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

SAN BENITO DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
January 26-27, 2021

TABLE OF CONTENTS

SAN BENITO DMC-ODS REPORT 6
Site Review Special Characteristics 6
Introduction 6
Access 7
Timeliness 7
Quality 8
Outcomes 8
Client/Family Impressions and Feedback 8
Recommendations 9

EXTERNAL QUALITY REVIEW COMPONENTS 10
Validation of Performance Measures 10
Performance Improvement Projects 10
DMC-ODS Information System Capabilities 11
Validation of State and County Client Satisfaction Surveys 11
Review of DMC-ODS Initiatives, Strengths and Opportunities for Improvement 12

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES 13
Changes to the Environment 13
Past Year's Initiatives and Accomplishments 13
San Benito Goals for the Coming Year 14

PERFORMANCE MEASURES 16
HIPAA Guidelines for Suppression Disclosure 17
Year One of Waiver Services 17
Performance Measures Findings: Impact and Implications 34

INFORMATION SYSTEMS REVIEW 37
Key Information Systems Capabilities Assessment (ISCA) Information Provided by the DMC-ODS 37
Summary of Technology and Data Analytical Staffing 38
Summary of User Support and EHR Training 39
Telehealth Services Delivered by County 41
Telehealth Services Delivered by Contract Providers 42
Current DMC-ODS Operations 43
The DMC-ODS Priorities for the Coming Year 43
Major Changes since Prior Year 44
Plans for Information Systems Change 44
DMC-ODS EHR Status 44
Contract Provider EHR Functionality and Services 45
Special Issues Related to Contract Agencies 47
Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey 47
Overview and Key Findings 48

NETWORK ADEQUACY 49

Network Adequacy Certification Tool Data Submitted in April 2020 49
Findings 50
Plan of Correction/Improvement by DMC-ODS to Meet NA Standards and Enhance Access for Medi-Cal Patients 50

PERFORMANCE IMPROVEMENT PROJECT VALIDATION 51
San Benito DMC-ODS PIPs Identified for Validation 51
Clinical PIP 51
Non-clinical PIP 54

CLIENT FOCUS GROUPS 58

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS 59
Access to Care 59
Timeliness of Services 60
Quality of Care 62

DMC-ODS REVIEW CONCLUSIONS 65
Access to Care 65
Timeliness of DMC-ODS Services 66
Quality of Care in DMC-ODS 66
Client Outcomes for DMC-ODS 67
Recommendations for DMC-ODS for FY 2019-20 67

ATTACHMENTS 69
Attachment A: CalEQRO Review Agenda 70
Attachment B: Review Participants 71
Attachment C: County Highlights 73
Attachment D: Continuum of Care Form 74
Attachment E: Acronym List Drug Medi-Cal EQRO Reviews 80

LIST OF TABLES AND FIGURES

Table 1: Penetration Rates by Age, FY 2019-20
Table 2: Average Approved Claims by Age, FY 2019-20
Table 3: Penetration Rates by Race/Ethnicity, FY 2019-20
Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2019-20
Table 5: Average Approved Claims by Eligibility Category, FY 2019-20
Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2019-20
Table 7: Days to First Dose of Methadone by Age, FY 2019-20
Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2019-20
Table 9: Timely Transitions in Care Following Residential Treatment, FY 2019-20
Table 10: Access Line Critical Indicators, FY 2019-20
Table 11a: High-Cost Beneficiaries by Age, San Benito FY 2019-20
Table 11b: High-Cost Beneficiaries by Age, Statewide, FY 2019-20
Table 12: Residential Withdrawal Management with No Other Treatment, FY 2019-20
Table 13: Congruence of Level of Care Referrals with ASAM Findings, FY 2019-20
Table 14: Percentage Served and Average Cost by Diagnosis Code, FY 2019-20
Table 15: CalOMS Living Status at Admission, FY 2019-20
Table 16: CalOMS Legal Status at Admission, FY 2019-20
Table 17: CalOMS Employment Status at Admission, FY 2019-20
Table 18: CalOMS Types of Discharges, FY 2019-20
Table 19: CalOMS Discharge Status Ratings, FY 2019-20

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2019-20
Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA

ISCA Table 1: Percentage of Budget Dedicated to Supporting IT Operations
ISCA Table 2: Business Operations
ISCA Table 3: Distribution of Services by Type of Provider
ISCA Table 4: Technology Staff
ISCA Table 5: Data Analytical Staff
ISCA Table 6: Count of Individuals with EHR Access
ISCA Table 7: EHR User Support
ISCA Table 8: New Users EHR Training
ISCA Table 9: Ongoing EHR Training and Support
ISCA Table 10: Summary of DMC-ODS Telehealth Services
ISCA Table 11: Contract Providers Delivering Telehealth Services
ISCA Table 12: Primary EHR Systems/Applications
ISCA Table 13: EHR Functionality
ISCA Table 14: Contract Providers' Transmission of Beneficiary Information to DMC-ODS EHR
ISCA Table 15: Type of Input Method for NTP/OTP Providers

ISCA Table 16: EHR Vendors Supporting Contract Provider to DMC-ODS Data Transmission
ISCA Table 17: Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey

PIP Table 1: PIPs Submitted by San Benito
PIP Table 2: General PIP Information, Clinical PIP
PIP Table 3: Improvement Strategies or Interventions, Clinical PIP
PIP Table 4: Performance Measures and Results, Clinical PIP
PIP Table 5: General PIP Information, Non-Clinical PIP
PIP Table 6: Improvement Strategies or Interventions, Non-Clinical PIP
PIP Table 7: Performance Measures and Results, Non-Clinical PIP

KC Table 1: Access to Care Components
KC Table 2: Timeliness to Care Components
KC Table 3: Quality of Care Components

Attachment Table A: CalEQRO Review Sessions
Attachment Table B1: Participants Representing San Benito

SAN BENITO DMC-ODS REPORT

Beneficiaries Served in Fiscal Year (FY) 2018-19: 196
San Benito Threshold Language(s): English and Spanish
San Benito Size: Small
San Benito Region: Central
San Benito Location: 1131 San Felipe Road, Hollister, CA
San Benito Seat: Hollister
San Benito Review Process Barriers: See section below, Site Review Special Characteristics

Site Review Special Characteristics

This review took place during the COVID-19 pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, the California External Quality Review Organization (CalEQRO) worked with San Benito to design an alternative to the usual in-person on-site review format. We had previously had three technical assistance virtual meetings to discuss and provide assistance with their PIPs. Due to its small size, there is a limited number of management staff and providers, and management staff also see clients due to their limited size population. San Benito also had a key leadership staff leave prior to the review time, leaving even fewer management staff to address client issues, the tasks associated with the COVID-19 pandemic, and the ability to develop and a support a plan to vaccine their residents. Consequently, this review, after discussion with the county Executive Team, was conducted via desk review with no virtual meetings. San Benito staff, and provider staff, were unable to attend virtual meetings.

Introduction

San Benito County is a small county south of Santa Clara County with Monterey County on the southwest border and Santa Cruz County to the west. The county also borders Merced County and Fresno County on the east, which lead into California's San Joaquin Valley.

San Benito County officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in July 2019 for Medi-Cal recipients as part of California's 1115 DMC Waiver. San Benito County was the 27th county, along with Tulare and Sacramento, to launch statewide. In this report, "San Benito County" shall be used to identify the San Benito County DMC-ODS program unless otherwise indicated.

San Benito County is a rural largely agricultural county with a total population, based on the 2020 Federal Census, of 58,671 residents. Approximately 56.4 percent of the population is Hispanic, with 35 percent speaking Spanish as their primary language.

The remainder (38.3 percent) are primarily Caucasian, non-Hispanic. There are two main population centers in San Benito County: Hollister, the county seat, and San Juan Bautista. The county conducted community outreach activities in both main cities. 19.6 percent of the population have incomes below 150 percent of the Federal poverty level, and 20.9 percent of the population over age 25 are not high school graduates. Agriculture is the primary employer for the county, followed by Hazel Hawkins Hospital, although many community residents commute to San Jose and other cities for work.

Access

After a client calls the Access Line and is considered appropriate for SUD services the individual is scheduled to attend an intake appointment with a SUD counselor Intake paperwork is completed, and the client is screened to identify the potential Level of Care (LOC). The screening also indicates whether the beneficiary needs an urgent or routine appointment. The client is then scheduled for an assessment with an LPHA or certified/registered alcohol and drug counselor. Following the completion of the assessment the client is formally linked to the appropriate LOC.

If a client calls the Access Line after hours and the screening tool indicates an immediate need for withdrawal management (WM), residential or inpatient services, the client is encouraged to go to the Emergency Department (ED) at Hazel Hawkins Hospital for additional screening, medical clearance, or to provide medical intervention if needed.

Hazel Hawkins Hospital staff and the Health Foundation, a Federally Qualified Health Center (FQHC) clinic conduct a substance abuse screening for all new patients and when the provider identifies potential substance use issues the staff use motivational interviewing (MI) to encourage the patient to obtain a substance use assessment and treatment.

Timeliness

Thirty-nine percent of San Benito’s beneficiaries are offered a first appointment within seven days of their first contact with the county, and 15 percent have their first treatment appointment within 14 days of their first request for services. Clients seeking methadone can receive their first dose within one day from their initial request for services. This exceeds the Department of Healthcare Services (DHCS) three-day standard to receive the first dose and is comparable to the statewide average. The county has not tracked transitions into lower LOCs following residential treatment, so it is not possible to quantify the timeliness of these services.

Quality

The county has implemented regular quarterly contract monitoring meetings to ensure there is constant communication with providers about the services they offer and their documentation. There was no American Society of Addiction Medicine (ASAM) LOC data available to assist in the analysis of quality, but the TPS (Treatment Perception Survey) demonstrates that clients are generally quite satisfied with services. Ninety-seven percent of TPS respondents indicated overall satisfaction with services, and 93.5 percent stated they are “better able to do things,” indicating an increase in functional capacity. Ninety-three percent of respondents said they “Got the help they needed,” indicating their presenting problems were addressed.

San Benito does not offer all levels of services so consequently not all clients are able to receive the appropriate level of care that would best assist them in their recovery process. This is the first year of service delivery for San Benito county and their first DMC-ODS EQRO review. It would be beneficial to provide Recovery Services (RS) to support clients and assist them in managing their triggers and accessing any needed additional services. At this time WM in a residential setting is not provided, nor are there any Non-NTP MAT programs. The county has two contracted Intensive Outpatient Treatment (IOT) providers and have referred clients to these programs starting in FY 20-21. Quality of care would also be enhanced by offering the full range of residential LOCs, and Medi-Cal services which are part of the Waiver plan, either directly or by contract with providers in Monterey, Santa Cruz or Santa Clara counties.

Outcomes

San Benito uses the TPS to demonstrate good client outcomes. As noted above, 93.5 percent of survey participants stated they are “Better able to do things.”

Forty percent of county adult discharges from treatment are standard discharges, compared to the statewide average of 42.1 percent. Statewide, administrative adult discharges average 47.1 percent, whereas San Benito’s rate of administrative discharges is 56.7 percent. However, more clients in San Benito had positive discharge ratings compared to the statewide average (58.5 percent vs 45.8 percent). Positive discharge ratings indicate the client showed some progress in treatment. Statewide 53.0 percent of clients left treatment with unsatisfactory progress, whereas 28.5 percent of San Benito clients left with unsatisfactory progress.

Client/Family Impressions and Feedback

Because this review was a desk review as requested by the county executive team, there were no client or family focus groups. All conclusions reached in this report are based on the documents the county submitted to CalEQRO.

Recommendations

In the conclusions section at the end of this report, CalEQRO prioritizes the most important opportunities for improvements into a closing set of recommendations that suggest specific actions. As a standard EQR protocol for all counties, at the time of the next EQR San Benito will summarize the actions it took and progress it made regarding each of the recommendations.

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has contracted with 30 separate counties and seven Partnership counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act.

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

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

Each DMC-ODS county is required to conduct two PIPs—one clinical and one non-clinical — during the 12 months preceding the review. These are special projects

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

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

intended to improve the quality or process of services for beneficiaries based on local data showing opportunities for improvement. The PIPs are discussed in detail later in this report. The CMS requirements for the PIPs are technical and were based originally on hospital quality improvement models and can be challenging to apply to behavioral health.

The CalEQRO staff provide trainings and technical assistance to the County DMC-ODS staff for PIP development. 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 San Benito meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of San Benito reporting systems and methodologies for calculating PMs. It also includes utilization of data for improvements in quality, coordination of care, billing systems, and effective planning for data systems to support optimal outcomes of care and efficient utilization of resources.

Validation of State and County Client Satisfaction Surveys

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

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

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

CalEQRO assesses the research-linked programs and special terms and conditions (STCs) of the Waiver as they relate to best practices, enhancing access to Medication Assisted Treatment (MAT), and developing and supervising a competent and skilled workforce with the ASAM criteria-based training and skills. The DMC-ODS should be able to establish and further refine an ASAM Continuum of Care modeled after research and optimal services for individual clients based upon their unique needs. Thus, each review includes a review of the Continuum of Care, program models linked to ASAM fidelity, MAT models, use of evidence-based practices, use of outcomes and treatment informed care, and many other components defined by CalEQRO in the Key Components section of this report that are based on CMS guidelines and the STCs of the DMC-ODS Waiver.

Discussed in the following sections are changes 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 documentation submitted by senior management to EQRO.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

The primary change to the environment is the COVID-19 pandemic which required the county to close all sites and in-person services in March 2020. This has resulted in changes in processes and procedures. Services are now offered via telehealth, including initial assessments. Groups are also offered online, and the county has not experienced a drop in request for services despite the restrictions that have come because of the pandemic. Because of the pandemic the county has begun to use social media more extensively to outreach clients.

Past Year's Initiatives and Accomplishments

Following are key initiatives and accomplishments during this past first year of the DMC-ODS:

- The Quality Improvement Team was expanded by adding two additional Quality Improvement Supervisors and one Staff Analyst. In addition, the county currently has an open recruitment to hire two more Quality Improvement Supervisors.

- In 2019 San Benito organized a Red Ribbon resource festival to conclude Red Ribbon week. There were 19 community agencies with informational booths and over 200 people in attendance. Most recently, in October 2020, during the COVID-19 pandemic the county hosted a series of virtual informational videos for Red Ribbon Week and hosted a Red Ribbon theme art contest that resulted in over 100 submissions from youth throughout the county.

- Community outreach has been expanded by using social media platforms and publishing various informational articles in the local online newspaper, Benito Link. These articles are then shared on the county's social media platforms to maximize outreach to educate the community and provide information on available SUD services.

- The Quality Leadership Committee has been expanded to include more Behavioral Health staff and members from community agencies.

- DMC-ODS components have been added to the agenda for the monthly Quality Improvement Committee and Quality Leadership Committee meetings.

- The county is working with its vendor, Kings View, to develop EHR dashboards. Six dashboards have been developed that track and show comprehensive data on case load assignments, case load penetration, high utilizers, productivity, service utilization, and timeliness.
- The county developed and is still improving a streamlined intake process for DMC-ODS services.
- A more robust Utilization Review and Access process was initiated.
- DMC-ODS services have been expanded through contracting with providers to include adult IOT.
- The county developed a timeliness record that tracks a client's date of first contact, the first, second, and third appointments offered for an assessment, the date they actually came in for an assessment, the first, second and third appointments offered for treatment and the date they actually came in for treatment.
- A data tracking and analysis method to manually track timeliness data was developed.
- After realizing that the CalOMS process was not accurate, county staff researched the CalOMS handbook to create staff training on the correct input of CalOMS data at the appropriate times.
- More frequent and accountability-driven quarterly contract monitoring meetings were established to ensure constant communication with contracted providers regarding contractual obligations, clinical documentation, and fiscal responsibility.
- After over a year of vacancy, a Substance Abuse Clinical Supervisor was hired to manage and guide the DMC-ODS program and the staff.

San Benito Goals for the Coming Year

Current initiatives include the following:

- Expand services for monolingual Spanish speakers by seeking to hire additional bilingual staff and expanding the number of Spanish-speaking groups.
- Expand the SUD team to include two SUDs clinicians and two additional counselors, one of which will be solely focused on prevention and recovery.
- Expand youth services to include more levels of care.

- Explore providing Intensive Outpatient in-house instead of contracting for IOT.
- Develop the recovery program with appropriate curriculum, activities, and staff training.
- Revamp and continue to develop an effective drug and alcohol prevention program, including Friday Night Live, that outreaches all county youth.

PERFORMANCE MEASURES

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

1. CalOMS Treatment Data Collection Guide:

   http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

2. TPS:

   http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf

3. ASAM Level of Care Data Collection System:

   https://www.dhcs.ca.gov/individuals/Documents/MHSUDS_Information_Notice_18-046.pdf

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

As noted above, CalEQRO is required to validate the following PMs using data from DHCS, client interviews, staff and contractor interviews, observations as part of site visits to specific programs, and documentation of key deliverables in the DMC-ODS Waiver Plan. However, due to the Governor's Executive Order that placed restrictions on in-person gatherings, and due to the increased workload on county management teams and providers, the information was gathered via desk review. The measures are as follows:

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries.

- Number of days to first DMC-ODS service after client assessment and referral.

- Total costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services to beneficiaries.
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes).
- Coordination of care with physical health and mental health (MH).
- Timely access to medication for Narcotics Treatment Program (NTP) services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percentage of clients with three or more WM episodes and no other treatment to improve engagement.

HIPAA Guidelines for Suppression Disclosure

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

Year One of Waiver Services

This is the first year that San Benito has been implementing DMC-ODS services. PM data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file, and from UCLA for TPS and ASAM (FY 2019-20). CalOMS data from UCLA was from FY 2018-19. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all

appropriate licenses and certifications. Thus, there may be a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2019-20 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2019-20

Clients Served, Penetration Rates and Claim Dollars per Beneficiary

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

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

San Benito served 196 unique clients in FY 2019-20, the majority of whom were between the ages of 18 and 64 (90.8 percent). The penetration rates for those ages 12-17 and 18-64 exceeded small county and statewide averages. San Benito served a very small number of older adults aged 65+ with a penetration lower than that of both the small and statewide averages.

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

San Benito				Small Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	2,494	*	n/a	0.25%	0.32%
Ages 18-64	9,114	175	1.92%	0.69%	1.33%
Ages 65+	1,367	*	n/a	0.35%	0.81%
TOTAL	**12,974**	**196**	**1.51%**	**0.58%**	**1.10%**

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

Table 2 below shows San Benito's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. San Benito's overall average approved claim is $2,304, less than the statewide average of $4,515. Average approved claims dollars were less in every age category when compared to statewide averages.

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

San Benito			Statewide
Age Groups	**Average Approved Claims**	**Total Approved Claims**	**Average Approved Claims**
Ages 12-17	$1,448	$24,614	$2,043
Ages 18-64	$2,384	$424,396	$4,644
Ages 65+	$2,509	$2,509	$4,448
TOTAL	**$2,304**	**$451,519**	**$4,515**

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

Figure 1 shows that San Benito's eligible Medi-Cal population is predominantly Latino/Hispanic (75.9 percent), yet only 69.9 percent of the beneficiaries served are Latino/Hispanic. Whites comprise only 16.4 percent of the eligible population, yet they comprise 19.4 percent of the beneficiaries served. A higher proportion of African Americans are served (1.5 percent) although they comprise 0.4 percent of the eligible population. In contrast, 0.5 percent of Asian/Pacific Islanders are served although they make up 2.2 percent of the eligible population.

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

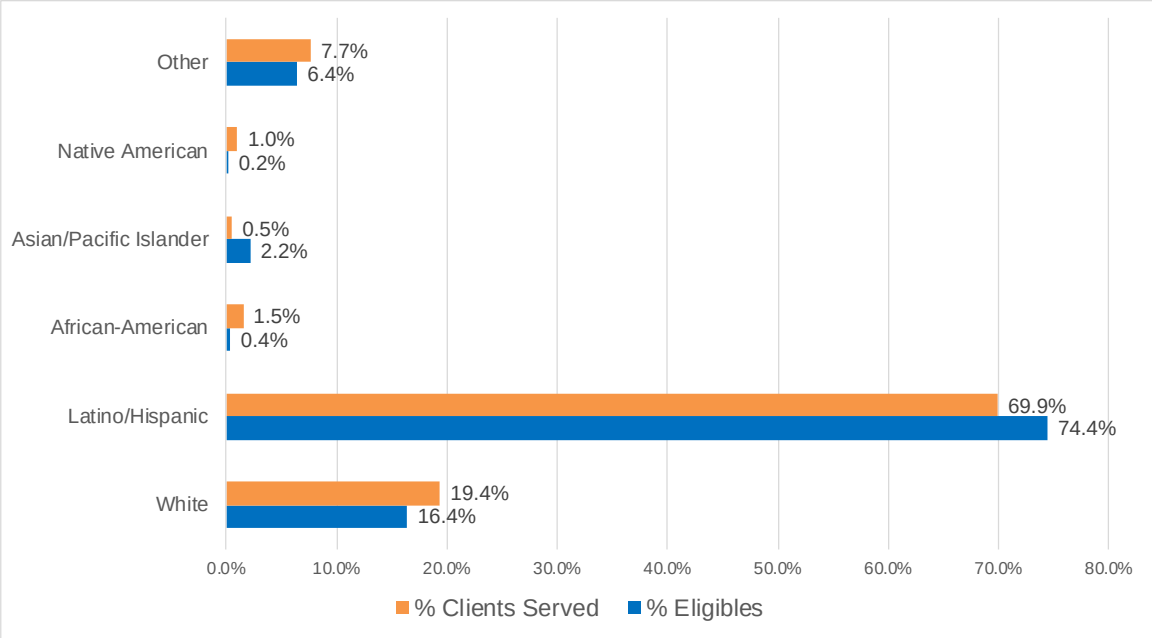


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. San Benito had higher penetration rates for all race/ethnicity groupings compared to both small county and statewide averages except for White. San Benito exceeds the small county penetration rate for White, but the rate is less than the statewide rate.

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

San Benito				Small Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	2,129	38	1.78%	0.66%	2.08%
Latino/Hispanic	9,657	137	1.42%	0.56%	0.76%
African American	50	*	n/a	0.54%	1.44%
Asian/Pacific Islander	284	*	n/a	0.10%	0.19%
Native American	24	*	n/a	0.29%	1.91%
Other	832	*	n/a	0.54%	1.38%
TOTAL	**12,976**	**196**	**1.51%**	**0.58%**	**1.10%**

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

Table 4 below shows San Benito's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. Clients in San Benito are largely eligible for services through the ACA (59.4 percent), Family Adult (21.7 percent) or Disabled (9.4 percent) eligibility categories. Their penetration rates exceed the state rate in all categories.

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

San Benito				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	931	20	2.15%	1.88%
Foster Care	34	*	n/a	2.46%
Other Child	1,470	*	n/a	0.34%
Family Adult	2,879	46	1.60%	1.15%
Other Adult	1,897	-	-	0.13%
MCHIP	1,163	*	n/a	0.24%
ACA	4,566	126	2.76%	1.74%

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

Table 5 below shows San Benito's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Except for Foster Care, average approved claim dollars are lower for all eligibility categories when compared to corresponding statewide averages.

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

San Benito				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	931	20	$2,372	$4,513
Foster Care	34	*	n/a	$1,578
Other Child	1,470	*	n/a	$1,943
Family Adult	2,879	46	$2,043	$3,792
Other Adult	1,897	-	-	$4,042
MCHIP	1,163	*	n/a	$2,039
ACA	4,566	126	$2,246	$4,667

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

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2019-20. Outpatient Services by far are the most used services (88.2 percent) followed by NTP at 8.3 percent. Other services are used sparsely.

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

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	17	8.3%	$2,482
Residential Treatment	*	n/a	$1,565
Res. Withdrawal Mgmt.	-	-	-
Ambulatory Withdrawal Mgmt.	-	-	-
Non-Methadone MAT	*	n/a	$174
Recovery Support Services	*	n/a	$397
Partial Hospitalization	-	-	-
Intensive Outpatient Tx.	-	-	-
Outpatient Services	180	88.2%	$2,257
TOTAL	**204**	**100.0%**	**$2,304**

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

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

Methadone is a well-established evidence-based practice for treatment of opiate addiction using a narcotic replacement therapy approach. Extensive research studies document that with daily dosing of methadone, many clients with otherwise intractable opiate addictions are able to stabilize and live productive lives at work, with family, and in independent housing. However, the treatment can be associated with stigma, and usually requires a regular regimen of daily dosing at an NTP site.
Persons seeking methadone maintenance medication must first show a history of at least one year of opiate addiction and at least two unsuccessful attempts to quit using opioids through non-MAT approaches. They are likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they may soon resume opiate use and an addiction lifestyle that can be life-threatening. For these reasons, NTPs regard the request to begin treatment with methadone as time sensitive.

The median time from the initial qualifying request to the first dose of methadone in San Benito is one day. This is comparable to the statewide average and is well within the DHCS standard of three days.

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

San Benito				Statewide		
Age Groups	**Clients**	**%**	**Median Days**	**Clients**	**%**	**Median Days**
Ages 12-17	-	-	-	*	n/a	n/a
Ages 18-64	*	n/a	n/a	37,884	90.8%	<1
Ages 65+	-	-	-	3,824	9.2%	<1
TOTAL	**13**	**100%**	**<1**	**41,714**	**100.0%**	**<1**

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

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

Some people with opiate addictions have become interested in newer-generation addiction medicines that have increasing evidence of effectiveness. These include buprenorphine and long-acting injectable naltrexone that do not need to be taken in as rigorous a daily regimen as methadone. While these medications can be administered through NTPs, they can also be prescribed and administered by physicians through other settings such as primary care clinics, hospital-based clinics, and private physician practices. For those seeking an alternative to methadone for opiate addiction, or a MAT for another type of addiction such as alcoholism, some of the other MATs have the advantages of being available in a variety of settings that require fewer appointments for regular dosing. The DMC-ODS Waiver encourages delivery of MATs in other settings additional to their delivery in NTPs. These services are often provided in FQHC clinics such as the one at Hazel Hawkins Hospital, but no data is available at this time about this service.

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

Table 8 display the number and percentage of clients receiving three or more MAT visits per year provided through San Benito providers and statewide for all actively implemented DMC-ODS counties in aggregate. Three or more visits were selected to identify clients who received regular MAT treatment versus a single dose. The numbers for this set of performance measures are based upon DMC-ODS claims data analyzed by EQRO.

The average percentage of those receiving non-Methadone MAT services in San Benito is lower than the statewide average for a single service (2.04 percent vs. 6.3 percent). Clients do not appear to be well engaged in Non-Methadone MAT because none of the clients who received one service went on to attend three or more services. The non-methadone services were provided by the NTP clinic but are clearly limited, hopefully in time these will be expanded as these other medication options are a requirement for the NTP providers.

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

San Benito					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	-	-	-	*	n/a	*	n/a
Ages 18-64	*	n/a	-	-	6,504	6.8%	3,036	3.2%
Ages 65+	-	-	-	-	147	3.4%	54	1.2%
TOTAL	**-**	**2.04%**	**-**	**-**	**6,658**	**6.3%**	**3,095**	**2.9%**

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

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

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

Table 9 shows two aspects of this expectation: 1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. The table shows the percentage of clients who began a new level of care within 7 days, 14 days, and 30 days after discharge from residential treatment. Also shown in the table are the percent of clients who had follow-up treatment from 31-365 days.

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, IOT, partial hospital hospitalization, MAT, NTP, WM, case management, recovery supports, and physician consultation. CalEQRO does not count re-admission to residential treatment in this measure. Additionally, CalEQRO was not able to obtain and calculate Fee for Service (FFS)/Health Plan Medi-Cal claims data at this time.

San Benito did not have any clients went to residential care and thus who received timely follow-up treatment upon leaving residential care.

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

San Benito (n= 2)			Statewide (n= 30,303)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	-	-	2,312	7.63%
Within 14 Days	-	-	3,161	10.43%
Within 30 Days	-	-	3,987	13.16%
Any days (TOTAL)	**-**	**-**	**6,016**	**19.85%**

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

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment of a person's reaching out for help to address a SUD represents a critical crossroad in that person's life, and the opportunity may pass quickly if barriers to accessing treatment are high. A county DMC-ODS is responsible to make initial access easy for prospective clients to the most appropriate treatment for their particular needs. For some people, an Access Line may be of great assistance in finding the best treatment match in a system that can otherwise be confusing to navigate. For others, an Access Line may be perceived as impersonal or otherwise off-putting because of long telephone wait times. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

Table 10 shows Access Line critical indicators from 12/1/2019 through 11/30/20.
San Benito County Behavioral Health (SBCBH) employs bilingual staff in the county's threshold language (Spanish) to assist clients with specialty mental health and substance use disorder during business hours. SBCBH uses the Crisis Support Services of Alameda County "Night Watch" to operate an after-hours line and log requests for services. The Access Line does not make authorizations for residential treatment, nor are callers linked to treatment through the Access Line. There is no data on how long it takes to answer a call. More information on what Access does provide to callers would be helpful.

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

San Benito	
Average Volume	175 calls per month
% Dropped Calls	6.2%
Time to answer calls	They do not measure.
Monthly authorizations for residential treatment	0
% of calls referred to a treatment program for care, including residential authorizations	0% of callers are linked to treatment through the Access Line.
Non-English capacity	Access Line staff are bilingual (English/Spanish), and San Benito has contracts with two language line vendors.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial number of DMC-ODS services in San Benito. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $12,973 in approved claims per year. The table lists the average approved claims costs for the year for San Benito HCBs compared with the statewide average. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

San Benito had a small number of clients that met the threshold to be considered a high-cost beneficiary.

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

San Benito						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	17	-	-	-	-	-
Ages 18-64	178	*	n/a	n/a	n/a	n/a
Ages 65+	*	-	n/a	-	-	-
TOTAL	**196**	**1**	**0.5%**	**$14,117**	**$14,117**	**3.1%**

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

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

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

Residential Withdrawal Management with No Other Treatment

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

San Benito did not serve any clients in residential WM during this first year of the Waiver.

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

San Benito			Statewide	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	0	0%	7,836	3.4%

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

Use of ASAM Criteria for Level of Care Referrals

The clinical cornerstone of the DMC-ODS Waiver is use of ASAM Criteria for initial and ongoing level of care placements. Screeners and assessors are required to enter data for each referral, documenting the congruence between their findings from the screening or assessment and the referral they made. When the referral is not congruent with the LOC indicated by ASAM Criteria findings, the reason is documented.

San Benito has no data for this indicator.

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

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

Diagnostic Categories

Table 14 compares the breakdown by diagnostic category of the San Benito and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2019-20. Alcohol Use Disorder was the predominant diagnosis (48.4 percent) in the county, followed by Cannabis Use Disorder at 19.7 percent. Opioid Use Disorder (OUD) is the most common diagnosis statewide at 45.7 percent, whereas 11.7 percent of San Benito beneficiaries have a diagnosis of OUD. The average cost for

each diagnosis is significantly less than the statewide average cost for that particular diagnosis.

Table 14: Percentage Served and Average Cost by Diagnosis Code, FY 2019-20

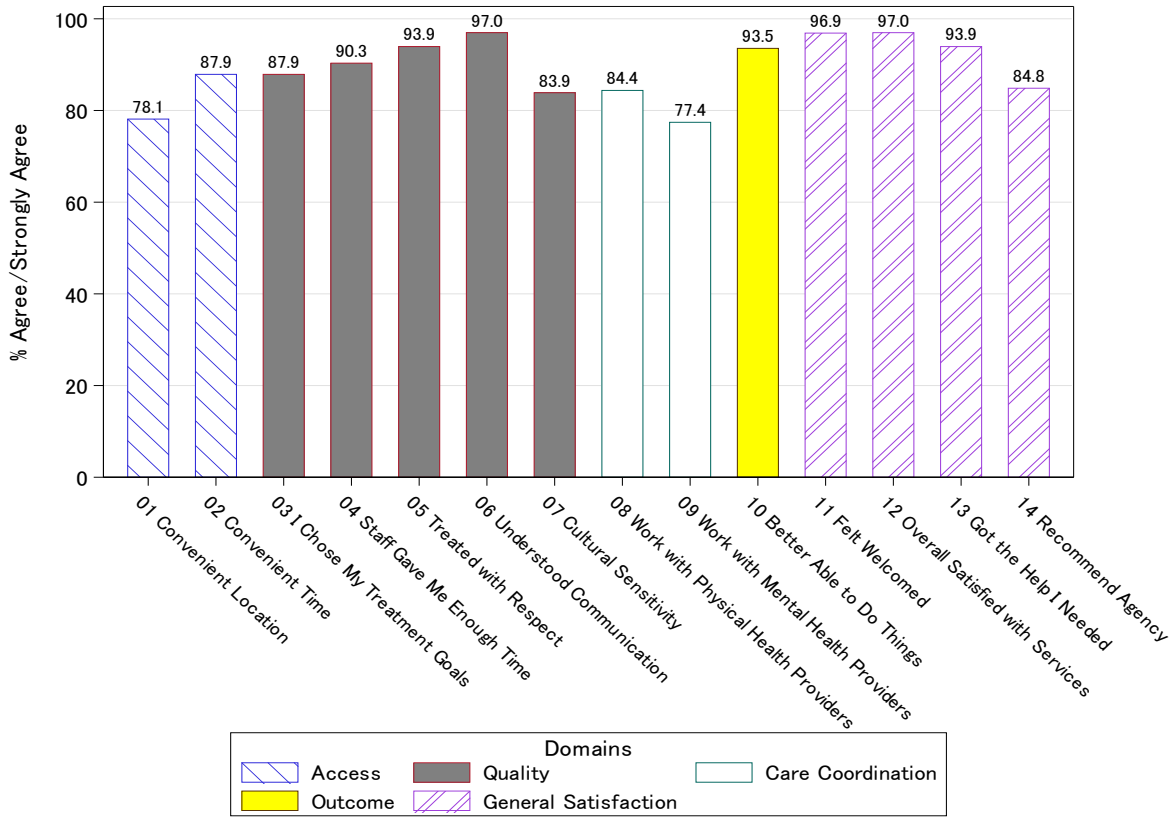
Diagnosis Codes	San Benito		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	48.4%	$1,622	17.1%	$5,317
Cannabis Use Disorder	19.7%	$1,805	9.0%	$2,328
Cocaine Abuse or Dependence	-	-	1.9%	$5,273
Hallucinogen Dependence	-	-	0.23%	$5,151
Inhalant Abuse	-	-	0.03%	$6,809
Opioid Use Disorder	11.7%	$4,174	45.7%	$5,084
Other Stimulant Abuse	18.1%	$4,297	24.4%	$4,723
Other Psychoactive Substance	-	-	0.11%	$6,172
Sedative, Hypnotic Abuse	1.1%	$2,156	0.52%	$5,095
Other	1.1%	$795	0.90%	$3,259
Total	**100.0%**	**$2,437**	**100.0%**	**$4,776**

Client Perceptions of Their Treatment Experience

CalEQRO regards the client perspective as an essential component of the EQR. CalEQRO uses quantitative information from the TPS administered to clients in treatment. Because this was a desk review, qualitative data from focus groups was not obtained and TPS data was utilized to paint the picture of client perceptions. DMC-ODS counties upload the TPS data to DHCS, it is analyzed by the UCLA Team evaluating the statewide DMC-ODS Waiver, and UCLA produces reports they then send to each DMC-ODS County. Ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction.

Of the 33 respondents who completed the survey, San Benito received its highest scores on Overall Satisfaction with Services (97 percent), Felt Welcomed (96.9 percent), and Understood Communication (97 percent). Their lowest scores were on Work with Mental Health Providers (77.4 percent), and Convenient Location (78.1 percent). Overall, the scores ranged from 77.4 percent to 97 percent with the General Satisfaction domain being ranked quite high.

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA



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

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

Tables 15-17 depict client status at admission compared to statewide averages regarding three important situations: living status, criminal justice involvement, and employment status. These data provide important indicators of what additional services San Benito will need to consider and with which agencies they will need to coordinate.

Compared to corresponding statewide averages at the time clients are admitted to services, San Benito has more clients living independently (88.1 percent vs. 45.7 percent), and fewer clients that are homeless (9.6 percent vs. 28.7 percent)

Table 15: CalOMS Living Status at Admission, FY 2019-20

Admission Living Status	San Benito		Statewide	
	#	%	#	%
Homeless	*	n/a	32,027	28.7%
Dependent Living	*	n/a	28,474	25.5%
Independent Living	193	88.1%	51,036	45.7%
TOTAL	**219**	**100.0%**	**111,537**	**100.0%**

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

San Benito's clients also differ from statewide populations in their legal status at the time of admission. There are fewer with no criminal justice involvement (25.6 percent vs. 61.7 percent), and more clients under AB109 post-release supervision than is typical statewide (63.5 percent vs. 27.5 percent).

Table 16: CalOMS Legal Status at Admission, FY 2019-20

Admission Legal Status	San Benito		Statewide	
	#	%	#	%
No Criminal Justice Involvement	56	25.6%	68,737	61.7%
Under Parole Supervision by CDCR	-	-	2,255	2.0%
On Parole from any other jurisdiction	-	-	1,676	1.5%
Post release supervision - AB 109	139	63.5%	30,671	27.5%
Court Diversion CA Penal Code 1000	*	n/a	2,111	1.9%
Incarcerated	-	-	711	0.6%
Awaiting Trial	*	n/a	5,324	4.8%
TOTAL	**219**	**100.0%**	**111,485**	**100.0%**

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

More San Benito clients are employed full or part-time than is typical statewide (31.5 percent vs. 19.5 percent). The percent of clients that are unemployed and looking for work is identical to the statewide rate of 29.7 percent, and the county has fewer clients that are unemployed and not seeking work than the statewide average (38.8 percent vs. 50.7 percent statewide).

Table 17: CalOMS Employment Status at Admission, FY 2019-20

Current Employment Status	San Benito		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	43	19.6%	13,156	11.8%
Employed Part Time - Less than 35 hours	26	11.9%	8,637	7.7%
Unemployed - Looking for work	65	29.7%	33,128	29.7%
Unemployed - not in the labor force and not seeking	85	38.8%	56,616	50.7%
TOTAL	**219**	**100.0%**	**111,537**	**100.0%**

The information displayed in Tables 22-23 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 22 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment. While the San Benito Standard Adult Discharge rate is 40.0 percent, most San Benito clients receive an administrative discharge (56.7 percent). San Benito's Standard Adult Discharge rate is similar to the statewide average of 42.1 percent, but the county Administrative Adult Discharge rate is higher than the statewide average of 47.1 percent. More than half of the county adult discharges are individuals who leave treatment without notifying their counselor and completing treatment. The youth standard discharge rate for the county is higher than the state average (3.3 percent vs. 2.1 percent).

Table 18: CalOMS Types of Discharges, FY 2019-20

Discharge Types	San Benito		Statewide	
	#	%	#	%
Standard Adult Discharges	*	n/a	49,577	42.1%
Administrative Adult Discharges	119	56.7%	55,467	47.1%
Detox Discharges	-	-	10,420	8.8%
Youth Discharges	*	n/a	2,415	2.1%
TOTAL	**210**	**100.0%**	**117,879**	**100.0%**

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

Table 19 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs. The first four rating options are positive. "Completed Treatment" means the client met all their treatment goals and/or the client learned what the program intended for clients to learn at that level of care. "Left Treatment with Satisfactory Progress" means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options indicate lack of satisfactory progress for different types of reasons.

More clients in San Benito had positive discharge ratings compared to the statewide average (58.5 percent vs, 45.8 percent). However, statewide 17.6 percent of clients that complete treatment are referred to another level of care, whereas only 1.9 percent of San Benito clients are referred post-treatment. 37.6 percent of San Benito clients complete treatment without receiving a referral, whereas only 5.8 percent of clients statewide complete treatment without being referred. Length of stay is treatment is associated with better long-term outcomes at any level of care because SUD is a chronic disease.

Table 19: CalOMS Discharge Status Ratings, FY 2019-20

Discharge Status	San Benito		Statewide	
	#	%	#	%
Completed Treatment - Referred	*	n/a	20,317	17.6%
Completed Treatment - Not Referred	79	37.6%	6,759	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	*	n/a	17,115	14.8%
Left Before Completion with Satisfactory Progress – Administrative Questions	35	16.6%	8,734	7.6%
Subtotal	*123*	*58.5%*	*52,925*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	*	n/a	16,693	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	57	27.1%	44,609	38.6%
Death	-	-	235	0.2%
Incarceration	*	N/A	1,058	0.9%
Subtotal	*87*	*41.4%*	*62,595*	*54.1%*

Discharge Status	San Benito		Statewide	
	#	%	#	%
TOTAL	**210**	**100.0%**	**115,520**	**100.0%**

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

Performance Measures Findings: Impact and Implications

Access to Care

- San Benito penetration rates exceed statewide averages in every race/ethnicity category except White.
- The Hispanic/Latino penetration rate exceeds the statewide average (1.17 percent vs. 0.63 percent).
- Although 47.3 percent of the county population are adults, 76.6 percent of the clients are adults. However, services were claimed for only one adult 65 years old or older received services.
- TAY make up 14.5 percent of San Benito's population and 21.9 percent of beneficiaries receiving services are TAY.
- San Benito's penetration rate for ages 12-17 is 0.34 percent, which exceeds the small county rate (0.12 percent) and the statewide rate of 0.16 percent.
- San Benito's penetration rate for youth in foster care of 6.25 percent exceeds the statewide average penetration rate of 1.54 percent.
- In FY 2019-20 there was an average of 168.3 calls per month to the Access Line, of which 31.2 percent were incomplete calls. 6.2 percent of calls were dropped.
- One of the lowest scores on the TPS, 78.1 percent, was convenience of the location of services, and the time of the services was rated favorably by 87.9 of adult participants in the survey.
- Services during the COVID pandemic were delivered via telehealth to 176 adults, 2 older adults and 26 youth. Telehealth services in English and Spanish provided new client intake and assessments, CM, individual and group counseling, and medication support.
- San Benito did not have any clients accessing residential treatment and transitioning into another level of care.

Timeliness of Services

- San Benito had timely dosing, less than a day, for NTP clients who request a first dose of methadone.
- Thirty Nine percent of first appointments are offered within seven days of the date of first contact, with Fifteen percent being offered within three days of the request.
- 25.0 percent of clients attended an assessment appointment with six days from the date of first contact.

Quality of Care

- Clients highly rated their treatment in the domains of Quality, Outcomes and General Satisfaction in the TPS. They rated Work with Mental Health Providers lower than any other element (77.4 percent).
- San Benito received its highest scores on Overall Satisfaction with Services (97.0 percent), Felt Welcomed (96.9 percent), and Understood Communication (97.0 percent). Their lowest scores were on Work with Mental Health Providers (77.4 percent), and Convenient Location (78.1 percent). Overall, the scores ranged from 77.4 percent to 97.0 percent.
- 93.9 percent of adult beneficiaries felt they were treated with respect, and 83.9 percent felt that staff were culturally sensitive. Importantly, 93.9 percent felt they got the help they needed.

Client Outcomes

- Better Able to Do Things was rated positively by 93.5 percent of clients in the TPS.
- Results of CalOMS discharge data indicate higher provider ratings of positive client progress in treatment compared to the statewide average (58.5 percent vs. 45.8 percent).
- The CalOMS administrative discharge rate is higher than the statewide average (56.7 percent compared to 47.1 percent).
- More clients have a full or part-time employment status compared to the statewide average (31.5 percent vs. 19.5 percent).
- 58.5 percent of county beneficiaries compared to 45.8 percent of statewide beneficiaries either completed treatment or were discharged with satisfactory progress. 53.0 percent of statewide beneficiaries left before completing

treatment with unsatisfactory progress compared to 28.5 percent of San Benito beneficiaries who left with unsatisfactory progress (this figure does not include clients that did not complete treatment due to incarceration).

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA) 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 DMC-ODS budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous two-year period, as well as the corresponding similar-size DMC-ODS and statewide averages.

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

Entity	FY 2020-21	FY 2019-20	FY 2018-19
San Benito	3.00%	n/a	n/a
Small Counties	n/a	n/a	n/a
Statewide	n/a	2.40%	3.16%

The budget determination process for information system operations is:

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

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

ISCA Table 2: Business Operations

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

- County IT provides DMC-ODS IT information security.
- In addition to having a BCP, the MHP receives additional critical business function EHR support from their ASP, Kings View Behavioral Health Systems (Kings View) and the Cerner Corporation (Cerner) hosting their EHR.

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

ISCA Table 3: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	20%
Contract providers	80%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0.4	0	0	0

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

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	2.5	0	0	0

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

- Technology staffing has been stable over the past year. Technology staffing includes one County IT employee and EHR support, such as EHR software upgrades and enhancements, from Kings View.

- Data analytic staffing has been stable over the past year and includes one Accountant III, one Quality Improvement Supervisor, 0.5 FTE from IDEA Consulting and additional reporting support from Kings View.

Summary of User Support and EHR Training

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

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	13	0	13
Clinical Healthcare Professional	44	4	48
Clinical Peer Specialist	0	0	0
Quality Improvement	4	1	5
Total	61	5	66

ISCA Table 7: EHR User Support

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

ISCA Table 8: New Users EHR Training

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

ISCA Table 9: Ongoing EHR Training and Support

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

Telehealth Services Delivered by County

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

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 10: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	4
Number of county-operated telehealth sites	1
Number of contract providers' telehealth sites	3

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

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

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

- The MHP added individual therapy, new client intake and assessment, case management, group education and support sessions and medication support telehealth services due to the COVID-19 pandemic.

- Telehealth services are available with English and Spanish speaking practitioners (not including the use of interpreters or language line).

- In the past year, 204 beneficiaries, including 176 adults, two older adults and 26 children/youth were served by telehealth.

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

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Valley Health Associates NTP/MAT	1
Door to Hope IOT	1
Sun Street IOT	1

Current DMC-ODS Operations

- The DMC-ODS utilizes the Cerner Community Behavioral Health (CCBH) system, in an application service provider (ASP) model, with Kings View as their provider. CCBH software promotion 230.10 was installed at the time of this review.

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

ISCA Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
CCBH	EHR/Practice Management	Cerner Corporation	14	Kings View

The DMC-ODS Priorities for the Coming Year

- Identify reporting needs and expand reporting capacity to include reports developed to be used on a weekly, monthly, and quarterly basis.
- Implement an ASAM-based assessment in CCBH.
- Complete ASC X12 – 274 transactions to support NACT Expansion.
- Review and evaluate data in the EHR to ensure it is being captured appropriately.
- Update EHR settings in accordance with a planned site relocation.

Major Changes since Prior Year

- Billing codes were updated to capture ODS billing for the transition to DMC-ODS.
- Timeliness and assessment tools were implemented in CCBH to track first date of contact, referral source, appointment dates offered, accepted, and medical necessity determination.
- Staff were trained on the CalOMS process and data collection.
- The refining of the workflow process, with input from SUD counselors and LPHAs, for moving clients from access to assessment, and then to treatment, all while streamlining the use of the EHR at each step was completed.
- CCBH was updated to Promotion 230.10.

Plans for Information Systems Change

- The DMC-ODS is considering a new system, but no formal project plan is in place and there is no project team assigned.

DMC-ODS EHR Status

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

ISCA Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	CCBH	☒	☐	☐	☐
Assessments	CCBH	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage	CCBH	☒	☐	☐	☐
Electronic Signature—DMC-ODS Beneficiary	CCBH	☒	☐	☐	☐
Laboratory results (eLab)	CCBH	☒	☐	☐	☐
Level of Care/Level of Service	CCBH	☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Outcomes	CCBH	☒	☐	☐	☐
Prescriptions (eRx)	CCBH	☒	☐	☐	☐
Progress Notes	CCBH	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	CCBH	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		10	0	2	

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

- The ASAM-based assessment is administered in paper format and scanned into the EHR.
- Timeliness reporting tools were implemented in CCBH.

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to DMC-ODS EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and DMC-ODS EHR system	0%	Not used
Electronic batch files submitted to DMC-ODS for further processing and uploaded into DMC-ODS EHR system	0%	Not used
Direct data entry into DMC-ODS EHR system by contract provider staff	0%	Not used
Electronic files/documents securely emailed or faxed to DMC-ODS for processing or data entry input into EHR system	90%	Monthly
Paper documents submitted to DMC-ODS for data entry input by DMC-ODS staff into EHR system	10%	Monthly

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

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

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

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

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

EHR Vendor	Product	Count of Providers Supported
Not Applicable		

Special Issues Related to Contract Agencies

- Contract providers deliver 80 percent of DMC-ODS services.
- Contract providers maintain and utilize disparate EHR systems.
- Ninety percent of services delivered by contract providers are submitted to the DMC-ODS by secure email or fax. This process is very labor intensive for both contact providers and the DMC-ODS staff.

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

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

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

Highlights or challenges of use of outcome tools above:

- The ASAM-based assessment is administered in paper format and scanned into the EHR.

- At 56.7 percent, the CalOMS administrative discharge rate exceeds the statewide average of 47.1 percent, meaning San Benito had a higher percentage of beneficiaries who end treatment before completion and without meeting with their counselors for an exit interview.

- Results of CalOMS discharge data indicate higher ratings of positive client progress in treatment compared to the statewide average (58.5 percent vs. 45.8 percent).

Overview and Key Findings

Operations and Structure

- The ASAM-based assessment is administered in paper format and scanned into the client chart.

- The disparate EHR systems used by contract providers combined with lack of CCBH access for service entry creates a labor-intensive billing submission process for contract providers and the Behavioral Health Fiscal Department.

Key Findings

- The MHP added individual therapy, new client intake and assessment, case management, group education and support sessions and medication support telehealth services due to the COVID-19 pandemic.

- In the past year, 204 beneficiaries, 176 adults, 2 older adults and 26 children/youth were served by telehealth.

- Timeliness and assessment tools were implemented in CCBH to track first date of contact, referral source, appointment dates offered, accepted and medical necessity determination.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Benito, the time and distance requirements are 90 minutes and 60 miles for SUD services, and 90 minutes and 60 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

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

Review Sessions

Because of the strain of the COVID-19 pandemic on county resources this EQR was conducting by reviewing submitted documents and CalEQRO did not conduct any client and family member focus groups, stakeholder interviews, or staff and contractor interviews.

Findings

The county DMC-ODS met all time and distance standards and did not require an AAS Request or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

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

Although the county met all time and distance standards, it is out of compliance in three youth and one adult programmatic area. The county does not have an IOT provider for youth up to age 18, nor does it have a youth residential provider, or an OTP provider for youth. It also must build IOT adult capacity. A current initiative is expanding the levels of care for youth, and the county is exploring the option of providing IOT in-house for both adults and youth rather than utilizing a contractor. The county does have adequate American Indian Health (AIF) services and language capacity.

SBCBH provides transportation to SBCBH services and programs for clients, when needed. Transportation for people with disabilities is also available through the county Dial a Ride Program at no cost with provided tokens, and a reduced fee bus pass program if the clients qualify. Jovenes de Antaño provides transportation to medical appointments including transportation to out-of-county appointments such as Stanford Hospital Services in Palo Alto. TTY is available for persons with hearing impairments. Audio versions of the beneficiary guide are available for the visually impaired. All SBCBH facilities that serve clients are ADA accessible.

Staff are available during regular business hours, Monday through Friday, 8:00 am to 5:00 pm and most services are offered during these business hours. However, services and activities are available in the evening or on weekends in special circumstances. For example, SUD groups are offered in the evenings, so clients can work during the day.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

San Benito DMC-ODS PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. EQRO has reviewed two PIPs, one of which is in the implementation phase, and the other of which is still being developed.

PIP Table 1: PIPs Submitted by San Benito

PIPs for Validation	Number of PIPs	PIP Titles
Non- Clinical PIP	1	Text Appointment Reminders
Clinical PIP	1	Reduce Drop-out Rate

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	San Benito
PIP Title	Reduce Drop-out Rate
PIP Aim Statement	Will a streamlined assessment process, recovery and evidence-based treatment services, and new Recovery Groups increase the retention rate to 65 percent over the next 12 months?

DMC-ODS Name	San Benito
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): All beneficiaries who receive outpatient substance use treatment services.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Implement a substance use disorder recovery and evidence-based treatment program. • Implement Recovery Groups post-discharge from substance use disorder services program.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Streamline the assessment process with new ASAM tool.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year
Percentage of clients who were discharged due to non-compliance/client withdrew/administrative	FY 2019-20	76 / 187 = 40.6%	☒ NA*
Percentage of clients in treatment for 90 days or more who achieved their goals at discharge	FY 2019-20	57 / 112 = 50.9%	☒ NA*
Percentage of clients in treatment for 90+ days	FY 2019-20	112 / 187 = 59.9%	☒ NA*
Consumer satisfaction as measured on survey	TBD	TBD	☒ NA*

Was the PIP validated?	☐ Yes	☒ No

Validation phase:

☐ PIP submitted for approval.
☐ Planning phase
☒ Implementation phase
☐ Baseline year
☐ First remeasurement
☐ Second remeasurement
☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The PIP has three interventions (assessment length, use of EBPs, and initiating RS) and it will be difficult to know which intervention impacted the length of time clients remained in treatment. But it is important to track impacts and baseline carefully. It seems unclear how the length of the assessment which occurs at the initiation of treatment will impact how many weeks a client remains in treatment. Long assessments can be discouraging and result in immediate dropouts, however. Clients have expressed that their immediate needs are not attended to, paperwork is priority.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: EQRO staff met virtually to review the PIP and provide feedback. The EQRO PIP consultant has also provided input.

Non-clinical PIP

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

DMC-ODS Name	San Benito
PIP Title	Text Appointment Reminders
PIP Aim Statement	Will utilizing text appointment reminders help reduce the overall no-show rate for substance use outpatient appointments to 10 percent over the next 12 months?

DMC-ODS Name	San Benito
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17) * ☐ Adults only (age 18 and above) ☒ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): All outpatient clients are included in the target population.	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Beneficiaries will receive text appointment reminders utilizing GoReminder.com. In addition, staff will be assigned to follow-up with the client when they cancel to reschedule their appointment, as well as to reschedule clients who no-show.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Staff shall use GoReminders.com software to remind each outpatient client of their upcoming appointment.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):

PIP Interventions (Changes tested in the PIP)
N/A

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year
Percentage of no shows/ cancelations for routine outpatient substance use appointments.	FY 2019-20	2,032/9,001 22.6%	☒ NA*
Percentage of no shows/ cancelations for substance use assessment appointments.	FY 2019-20	14/309 4.5%	☒ NA*
Percentage of clients who have canceled or no showed who are called to reschedule.	FY 2020-21	NA	☒ NA*
Percentage of clients who are called to reschedule then no show to rescheduled appointment.	FY 2020-21	NA	☒ NA*
Client satisfaction as measured on survey.	FY 2020-21	NA	☒ NA*

Was the PIP validated?	☐ Yes	☒ No

Validation phase:

☐ PIP submitted for approval.
☐ Planning phase
☒ Implementation phase
☐ Baseline year
☐ First remeasurement
☐ Second remeasurement
☐ Other (specify):

Validation rating:

☐ High confidence
☐ Moderate confidence
☒ Low confidence
☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

Data could be gathered on youth and adults separately, and different ethnicities, to see if the interventions have a different impact depending on the cohort of the population. More TA needed to move ahead successfully but potential is there for PIP to bear fruit in improvements.

The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of:
Calls with the San Benito team to review and revise the PIP and review by EQRO PIP consultant Amy Schwartz.

CLIENT FOCUS GROUPS

There were no client focus groups conducted during this review due to the COVID-19 public health emergency. Due to the Governor’s safety directives, client-to-client contact has been limited and focus groups during this time require additional staff support. Staff were re-assigned to the emergency services center and other COVID-19 related tasks as well as vaccine distribution support and were unavailable to plan for support and coordination of focus group activities per discussion with their executive team.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	M
The San Benito Cultural Competency Plan 2019 reflects an extensive assessment of cultural, ethnic, racial, and linguistic needs. The DMC-ODS has developed and implemented two strategies to help meet these needs. The identified strategies include improving staff ability to provide more culturally competent services, and training staff on diversity issues. Because of the remote location of the county, it has been difficult to hire licensed staff, and the number of staff is small, so the county focused on training existing staff in cultural competency and diversity issues. Well attended trainings on cultural competency, diversity, the role of the interpreter, and veteran justice were held in 2018 and 2019. To evaluate these strategies, SBCBH surveyed staff extensively on the impact of the trainings and implemented staff discussions on these topics. Of TPS participants 83.9 percent stated that staff exhibited cultural sensitivity, which was the lowest score in the Quality Index of the TPS. And, 93.9 percent stated that they were treated with respect, and 97.0 percent said their communication was understood.		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
The DMC-ODS added telehealth to increase access for new client intake and assessment, case management, individual therapy, group services, and medication support services. San Benito stated that there are no time and distance issues due to Telehealth. A total of 204 beneficiaries, composed of 176 adults, 2 older adults, and 26 youth, were served by telehealth. The county does monitor the flow of admissions and discharges but not transitions between LOCs. The county is implementing a PIP that addresses improved transition and flow tracking. The county regularly analyzes the clinical, cultural, and linguistic needs of its beneficiaries and has taken steps to meet these needs.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
The SBCBH Cultural Competence Committee (CCC) was implemented in 2000 and now is comprised of Behavioral Health staff, clients, staff from other county agencies, and interested community stakeholders. The CCC meets at least quarterly and reviews data; plans activities to support the development of culturally and linguistically appropriate services; and identifies training and outreach activities. The CCC also reviews data on access, quality, and timeliness of services, by age, race/ethnicity, and gender. The county partners with PCPs, clinics, Child Welfare, Criminal Justice, health plans, and CBOs. It partners with Hazel Hawkins Hospital to provide emergency services such as withdrawal management and medical clearances. Hazel Hawkins also provides SBIRT for new patients. San Benito has an integrated behavioral health department and there is much interface with mental health programming.		

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
During business hours, the clerical staff enter the data in their Access Log spreadsheet. If the client is requesting services and not just seeking information, a SUDs Assessment Record is filled out in the client chart in the EHR. The data is then extracted manually and reviewed monthly. The current access systems were implemented at the beginning of FY 2020-21 and the accompanying systems and tools are constantly being evaluated to make sure they are being used effectively and efficiently. The county has a robust QI Plan that addresses needed improvements in performance.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	PM
San Benito records the range of days to first appointment but does not track how many meet the 3-day standard. The county's penetration rate of clients accessing MAT is much lower than the state average and there appears to be very limited access to non-methadone MAT which is required in NTPs.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	NM
The Access Line only asks if a situation is urgent and urgent calls are not tracked to ascertain timeliness to the first face to face appointment. Therefore, no trends have been established. One of the current PIPs addresses reducing the number of no-shows, but it does not specifically track urgent condition calls. Access Line testing has found that not all callers are asked if they are in crisis. This is often not met in year one of services but should be a goal for year two.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	NM
San Benito's tracking is difficult to assess because many required areas are either not tracked, or only county or contract programs are tracked. No clients at this point have transitioned to post-residential services.		
2E	Tracks and Trends Data on Follow-up and Re-Admission to Residential Withdrawal Management	NM
The county is not currently tracking residential WM follow-ups or re-admission, although a current PIP addresses tracking issues.		
2F	Tracks Data and Trends No Show Data for Initial Appointment	NMPM
Outpatient no-shows are tracked and are able to be differentiated by type of no-show or cancellation via the scheduler feature linked to the EHR. IOP data is not tracked. However, the county has a PIP that is seeking to reduce the no-show rate.		

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
A current FY 2020-21 QI workplan was not provided but the FY 2019-20 workplan and review of FY 2018-19 were available for review. The QI Plan includes both DMC and MH. Designated members of the QIC include the SBCBH Assistant Director; QI Supervisors; the Staff Analyst; representatives from MH, SUD, the Access Team, Crisis, Medication Support, Administrative Services, Fiscal, and contract providers. The QIC reports directly to the Director. The Quality Leadership Committee oversees and evaluates the Plan. Its members include clients, family members of clients, community representatives, external service providers of care, medical team representatives, and representatives of other agencies. There are measurable SUD goals and objectives that measure improvement for the current and past two years. Data is extracted and analyzed to establish improvement. The plan had many good elements.		
3B	Data is used to inform management and guide decisions	M
Data analytic staffing has been stable over the past year and consists of 0.5 FTE from IDEA Consulting and additional reporting support from Kings View. Extensive data is collected and analyzed. Data sources include, but are not limited to the following: Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, LGBQT, and veteran status; EHR reports; Access Logs (initial contact log); Crisis Logs; Test Call logs; Client and family satisfaction surveys; Client Grievance/Appeal Logs; State Fair Hearing Logs; Change of Provider forms and logs; Medication Monitoring forms and logs; staff training logs; Notice of Adverse Benefit Determination (NOABD) forms and logs; Second Opinion requests and outcomes; Treatment Authorization Requests (TAR) and inpatient logs; Service Authorization Request (SAR) logs; staff productivity reports; Clinical QI Chart Review		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
Checklists and plans of correction; Peer Chart Review Checklists and plans of correction; Compliance logs; policies and procedures; QIC and QLC meeting minutes; Internal MH and DMC-ODS monitoring activities; EQR and Medi-Cal Audit results; Special Reports from DHCS or other required studies. The county is initiating PIPs to address identified issues.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
The changes to programs and/or interventions resulting from data analysis are discussed with individual staff, QIC/QLC members (including consumers and family members), Behavioral Health Board members, and management.		
3D	Evidence of an ASAM continuum of care	PM
The ASAM-based assessment is administered in paper format and scanned into the EHR. After realizing that the CalOMS process was not accurate, staff researched and studied the CalOMS handbook to create training for staff to correctly input CalOMS data at the appropriate times. Staff provide some Recovery Services, but training is needed to bill for the delivered Recovery Services. There are three certified 3.1 residential facilities but no 3.3, 3.5 residential facilities nor 3.2 WM services. There is one Level 1 Ambulatory Withdrawal Management facility and two certified 2.1 IOT contracted providers. Access to these entitlement services is important to plan for via contract if the county cannot provide them.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	NM
The website does say there are MAT services, but there is no number on the page for clients to call. There does not appear to be a MAT committee or an Opioid Overdose Taskforce, nor is there mention of psychoeducation on MAT during the assessment and treatment planning process. There is no evidence that the DMC-ODS is monitoring overdose deaths or prescribing information, nor is there anything on the webpage or elsewhere about encouraging families to keep controlled substances secure. The NTP needs to expand to provide required non-methadone medications per the STCs.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	PM
ASAM is a required training for staff and contract providers. Additional information on fidelity to core principles throughout the continuum of care was unavailable due to the special characteristics of this review.		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3G	Measures clinical and/or functional outcomes of clients served	M
The county gathers TPS outcome data and participates in the UCLA study as well as CalOMS.		
3H	Utilizes information from client perception of care surveys to improve care	PM
San Benito will study this data and use it to compare with future years of services.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- The DMC-ODS provided telehealth services to deliver individual therapy, new client intake and assessment, case management, group education and support sessions, and medication support to meet client needs during the COVID-19 pandemic.
- In the past year, 204 beneficiaries which includes 176 adults, two older adults and 26 children/youth were served by telehealth.
- Data supporting access and services to Latino beneficiaries reflects robust and effective implementation of the cultural and linguistic competence plan. Latinos comprise 76 percent of the county's eligible beneficiaries and 70 percent of beneficiaries served. The county's Latino penetration rate of 1.17 percent exceeds the statewide average of 0.63 percent.
- The county has a Spanish-speaking psychiatrist that can meet the co-occurring needs of bilingual beneficiaries.

Opportunities:

- The penetration rate for older adults is less than the statewide average (0.05 percent vs. 0.23 percent).
- The Access Line staff asks whether the matter is routine or urgent. There is no definition of 'urgent'. Urgent calls are not traced to first face to face contact so there is no data to determine if clients with urgent needs are being served promptly.
- The absence of 3.3 and 3.5 Residential Services, WM services and 2.1 IOT leaves a gap in resources for clients with more intensive treatment needs.
- For three levels of care there is no claims data due to EHR issues in billing. This includes recovery services, NTP, and level 3.1 residential services. Consequently, the lack of this data creates funding and utilization management gaps.
- There were no transitions recorded for clients following residential care. Gathering this data will allow the county to better ensure that clients continue

in treatment for adequate periods of time to assist with their long- term recovery.

- Often beneficiaries will search on websites to locate services. When beneficiaries go to the San Benito County website it is challenging to find SUD information. Each time an internet search is conducted for San Benito County Behavioral Health an individual is directed to a different location. It can be challenging to locate the Guide to Substance Use Treatment services and the substance use treatment beneficiary handbook.

- Farm workers and their families are less likely to access services than other community members. Outreach to this population may be beneficial.

- It is challenging to access SUD information on the county website, nor is it easy to locate information on the types of services offered. It would be beneficial to make the website more robust and easier to use.

Timeliness of DMC-ODS Services

Strengths:

- Timeliness and assessment tools were implemented in CCBH to track first date of contact, referral source, appointment dates offered, accepted and medical necessity determination.

- There is timely dosing, less than a day, for NTP clients who request a first dose of methadone.

Opportunities:

- Timeliness data for urgent appointments is not tracked.

- Timeliness to follow-up services post residential treatment is not tracked at this time.

Quality of Care in DMC-ODS

Strengths:

- Clients highly rated their treatment in the domains of Quality, Outcomes and General Satisfaction in the TPS.

- Only five grievances were filed suggesting that most clients are satisfied with their care. All grievances were resolved, and the client and provider were notified in writing within 60 calendar days of receipt of the grievance.

- All county counselors can provide case management, including transportation.

- In some cases, the county had better attendance in telehealth group services than they had previously at on-site group meetings.

- The FY 2019-20 QI Plan is comprehensive, the committee membership is inclusive of all parties that contribute to or receive services, the committee meets frequently, there is staff assigned to collect and analyze data, and there are clear measurable quality improvement goals and interventions.

Opportunities:

- The number of service types and LOCs is limited, as is evidenced by ninety two percent of services being delivered are Outpatient Drug Free.

Client Outcomes for DMC-ODS

Strengths:

- Results of CalOMS discharge data indicate higher ratings of positive client progress in treatment compared to the statewide average (58.5 percent vs. 45.8 percent).

- More clients have a full or part-time employment status compared to the statewide average (31.5 percent vs. 19.5 percent).

- Better Able to Do Things was rated positively by 93.5 percent of clients in the TPS.

Opportunities:

- Tracking the number of residential treatment clients who receive post-treatment services would allow the county to assist client in having better outcomes.

- Utilizing the TPS survey data would allow the county to develop client-focused and client-initiated quality improvement projects.

- Tracking transitions between levels of care would assist in evaluating if each client's treatment is being adjusted to match their current level of need.

Recommendations for DMC-ODS for FY 2019-20

1. Expand the Continuum of Care to offer a wider variety of Levels of Care.

   a. Expand the youth continuum of care to include residential services.

   b. Expand services to include Level 3.5 or 3.3 residential for adults.

   c. Expand services to include Level 3.2 Withdrawal Management beds.

   d. Expand services to include Intensive Outpatient Treatment for both youth adults.

2. Title 42, CFR, §438.330 requires two PIPs; the DMC-ODS is urged to meet this requirement going forward by implementing both PIPs with technical assistance as needed to support your efforts.

3. Improve the functionality of the EHR and Cerner.

   a. Complete the current initiative to implement an electronic ASAM-based assessment within the EHR and eliminate the process of scanning assessments into the EHR.

   b. Develop the ability for providers to electronically submit billing instead of using the current contract provider paper billing and fax.

4. Implement the DHCS required timeliness metric of tracking the length of time from urgent appointment request to initial service. It is also recommended to develop define urgent conditions and needs.

ATTACHMENTS

Attachment A: CalEQRO Review Agenda

Attachment B: Review Participants

Attachment C: County Highlights

- None at this time.

Attachment D: Continuum of Care Form

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO Review Agenda

Due to COVID-19 restrictions and staff shortages, the review was conducted via a desk review. No sessions were conducted on-site or virtually. Consequently, EQRO gleaned information from the website, QI meeting minutes, the Cultural Competency Plan, PMs such as the TPS and other submitted documents to complete this review.”

Attachment B: Review Participants

CalEQRO Reviewers

Sue Nelson, EdD, Lead Reviewer
Rod Libbey, Quality Reviewer
Lisa Ferrall, Information Systems Reviewer
Valerie Garcia, Client and Family Member Consultant

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

Sites for San Benito's DMC-ODS Review

DMC-ODS Sites

The EQR was conducted solely through documents submitted by San Benito County to CalEQRO. Consequently, no sessions were held on site.

Contract Provider Sites

No sessions occurred at provider sites.

Table B1: Participants Representing San Benito			
Last Name	**First Name**	**Position**	**Agency**
Yamamoto	Alan		SBBH
Rios	Grizelle	QI Supervisor	SBBH
Lopez	Elizabeth	SUDS Clinical Supervisor	SBBH
White	Rachel	Assistant Director	SBBH
Orozco	Gabriel	Accountant III	SBBH
Sanchez	Maria	Case Management Services Manager	SBBH
Cendana	Maxe	QI Supervisor	SBBH
Cardoza	Eric	Director of Research and Development/Special Projects	Kings View IT Services
Turner	Sandra	Director of Software Support and Implementation	Kings View IT Services
Callahan	Nancy	Consultant	IDEA Consulting

Attachment C: County Highlights

Because this was a desk review due to the COVID-19 pandemic the county did not do a presentation or provide any additional slides, graphs, or charts at this time. They may add any additional materials to the Final Report if they so choose.

Attachment D: Continuum of Care Form

Continuum of Care: DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: San Benito County Review date(s): 07/01/2019-10/31/2020
Person completing form: Grizelle Rios & Gabriel Orozco

Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: 80%

County role for Access and coordination of care for persons with SUD requiring social work/linkage to coordinate care and ancillary services.

Describe county role and functions linked to access processes (Access Call Center) and coordination of care linked to access services:

When clients call our call center, they are greeted by a live person, their needs addressed, and the call is logged. If the client is needing an appointment, our clerical staff will schedule this with the client and log all efforts. If the client is needing case management/linkage, after an assessment has been completed, the client is assigned a SUDs counselor that will also take care of any case management needs. Clients are able to speak directly with their counselor and the counselor works with the client to coordinate care and/or access other services via linkage or referral.

Case Management- Describe if it is done by DMC-ODS via centralized teams or integrated into DMC certified contract or county programs or both:

Monthly estimated billed units of case management: 282.39 units per month

Comments:

For Outpatient, our SUDs counselors also perform case management duties when needed for their caseload. For all other contracted levels of care, the contractor has a designated amount for case management services for the clients placed under their care.

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, relapse prevention, peer support.

Pick 1 or more as applicable and explain below:

1) Included with program sites for linkage to treatment.
2) Included with outpatient sites as step-down.

3) Included with residential levels of care as step down.
4) Included with NTPs as stepdown for clients in remission.

Choices: 1 & 2
Total Legal entities offering recovery services: 1
Total number of legal entities billing DMC-ODS recovery services: 1
Monthly estimated billed units of case management: The report for recovery monitoring shows 0 services this fiscal year

Comments:

Some clients do stay with us for some of these services. However, our staff continues to need training on using the appropriate codes to identify these clients. We are working on developing our recovery services program once we are fully staffed.

Level 1 WM and 2 WM: Outpatient Withdrawal Management – Withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).

Number of Sites: 1
Total number of legal entities billing DMC-ODS: 1
Estimated billed units per month: 0
How are you structuring it? - *Pick 1 or more as applicable and explain below*

1) NTP
2) Hospital-based outpatient
3) Outpatient
4) Primary care sites

Choice(s): 3

Comments:

This service is currently contracted (WM-Level 1). We have not yet had to use this level of care. In addition, we are currently waiting on EHR unit/subunit set up to finalize for us to bill for these services, if any, to Medi-Cal.

Level 3.2 WM: Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports.

Number of sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Total number of beds: N/A
Estimated billed days/units per month: N/A
Pick 1 or more as applicable and explain below:

1) Freestanding
2) Within residential treatment center

Choice(s): N/A

Comments:

We currently do not provide this level of care.

NTP/OTP Programs- Narcotic treatment programs for opioid addiction and stabilization including counseling, methadone, other FDA medications, and coordination of care.

Total legal entities in county: 0
In county NTP: Sites 0 Slots: 0
Out of county NTP: Sites 1 Slots: 10
Total estimated billed counseling units per month: 900 units per month
Are all NTPs billing for non-methadone required medications? ☒ Yes ☐ No
Comments:

This service is currently contracted. On average, we have 3-5 clients using these slots throughout the year. Although the NTP has billed us for services and non-methadone medication, we have paid the NTP but have not yet billed these services to Medi-Cal.

Non-NTP-based MAT programs - Outpatient MAT medical management including a range of FDA SUD medications other than methadone, usually accompanied by counseling and case management for optimal outcomes.

Total legal entities: N/A Number of sites: N/A
Total estimated billed units per month: N/A

Comments:

Out NTP/OTP Program also provides MAT services.

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

Total legal entities: 1 Total sites: 1
Total number of legal entities billing DMC-ODS: 1
Average estimated billed units per month: 793.07 units per month

Comments:

This service is county ran. These units do not include Case Management services (CM services included in first section).

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 billed hours per month: N/A
Total legal entities: 2 Total sites for all legal entities: 2
Total number of legal entities billing DMC-ODS: 1
Average estimated billed units per month: N/A

Comments:

This service is currently contracted. The contract has been in effect since 7/1/2020 and although we have referred clients to these providers, the provider has not yet billed us for services. We are currently waiting on EHR unit/subunit set up to finalize for us to bill for these services, if any, to Medi-Cal.

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 sites for all legal entities: N/A
Total number of legal entities billing DMC-ODS: N/A
Total number of programs: N/A
Average client capacity per day: N/A
Average estimated billed treatment units per month: N/A

Comments:

We currently do not provide this level of care.

Level 3.1: Residential Structured SUD treatment / recovery services that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.

Total sites for all legal entities: 4
Total number of legal entities billing DMC-ODS: 1
Number of program sites: 4
Total bed capacity: 21
Average estimated billed bed days/units per month: 123 units per month

Comments:

This service is currently contracted. Providers have billed for these services, but we have not yet entered in these services to recoup billing for Medi-Cal because we have not yet been completely set up in our EHR.

Level 3.3: Clinically Managed, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.

Total sites for all legal entities: N/A
Number of program sites: N/A
N/A
Total bed capacity: N/A
Average estimated billed bed days/units per month: N/A
(Can be flexed and combined in some settings with 3.5)

Comments:

We currently do not provide this level of care.

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.

Total sites for all legal entities: N/A
Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Total bed capacity: N/A
Average estimated billed bed days/units per month: N/A
(Can be flexed and combined in some settings with 3.5)

Comments:

We currently do not provide this level of care.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services/ or WM – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) ☐ Yes ☐ No

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed Capacity: N/A
Average estimated billed bed days/units per month: N/A

Comments:

We currently do not provide this level of care.

Level 4: Medically Managed Intensive Inpatient Services or WM – 24-hour services delivered in an acute care, inpatient setting. (Billing Health Plan/FFS can you access services? ☐ Yes ☐ No
Access)

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed capacity: N/A
Average estimated billed bed days/units per month: N/A

Comments:

We currently do not provide this level of care.

Recovery Residences – 24-hour residential drug free housing for individuals in outpatient or intensive outpatient treatment elsewhere who need drug-free housing to support their sobriety and recovery while in treatment.

Total sites for all legal entities: 2

Number of program sites: 2

Bed capacity for women with children: 954 days
Total bed capacity: 1908 days

Comments:

This service is currently contracted. There are two locations with the same provider, one for women and women with children and one for men. The 954-day capacity for women with children includes all women, for tracking purposes we do separate the bed days 50/50. However, the contracted provider accepts women and women with children at the same rate.

Are you still trying to get additional services Medi-Cal certified? Please describe:

Not at the moment.

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

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

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

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