Medicine
Tullys	Toni	Director	BHSD
Vasquez	Cynthia	Alcohol and Drug Counselor	Horizon South Inc.
Villanueva	Leilani	Sr. Health Care Program Analyst	BHSD SUTS Administration
Vilms	Dinaz	Licensed Clinical Social Worker	BHSD Children, Family & Community Services
Wiley	Deane	Deputy Director	BHSD
Windett	Lara	Health Care Program Manager II	Addiction Medicine Treatment

Attachment C – PIP Validation Tools

GENERAL INFORMATION	
DMC-ODS: Santa Clara	☒ Clinical PIP ☐ Non-Clinical PIP
PIP Title: Increasing four clinical contacts in 30 days; Clinical Engagement and Retention	
Start Date: 06/01/18 **Completion Date expected completion:** 12/01/18 **Projected Study Period**: 6 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 09/01- 09/03/18 **Name of Reviewer**: Maureen Bauman	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish): Pilot study of a single outpatient (OP) provider's delivery of a simple, convenient treatment service. The service is a clinical phone call between the beneficiary and their primary clinician that occurs between the first and typically second session. This is designed as a new engagement intervention to improve patient experience and satisfaction with care resulting in enhanced engagement as evidenced by 4 sessions within 30 days.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Behavioral Health Quality Improvement Committee (BHCIC) consisting of involved consumer members, consumer family members, criminal justice partners, cultural competency experts, mental health and substance use partners, direct clinical staff from MH and SUD, executive staff, primary care and other health representatives.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The 180 Scan findings (providing a wide view of the new system of care for the first six months (July – December 2017) including clinical processes, client outcomes, system performance and system efficiencies were reviewed. This was then compared to national background and benchmark information with the best practices. The topic of engaging OP beneficiaries early in their treatment by maximizing the number of treatment services received in the initial stage of the program was identified as an area of program improvement. Data showed approximately 45% of OP beneficiaries received 4 in 30 across the entire system.

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

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The key aspect was early engagement as demonstrated by an increase number of beneficiaries received 4 services in 30 days to more successfully engage persons into treatment. The goal was to increase treatment initially to engage and to keep persons in treatment longer. Research was cited to show longer stays result in better consumer outcomes.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All populations were addressed at one provider agency as a pilot prior to bringing the study to scale across the system.
Totals		**4** Met **0** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will a primary clinician's phone call to a client between the first and second session of a client's outpatient treatment increase the likelihood the client will continue treatment?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Study question is clear and specific. A single intervention will be measured to see if it increased the likelihood of the person engaging in treatment as measured by the 4 sessions in 30 days. Additional data could be analyzed to validate this assumption. The pilot will be at Adult Pathway Society for all clients in Level 1.0 Outpatient Substance Use Services. This program was selected using specific criteria designed as a part of the study
Totals		**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All beneficiaries entering the level 1.0 at the pilot site will be in the study.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Discharge data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Service authorization and utilization data will be used to determine engagement and intervals between services. Key beneficiary level outcomes include treatment exit and discharge status.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Increase percent of clients who had 4 or more services in the first 30 days from 45% to 65%.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The intervention will increase the number of beneficiaries who engage in treatment as measured by the same scale from baseline 45% to goal of 65%. The PIP needs to clarify the baseline, so it is consistent in the document. The phone call intervention will be documented as the second session.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused. ☐ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study has a specific goal to increase engagement however; the research cited implies that the early engagement can lead to outcomes that are more successful. The study does not discuss the outcomes indicated in health, functioning, member satisfaction or provider satisfaction. The study could include outcome data for this population to see if there are improvements over time.
	Totals	**0** Met **2** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No Sampling

5.2 Were valid sampling techniques that protected against bias employed?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **3** Not Applicable **0** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data to be collected is identified
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data will be service data that is currently collected in the EHR.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The timing of the data was not clarified in the study design although the number of beneficiaries entering the pilot in the first 15 days was identified.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☒ Level of Care tools	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Medical Record data will be utilized for this study
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The data will be compared to the baseline group of beneficiaries at the same agency who received 4 services in 30 days without the clinician call. Chi-square test of difference in proportions of those receiving 4 in 30 will be compared. Outcome data will also be compared but that analysis is less clear.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Tianna Nelson PhD Title: Quality Improvement Director Role: Project Lead *Other team members:* Names: Research and Outcome Measurement Analysts	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Project leader for both clinical and non-clinical PIPS is Tianna Nelson, Quality Improvement and Data Support. The Division Director, Kakoli Banerjee of the Research and Outcome Measurement Division be overseeing the data collection.
Totals		**4** Met **2** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *<Text>*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP used criteria to determine the most appropriate provider to be selected for the study. In addition, there were specific directions provided that outlines the expectations of the phone intervention. The expectations allowed for diverse clinical styles but clarified clearly the goal of the intervention.
Totals		**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data analysis is brief and could be described in more detail for more clarity.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	There has been only a small amount of data collected at the time of the review.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements:_____ Indicate the statistical analysis used:_____ Indicate the statistical significance level or confidence level if available/known:_____% _**X**_Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	It is not clear what time periods will be used for comparison. The initial proposal is to increase engagement comparing the two populations who have 4 services in 30 days. Additional discharge status data is identified with a plan to use a t-test to compare outcomes of beneficiaries in baseline and pilot.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Not enough data has been collected at this point to make this determination.
Totals		**0** Met **1** Partially Met **0** Not Met **0** NA **3** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Not enough data has been collected at this point to make this determination.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Not enough data has been collected at this point to make this determination.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Not enough data has been collected at this point to make this determination.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Not enough data has been collected at this point to make this determination.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Not enough data has been collected at this point to make this determination.
	Totals	**0** Met **0** Partially Met **0** Not Met **0** NA **5** UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: The PIP is based in research that indicates that early engagement in treatment result in improved outcomes. The PIP was put in place after a review of data that showed approximately 45%of the clients were not receiving four services in 30 days. This does not mean the clients were dropping out. It means that on average, approximately half of the clients were receiving only one, two, or three services in 30 days. This is not optimal engagement for treatment. The intervention was put in place to engage clients and be convenient for the client since it was a telephone call and transportation was not needed.
Recommendations: The PIP is well thought out and in process of implementation. Once the pilot data validates the initial assumptions it is recommended that they begin to implement systematically with other providers in order to expand the pilot.

Check one:	☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time

GENERAL INFORMATION

DMC-ODS: Santa Clara ☐ Clinical PIP ☒ Non-Clinical PIP

PIP Title: Boosting outpatient (OP) beneficiary Treatment Perceptions Survey response rate; Non-clinical

Start Date: Not yet started
Completion Date: 03/30/19
Projected Study Period: 6 Months
Completed: Yes ☐ No ☒
Date(s) of On-Site Review: 09/01- 09/03/18
Name of Reviewer: Maureen Bauman

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

☐ Active and ongoing (baseline established, and interventions started)

☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

☒ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

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

In addition to the annual point-in-time administration of the Client Feedback Survey, SUTS OP beneficiaries will be asked to complete the survey prior to their 4th appointment in the treatment episode in support of SUTS's.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Stakeholders include consumer members and consumer family members, criminal justice partners, cultural competency experts, mental health and substance use partners, direct clinical staff from both mental health and substance use providers, quality management division directors and executive members, primary care and other health plan representatives, and quality improvement coordinators. These persons are part of the BH Quality Improvement Committee.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Santa Clara reviewed early SUTS data with stakeholders and it became evident that client drop-out rates in outpatient programs were unacceptably high and needed an intervention. An early drop-out in outpatient services is defined as leaving treatment within 30 days of admission. Consistently high drop-out rates were reported in quarterly Contract Performance Measures (CPMs), and it was not clear as to why clients were dropping out prior to treatment completion.

Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-Clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The concern about clients dropping out was across the outpatient system.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☒ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP will intervene on all persons in outpatient treatment.
Totals		**4** Met **0** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* (iv) Is there a systematic difference in treatment perception between clients who drop out early and that complete treatment? (v) (ii) Are there differences in dropout rates by gender, age, ethnicity/race, criminal justice status and other variables? (vi) (iii) Are there systematic differences by outpatient programs? The purpose of investigating these questions is to identify factors that are amenable to intervention by programs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is clear.
Totals		**1** Met **0** Partially Met **0** Not Met **0** UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☒ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All outpatient Medi-Cal enrollees are included
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This study is hoping to target early dropouts of treatment so that an intervention can be tailored to them once data is identified. This will be dependent on whether the information from the additional survey provides information that identifies a person's profile or provides data relevant to develop an intervention. This is a good first step.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Increase in percent of OP beneficiaries who complete a Client Feedback Survey within four weeks of treatment	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Santa Clara looked at data from their first 6 months of operation and determined with the data that percent of persons dropping out of treatment very early was too high.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused. ☐ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	This study is designed to gather data from clients who do not have planned exits and therefore do not provide information on their perception of the treatment they are receiving. The early request for completion of the Treatment Perception Survey (TPS) will gather information not yet received. The plan could more clearly state what will be done with this additional information.
	Totals	**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **3** NA **0** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	SUTS staff has created a detailed instruction guide to assist county and contract providers to administer the TPS. TPS data will be gathered at two points in time: by the 4th outpatient session (the first administration) and close to a discharge (2nd administration).
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	SUTS is set up to support providers and monitor fidelity to the intervention. SUTS will send weekly reminders to providers. Providers have been asked to designate an individual within each agency to be the point person for SUTS administration. SUTS administration monitors survey submissions on a weekly basis and provides real-time feedback to providers whose survey submissions fall below the number expected based on rolls of active clients.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data entry: A scannable version of the TPS survey was created using software known as Teleform. Providers are instructed to make the TPS available to clients. There were detailed instructions sent to the providers. Completed surveys are uploaded to SUTS via secure portal by provider staff or emailed directly to SUTS staff from county clinics. Data are stored in a SQL database and can be retrieved at any time after being committed to the database in common formats such as EXCEL.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Treatment Perception Survey also known as Client Perception Survey is a validated instrument. Santa Clara has added 4 additional questions to this instrument. The same survey will be sent out a second time. There was a delay in the plan due to a change by the state of the instrument that resulted in the collection process needing to be changed (it is embedded in their electronic system) and these changes caused the start date to be delayed.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Data will be analyzed to create a drop-out risk profile based on age, gender, race-ethnic background, homelessness, criminal justice background and responses on the TPS. This risk profile can be tailored to specific outpatient programs. Individual outpatient programs will be able to use these data to identify clients who fit the profile for early drop-out for interventions, designed to keep them in treatment. No contingencies for untoward results were identified.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Tianna Nelson Title: Quality Improvement Director Role: Lead *Other team members:* Names: Analysts from this unit	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Staff from the Research and Outcome Measurement Division were overseeing the collection of this data.
	Totals	**5** Met **1** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *<Text>*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	A strategy was developed to regularly remind providers and staff to turn in these early TPS. This was put in place due to experience in putting new requirements in place and understanding it takes regular prompting to receive all the anticipated data.
Totals		**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	No data has been collected
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	No data has been collected

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known:_____% ___unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The study plans to use the same instrument that is currently required by the state at a point in time and required by the county to be used at discharge to now be used prior to the 4th treatment session of each person in outpatient client treatment
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	No data was collected
Totals		**0** Met **0** Partially Met **0** Not Met **0** NA **4** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The same instrument will be used

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **0** NA **5** UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: This study is still conceptual but is expected to provide information from clients who previously were not regularly surveyed.
Recommendations: No recommendations. The PIP was developed with TA from the EQRO staff.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☐ Confidence in PIP results cannot be determined at this time

Attachment D—County Highlights

Santa Clara did a comprehensive 180 Scan of their system after six months and the results represented a positive and effective quality improvement analysis and action steps.

The link to this report is below:

*https://www.sccgov.org/sites/bhd-p/QI/SUTS/Documents/SUTS%20180%20SCAN%202.27.18%20Presentation-revision-OP%20version.pdf

Attachment E—Client Focus Group Forms

Client Focus Group form
Parents/ Guardians of Adolescent Clients Focus Group Feedback

Program/Clinic Name: _____ Date: _____

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

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

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

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

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

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

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

---

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

Discussion questions:

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

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

Client Focus Group form
Transitioning Age Youth (TAY) Focus Group Feedback

Program/Clinic Name: _____ Date: _____

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

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

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

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

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

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

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

---

1. I easily found the treatment services I needed.


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

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


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

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

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

Client Focus Group form
Adult Client Focus Group Feedback

Program/Clinic Name: _____ Date: _____

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

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

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

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

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

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

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

---

1. I easily found the treatment services I needed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

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

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

Attachment F—Summary of Access Call Center Key Indicators

Access Line Performance Measure

Overview/ Analysis

Average Monthly Call Volume in Last 12 months
Average Monthly Calls: **2320 from** 7/1/2017 **to** 5/31/2018

Average Dropped Calls Per Month: 9.2%

Average Wait Time on the Phone until Answered: 40 seconds

Dedicated Full Time Equivalent (FTE) Staff Assigned to Call Center: 8.0

Software/Vendor for Tracking Call Metrics
Software Name: Cisco
Software Version: Unified Contact Center Enterprise (UCCE) version 10.5.1

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

Disposition of calls is in clinical charts. Santa Clara uses Santa Clara developed ASAM tool but hopes to use UCLA tool when ready. Software for call center gives clients a choice of languages and then the call is transferred to someone with those language skills. Gateway staff work with translation unit in three-way call. There is no built-in satisfaction survey in the call center at this time.

Attachment G—Continuum of Care Form

Continuum of Care–DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Capacity: County: Santa Clara Review Date(s): August 1-3, 2018

Person Completing Form: Tianna Nelson PhD, LMFT

County Role for Access and Coordination of care for persons with SUD requiring social work/linkage/peer supports to coordinate care and ancillary services.
Access to services can occur through the Gateway Call Center or post-authorization sites (specific locations such as courts, schools, Juvenile Hall, Re-entry, and Withdrawal Management). Care can be coordinated b different staff and different locations; however, primary clinicians at SUTS sites are assigned to beneficiaries and act as point persons for coordination of care. QI Coordinators may also facilitate and coordinate care throughout the system.

Case Management- Describe if it's centralized or integrated into programs or both:	
Monthly Estimated Billable hours of Case Management:	**52 hours/month (7/1/17-2/28/2018)**

Comments:
TCM is potentially provided by all clinicians/counselors throughout the whole system; therefore, it is integrated into all programs. TCM is individualized per client, some may not be in need while others may require multiple types of TCM depending on the complexity of the clients' needs. First year data will establish a benchmark for average estimated billable hours. Still pending.

How are you structuring Recovery Services?

Recovery Services – Support services for clients in remission from SUD having completed treatment services but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing peer support.			
Pick 1 or more as applicable and explain below: **1) Included with Outpatient sites as step-down** **2) Included with Residential levels of care as step down** **3) Included with NTPs as stepdown for clients in remission**			
Total Legal Entities:	**One (1)**	Choice(s):	**One (1)**

Explanation:
1, 2, and 3 can provide Recovery support.
What is your estimated monthly estimated billable hours of recovery support services? 5 hours (9/1/2017-10/31/2017)

Withdrawal Management – withdrawal from SUD related drugs that lead to opportunities to engage in treatment programs (use DMC definitions).			
Number of Sites:	One (2)	Estimated Billable days per month:	**2100**
How are you structuring it? - *Pick 1 or more as applicable and explain below* **1) NTP?** **2) Hospital** **3) Outpatient** **4) Primary Care Sites**			
Choice(s):	Linked to residential, no outpatient WM at this time.		

Explanation:
Currently we have two ASAM level 3.2 Clinically Managed Residential WM sites. Both are located adjust to residential ASAM 3.1 treatment centers. Please note that Level 3.2 began billing DMC in March of 2018.

Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports for the withdrawal.			
Number of Sites:	Two	Estimated Billable	2100
Total Legal Entities:	**Two**		
Pick 1 or more as applicable and explain below: **1) Hospitals** **2) Freestanding** **3) Within residential treatment center**			
Choice(s)	**Three (3)**		

Comments:

The components of withdrawal management services are intake, observation, medication services and discharge services. Case Management will be provided to coordinate care with ancillary service providers and facilitate transitions between levels of care.

How are they organized?

Explanation:

The facilities are DMC certified to provide withdrawal management and residential treatment services.

NTP Programs- Narcotic Treatment Programs for opioid addiction and stabilization including counseling, methadone, and coordination of care.				
Total Slots:	959		Number of Sites:	Four
Total Legal Entities:	**Two**			
Out of County NTP	**Slots:**	109	**Sites:**	one
In County NTP	**Slots:**	**850**	**Sites:**	**three**

Comments:
We have 4 NTP clinic sites that span from south of the county, to east and central San Jose, and contract with a clinic in San Mateo for northern county residents. Care is often coordinated with primary care, specialty care, and mental health services. Perinatal services are also offered for pregnant women and women with newborns who are prescribed methadone.

MAT Outpatient (providing other drugs besides methadone) - Outpatient services providing MAT medical management including a range of medications other than methadone, usually accompanied by counseling for optimal outcomes.			
Total Legal	1	Number of Sites:	3

Comments:
Our MAT teams are comprised of 4 doctors, 17 counselors, and 14 nurses. These teams are in three sites and support NTP Methadone services as well.

Level 1: Outpatient – Less than 9 hours of outpatient services per week (6 hrs. /week for adolescents) providing evidence-based treatment.			
Average estimated billable hours per month:	***1504 hours/month (7/1/2017-2/28/2018)***		
Total Legal	Five (5)	***Total Sites for all Legal Entities:***	Five

Comments:
Adult and youth outpatient providers span our county. One of the unique features on our adolescent youth services side is the MOUs with various school districts all over the county. Both county and contract providers offer DMC services for youth in confidential settings at these school sites for ease of access. Outpatient providers for both adult and youth utilize Motivational Interviewing, Cognitive Behavioral Techniques and therapies, Relapse Prevention, and Trauma Informed developmentally appropriate models of care for SUD.

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.			
Estimated Billable hours per month:	***442 hours/month***		
Total Legal Entities:	One	***Total Sites for all Legal Entities:***	One

Comments:
None

Level 2.5: Partial Hospitalization – 20 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient treatment but not 24-hour care.			
Total Number of Programs:	One	***Total Sites for all Legal***	One (1)
Average Client Capacity per	28		

Comments:
In February 2018, Partial Hospitalization was added into the Santa Clara County SUD system of care. The program has four full time counselors, one nurse practitioner, and one clinical supervisor. Current capacity is 28 slots.

Level 3.1: Residential – Planned, and structured SUD treatment / recovery that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.			
Number of Program Sites:	Three	***Number of Legal Entities:***	***Two***
Total Beds:	***134***		

Level 3.3: Clinically Managed, Population Specific, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.			
Number of Program Sites:	0	***Number of Legal Entities:***	***0***
Total Bed Capacity:	**0**		

Level 3.5: Clinically Managed, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.			
Number of Program Sites:	0	***Number of Legal Entities:***	***0***
Total Bed Capacity:	***0***		

(Can be flexed and combined with 3.1)

Comments:
Expansion in second year of the waiver to include this level of care.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting.			
Total Program Sites:	0	***Number of Legal Entities-***	***0***
Total Bed Capacity:	***0***		

Comments:
Ongoing discussion occurs as to how Santa Clara County's system of SUD care will address the need for this level of care.

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting.			
Total Program Sites:	0	***Number of Legal Entities-***	***0***
Total Bed Capacity:	***0***		

Comments:
Santa Clara County Substance Use Treatment Services (SSC SUTS) has developed a seamless continuum of care with Inpatient Valley Medical Center's SBIRT project. This process screens patients, while they are in the hospital, and if the patient screen positive for at risk drinking, opioids, amphetamines, or other substances, patients are aligned with the appropriate level of care referral. SUTS Quality Improvement Coordinators facilitate this care coordination and transfer process. Patients, who may require Medical Respite after inpatient or acute care, are also transitioned into the appropriate level of care once their medical conditions have been stabilized.

In terms of co-occurring care, SCC SUTS is continuing to develop and enhance our services. Agreements with Telecare Corporation are in place to provide two different programs as follows: (1) substance use residential services will provide 30 beds for adult criminal justice clients and offer co-occurring treatment; and (2) crisis residential services (CRS) will provide 15 beds as an alternative to acute psychiatric hospitalization for adults and older adults involved in the criminal justice system who would otherwise require inpatient care.

Attachment H—Acronym List Drug Medi-Cal EQRO Reviews

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

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

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