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# FY 2021-22 MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

## SAN BENITO FINAL REPORT

- MHP
- DMC-ODS

Prepared for:

**California Department of  
Health Care Services (DHCS)**

Review Dates:

**Thursday, January 13<sup>th</sup>, 2022**

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## EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Drug Medi-Cal Organized Delivery System (DMC-ODS) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, “San Benito” shall be used to identify the San Benito County DMC-ODS program, unless otherwise indicated.

### DMC-ODS INFORMATION

**DMC-ODS Reviewed** — San Benito

**Review Type** — Virtual

**Date of Review** — Thursday, January 13<sup>th</sup>, 2022

**DMC-ODS Size** — Small

**DMC-ODS Region** — Bay Area

**DMC-ODS Location** — South of Santa Clara County, east of Santa Cruz County, and north of Monterey County

**DMC-ODS Beneficiaries Served in Calendar Year (CY) 2020** — 221

**DMC-ODS Threshold Language(s)** — English, Spanish

### SUMMARY OF FINDINGS

Of the four recommendations for improvement that resulted from the FY 2020-21 EQR, the DMC-ODS addressed or partially addressed all three recommendations, and one was not addressed.

CalEQRO evaluated the DMC-ODS on the following four Key Components that impact beneficiary outcomes; among the 23 components evaluated, the DMC-ODS Met or partially Met the following by domain:

- Access to Care: 33.3 percent met (one of three KC's) 66.7 percent partially met (two of three KC's)
- Timeliness of Care: 33.4 percent met (two of six KC's), 33.3 percent partially met (two of six KC's), 33.3 percent not met (two of six KC's)
- Quality of Care: 12.5 percent met (one of eight KC's), 75 percent partially met (six of eight KC's), 12.3 percent not met (one of eight KC's)
- Information Systems (IS): 50 percent met (three of six KC's), 33.3 percent partially met (two of six KC's), 16.7 percent not met (one of six KC's)

The DMC-ODS submitted both required Performance Improvement Projects (PIPs). The clinical PIP, Reducing Drop-out rates, is in the first remeasurement phase with a low confidence validation rating. The non-clinical PIP, Text Appointment Reminders, is in the first remeasurement phase with a moderate confidence validation rating.

CalEQRO conducted one consumer family member focus groups, comprised of a total of seven participants.

## SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The DMC-ODS demonstrated significant strengths in the following areas: San Benito was able to add provider capacity for youth residential contracts, a withdrawal management (WM) contract with the perinatal residential within the county, and add intensive outpatient to its existing outpatient capacity within the county. They were also able to add two additional substance use disorder (SUD) clinical staff and move into a new building with expanded space for integrated services and coordinated care and add the American Society of Addiction Medicine (ASAM) assessment into their electronic health record (EHR).

The DMC-ODS was found to have notable opportunities for improvement in the following areas: San Benito was experiencing challenges with rising fentanyl overdoses for their small county and challenges with developing an in-county medication assisted treatment (MAT) option other than telehealth MAT. Also, perinatal was the only residential option available in the county, and this also presented access challenges. The workforce was also a significant challenge in that there is only one manager with an SUD credential, and she is in quality improvement (QI).

FY 2021-22 CalEQRO recommendations for several key improvements include implementing timeliness tracking for urgent conditions and continued efforts to add more X-Waivered providers who could prescribe needed opioid medications. Also, there is a need to bring MAT services into the county and develop new services with recently signed contracts.

# INTRODUCTION

## BACKGROUND

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

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

Additionally, DHCS requires the CalEQRO to evaluate counties on the following: delivery of SUD treatment services in a culturally competent manner, coordination of care with other healthcare providers, and beneficiary satisfaction. CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205.

This report presents the FY 2021-22 findings of the EQR for San Benito DMC-ODS by Behavioral Health Concepts, Inc., conducted as a virtual review on Thursday, January 13<sup>th</sup>, 2022.

## METHODOLOGY

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



Data used to generate Performance Measures (PM) tables, and graphs throughout this report are derived from multiple source files, unless otherwise specified. These statewide data sources include the following: Monthly Medi-Cal Eligibility Data System Eligibility File, DMC-ODS approved claims, the Treatment Perception Survey (TPS), California Outcomes Measurement System (CalOMS), and the ASAM level of care data. CalEQRO reviews are retrospective; therefore, data evaluated are from FY 2020-21, unless otherwise indicated. As part of the pre-review process, each county is provided a description of the source of data and a summary report of their PMs, including Medi-Cal, approved claims data. CalEQRO also offers individualized technical assistance (TA) related to claims data analysis upon request.

## FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the county's approach to performance management – emphasizing the utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of two elements pertaining to NA: Alternative Access Standards (AAS) requests and use of out-of-network (OON) providers.
- Summary of county-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of QI and those impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, including sixteen PMs.
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the county's quality and operational processes.
- Consumer perception of the county's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of county strengths, opportunities for improvement, and recommendations for the coming year.

## HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (\*) to protect the confidentiality of county beneficiaries. Further suppression was applied, as

needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate percentages, and cells containing zero, missing data, or dollar amounts.

## CHANGES IN THE DMC-ODS ENVIRONMENT AND WITHIN THE COUNTY

In this section, the status of last year's (FY 2020-21) EQRO review recommendations are presented, as well as changes within the county's environment since its last review.

### ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic, which occurred on January 15, 2022, in San Benito. The DMC-ODS described continued need for social distancing, vaccine monitoring and education of clients, staff redirection, and illness impacting programs and services, both contract and county. CalEQRO worked with the county to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges. The review was virtual using zoom sessions.

### SIGNIFICANT CHANGES AND INITIATIVES

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

- The Director was retiring the following month and a recruitment was in process.
- Hiring managers with both SUD and Mental Health (MH) credentials was so challenging that only the QI Manager has an SUD credential.
- Major increases in population have impacted the county and its services due to having less expensive housing than Santa Clara county, but impacting San Benito by increasing its housing costs.
- A new evidence-based curriculum was purchased and is being implemented in the outpatient. Service expansion also included new contracts for youth residential and WM.
- Behavioral health moved to a new building and has selected a new computer software system for future services including an EHR and billing.

### RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

## Assignment of Ratings

**Addressed** is assigned when the identified issue has been resolved.

**Partially Addressed** is assigned when the county has either:

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

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

## Recommendations from FY 2020-21

**Recommendation 1:** Expand the Continuum of Care to offer a wider variety of Levels of Care:

- Expand the youth continuum of care to include residential services.
- Expand services to include Level 3.5 or 3.3 residential for adults.
- Expand services to include Level 3.2 WM beds.
- Expand services to include Intensive Outpatient Treatment for both youth adults.

Addressed                       Partially Addressed                       Not Addressed

- San Benito contracted with two residential providers for youth residential: Advent Services in Santa Clara County and Tarzana in Los Angeles.
- San Benito contracted in FY 2021-22 with Sun Street Centers for level 3.5 for adults and is negotiating the rate.
- San Benito also contracted with Sun Street Center for WM bed capacity and is negotiating a rate for this level of care (LOC). This expanded capacity at its local residential program, which includes WM beds as well. However, that program is perinatal only, and thus, there will be no male WM bed capacity.
- San Benito expanded its outpatient to offer intensive outpatient 2.1.

**Recommendation 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 TA as needed to support your efforts.

Addressed                       Partially Addressed                       Not Addressed

- There are two active PIPs.

**Recommendation 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.

Addressed

Partially Addressed

Not Addressed

- San Benito added the ASAM to the EHR.
- San Benito notes that it went out to RFP to get a new system to prepare for major Medi-Cal changes and it was include this change with the new system.

**Recommendation 4:** Implement the DHCS required timeliness metric of tracking the length of time from urgent appointment requests to initial service. It is also recommended to develop an urgent definition to implement conditions and needs.

Addressed

Partially Addressed

Not Addressed

DMC-ODS reported they did not have resources to address this measure within the system during this year but would sent any clients who appeared to have acute needs for services to the emergency department.

# NETWORK ADEQUACY

## BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All DMC-ODSs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the DMC-ODS provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's national provider identification (NPI) number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and Narcotic Treatment Program (NTP)/Opioid Treatment Program (OTP) services for youth and adults. If these standards are not met, DHCS requires the DMC-ODS to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if a DMC-ODS can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with DMC-ODS staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the DMC-ODS's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the DMC-ODS, or its subcontractors.

## FINDINGS

For San Benito County, the time and distance requirements are 90 minutes and 60 miles for outpatient SUD services and 90 minutes and 60 miles for NTP/OTP services.

These services are further measured in relation to two age groups – youth (12-17) and adults (18 and over)<sup>1</sup>.

### **AAS and Out-of-Network Access**

San Benito submitted an AAS and a Corrective Action Plan (CAP) for youth NTP Opioid services to DHCS which was reviewed and approved for the following zip codes: 95023, 95045, 95004, 95043, and 95075. Numerous documents were provided to CalEQRO related to the process with this set of zip codes and efforts to secure opioid services for youth and their work with DHCS and document submitted and exchanged. The nearest in network provider was Valley Health Associates, 427 Pajaro St., Salinas and was 35 minutes' drive from the 95023-zip code cluster which was the closest to the critical zip codes needing services. They are also contracted to provide youth NTP services. As part of the CAP, the county contracted with Advent residential services in Santa Clara, however since this time Advent has chosen to close as a provider. Also, San Benito committed to continued efforts to pursue OON providers for this service for youth as well, closer to the county on an ongoing basis.

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<sup>1</sup> [AB 205](#) and [BHIN 21-023](#)

## ACCESS TO CARE

### BACKGROUND

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

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

### ACCESS IN SAN BENITO COUNTY

San Benito's SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Regardless of payment source, approximately 92 percent of services were delivered by county-operated/staffed clinics and sites, and 8 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 73.63 percent of services provided are claimed to Medi-Cal.

The DMC-ODS has an integrated toll-free Access Line with MH available to beneficiaries 24 hours, seven days per week. During business hours, county staff answer the line, and nights and weekends, there is a contract with an Alameda crisis service. Beneficiaries may request services through the Access Line, as well as through the following system entry points: Access Center Walk-In, Outpatient Clinic, Valley NTP, three residential sites, residential WM, local hospital emergency department. San Benito DMC-ODS operates a centralized access and assessment team that is responsible for linking all beneficiaries to appropriate, medically necessary services. All beneficiaries requesting care must currently be evaluated by the county assessment team, which can link them to case management if appropriate and a treatment program after their full ASAM assessment. Currently, 90 percent of clients are referred to the county-operated outpatient programs for treatment. Outpatient, perinatal with WM, and telehealth are the only services located in the county. NTP and all levels of residential for males and youth are provided under contracted services in surrounding counties.

In addition to clinic-based services, the DMC-ODS provides telehealth services. Specifically, the DMC-ODS delivers outpatient services via telehealth to youth and adults. In FY 2020-21, the DMC-ODS reports having served 276 adult beneficiaries, 20



youth beneficiaries, and a small number<sup>2</sup> of older adult beneficiaries via telehealth across one county-operated site and four contractor-operated sites. Among those served, 31 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

## ACCESS KEY COMPONENTS

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

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

**Table 1: Key Components – Access**

KC #	Key Component – Access	Rating
1A	Service Access are Reflective of cultural Competence Principles and Practices	Partially Met
1B	Manages and Adapts its NA to Meet SUD Client Service Needs	Partially Met
1C	Collaboration and Coordination of Care to Improve Access	Met

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

- Interagency collaboration especially related to the local San Benito opioid Task Force, grants, prevention activities and referral efforts were excellent and showed commitment, innovation with scarce resources, and efforts to improve systems of care through teamwork.
- Identification of MAT provider/prescriber resources that can be brought into the county for its needs are critical for the rising overdose issues and meeting SUD client needs. Staff leadership is evident in attempting to engage providers from

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<sup>2</sup> Due to HIPAA regulations, because the number is smaller than 12, it cannot be specified.

surrounding counties to offer these critical services. Hospitals wanted to provide Emergency Department-Bridge services but said they had no one to refer to for aftercare and ongoing prescribing, and the Sheriff’s staff shared a willingness to offer MAT to prepare inmates for discharge but wanted inmates to have reliable treatment in the community for follow-up. It was suggested that if the Sheriff’s Department and Health could find a provider together, it would make all the difference in successful access. Positive concern for community members and a willingness to collaborate was evident in the stakeholders present.

- The Cultural Competence Plan had included an excellent detailed analysis of penetration rates for substance use clients and prevalence data, which should be continued. Also, continued effort to show expanded use of services at different LOCs in the past year by clients as a whole and on average.

## PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the DMC-ODS:

- Total beneficiaries served, stratified by age and race/ethnicity.
- Penetration rates are stratified by age, race/ethnicity, and eligibility categories.
- Approved claims per beneficiary (ACB) served, stratified by age, race/ethnicity, eligibility categories, and service categories.
- Initial service used by beneficiaries.

### Total Beneficiaries Served

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

The majority of clients served were in the 18-64 age group with a penetration rate of 2.11 percent, higher than the statewide rate. Few clients were served in the youth and older adults age groups; thus, suppression rules were applied to Table 2, as well as in many of the PM tables throughout the report.

**Table 2: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2020**

San Benito				Small Counties	Statewide
Age Groups	Average # of Eligibles per Month	# Of Beneficiaries Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	2,521	*	n/a	0.23%	0.25%
Ages 18-64	9,426	199	2.11%	1.01%	1.26%

Ages 65+	1,402	*	n/a	0.37%	0.77%
<b>TOTAL</b>	<b>13,349</b>	<b>221</b>	<b>1.66%</b>	<b>0.81%</b>	<b>1.03%</b>

The race/ethnicity group with the most significant percentage of eligible clients was Latino/Hispanic (74.9 percent of all eligibles) and 67.4 percent of clients served. The penetration rate for this race/ethnicity group was higher than in other small counties and statewide. Penetration rates for White and Other were also higher than in other small counties and statewide.

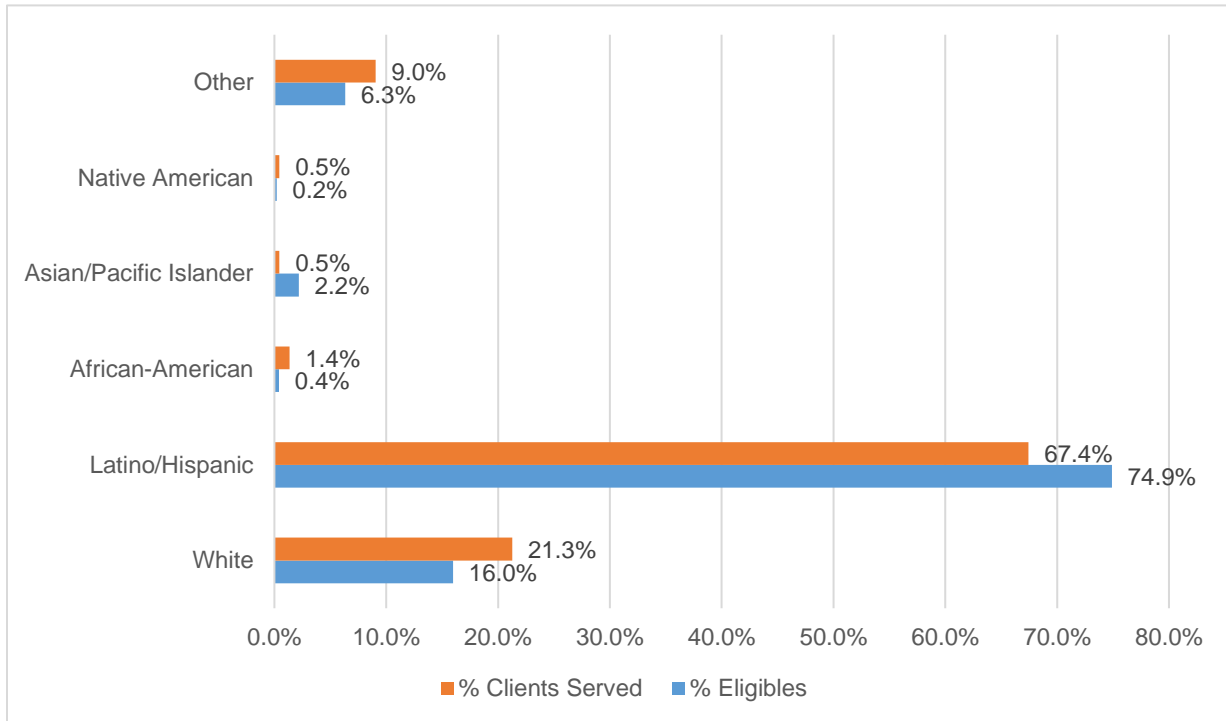
**Table 3: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2020**

San Benito				Small Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# Of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	2,132	47	2.20%	1.14%	1.96%
Latino/Hispanic	9,998	149	1.49%	0.56%	0.69%
African American	55	*	n/a	0.78%	1.34%
Asian/Pacific Islander	292	*	n/a	0.16%	0.17%
Native American	27	*	n/a	0.70%	1.84%
Other	846	20	2.36%	0.73%	1.41%
<b>TOTAL</b>	<b>13,350</b>	<b>221</b>	<b>1.66%</b>	<b>0.81%</b>	<b>1.03%</b>

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.

There was proportionality across race/ethnicity groups in comparing the percentage of eligibles to clients served.

**Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020**



**Penetration Rates and Approved Claim Dollars by Eligibility Category**

The average ACB 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.

Tables 4 and 5 highlight penetration rates and average approved claims by eligibility category.

Penetration rates for clients eligible through the Affordable Care Act (ACA) was 3.1 percent, higher than the statewide rate of 1.6 percent. The majority of clients receiving DMC-ODS services in San Benito were eligible through ACA. Family Adult and Disabled were also common eligibility categories. Penetration rates for these two eligibility categories were higher than statewide as well. The cells for youth served were

suppressed due to small numbers for Foster Care, Other Child, and Medicaid Children’s Health Insurance Program (MCHIP).

**Table 4: Clients Served and Penetration Rates by Eligibility Category, CY 2020**

San Benito				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Penetration Rate	Penetration Rate
Disabled	958	18	1.9%	1.8%
Foster Care	32	*	n/a	2.3%
Other Child	1,498	9	0.6%	0.3%
Family Adult	3,015	52	1.7%	1.1%
Other Adult	1,903	*	n/a	0.1%
MCHIP	1,170	*	n/a	0.2%
ACA	4,758	145	3.1%	1.6%

Average approved claims by eligibility categories are lower in San Benito compared to statewide for the adult categories. This may be because most clients are served in outpatient treatment rather than more costly LOCs. Other factors, such as county reimbursement rates, also impact average approved claims.

**Table 5: Average Approved Claims by Eligibility Category, CY 2020**

San Benito				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Average Approved Claims	Average Approved Claims
Disabled	958	18	\$1,818	\$4,559
Foster Care	32	*	n/a	\$2,037
Other Child	1,498	*	n/a	\$2,492
Family Adult	3,015	52	\$2,362	\$4,231
Other Adult	1,903	*	n/a	\$3,386
MCHIP	1,170	*	n/a	\$2,748
ACA	4,758	145	\$2,474	\$5,131

Table 6 tracks the initial DMC-ODS service used by clients to determine how they first accessed DMC-ODS services and shows the diversity of the continuum of care. The majority of clients in San Benito initially access DMC-ODS services in outpatient treatment (94.0 percent). Only small numbers of clients initiate in other LOCs; hence suppression rules are applied.

**Table 6: Initial DMC-ODS Service Used by Beneficiaries, CY 2020**

San Benito			Statewide	
DMC-ODS Service Modality	#	%	#	%
Outpatient treatment	205	94.0%	33,885	33.1%
Intensive outpatient treatment	-	0.0%	2,679	2.6%
NTP/OTP	*	n/a	40,908	40.0%
Non-methadone MAT	-	0.0%	291	0.3%
Ambulatory Withdrawal	-	0.00%	22	0.02%
Partial hospitalization	-	0.00%	23	0.02%
Residential treatment	*	n/a	16,620	16.3%
Withdrawal management	-	0.0%	6,790	6.6%
Recovery Support Services	-	0.0%	1,006	1.0%
<b>TOTAL</b>	<b>218</b>	<b>100.0%</b>	<b>102,224</b>	<b>100.0%</b>

Table 7 shows the percentage that each type of service category contributes to the total number of client treatment episodes for CY 2020. The service category used in most client episodes was outpatient (89.3 percent). Residential services were the next most common service category, used in 3.0 percent of the total client treatment episodes.

Average approved claims for outpatient services were slightly higher in San Benito compared to statewide, whereas NTP and residential average approved claims were lower than statewide.

**Table 7: Average Approved Claims by Service Categories, CY 2020**

Service Categories	% Served	Statewide % Served	Average Approved Claims	Statewide Average Approved Claims
Narcotic Tx. Program	6.0%	30.7%	\$2,646	\$4,097
Residential Treatment	3.0%	17.5%	\$4,775	\$8,846
Res. Withdrawal Mgmt	0.0%	6.8%	\$0	\$2,057
Ambulatory Withdrawal Mgmt	0.0%	0.0%	\$0	\$654
Non-Methadone MAT	1.7%	5.2%	\$174	\$1,093
Recovery Support Services	0.0%	2.7%	\$0	\$1,521
Partial Hospitalization	0.0%	0.0%	\$0	\$1,926
Intensive Outpatient Tx	0.0%	6.4%	\$0	\$966
Outpatient Services	89.3%	30.6%	\$2,324	\$2,037
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>\$2,509</b>	<b>\$4,894</b>

## IMPACT OF FINDINGS

Penetration rates for San Benito for adults, Latino/Hispanic, White, Other, and adult beneficiary categories were higher than statewide. Generally, clients are proportionally served when compared to the percentage of eligibles. In fact, Latino/Hispanic clients are the most common race/ethnicity group served in San Benito County and comprise nearly three-quarters of eligibles. The majority of clients were served in outpatient treatment (89.3 percent), which may reflect that the continuum of care needs further expansion to be able to meet the needs of clients with more intensive treatment needs.

The centralized access system may be slowing down access to residential and NTP services. Screenings at the Access Center can improve timeliness for residential and NTP services, as well as reduce dropouts and enhance engagement. Once the LOCs are identified, offering appointments immediately is easier for staff and eliminates steps in the access process.

## TIMELINESS OF CARE

### BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is a critical component of engagement, retention, and the ability to achieve desired outcomes. Studies have shown that the longer it takes to engage in treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system, including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to adjust their service delivery system in order to ensure that timely standards are being met. CalEQRO uses several indicators for tracking, and trending timeliness, including the Key Components and PMs, addressed below.

### TIMELINESS IN SAN BENITO COUNTY

The DMC-ODS reported timeliness data in aggregate. Further, timeliness data presented to CalEQRO represented county-operated services only.

### TIMELINESS KEY COMPONENTS

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

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



**Table 8: Key Components – Timeliness**

<b>KC #</b>	<b>Key Components – Timeliness</b>	<b>Rating</b>
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	Initial Contact to First MAT Appointment for NTP	Met
2C	Urgent Appointments	Not Met
2D	Follow-Up Services after Residential Treatment	Partially Met
2E	WM Readmission rates	Not Met
2F	No-Show rates	Partially Met

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

- Because of the intensity of outpatient care options and the lower percent of clients engaging in residential care, there was a positive rate of engagement after residential treatment into outpatient. This was twice as high as statewide and positive for clients coming out of residential care.
- There is still no definition for urgent requests or tracking. This was discussed at length during the review and operational urgent definitions of other counties were reviewed. Now that San Benito has a contractor for WM, they could use the most common definition, which is “clients in withdrawal with active symptoms.” CalEQRO reviewed other definitions and federal priorities were discussed.
- The concern is the current WM residential is for females only, and many persons who present in WM are likely to be male. There is still no male WM residential 3.2 option, so these individuals would need to be directed to the hospital emergency department. This already occurs for those in alcohol withdrawal.

## PERFORMANCE MEASURES

DHCS has established timeliness metrics to which DMC-ODSs must adhere for initial offered appointments for non-urgent outpatient SUD services, non-urgent MAT, and urgent care. In preparation for the EQR, DMC-ODS programs complete and submit the Assessment of Timely Access form in which they identify DMC performance across several key timeliness metrics for a specified time period.

Additionally, utilizing approved claims data, CalEQRO analyzes DMC performance on WM readmissions and follow-up care after discharge from residential treatment.

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

- First Non-urgent Appointment Offered
- First Non-urgent Appointment Rendered
- Non-Urgent MAT Request to First NTP/OTP Appointment
- Urgent Services Offered
- Average Days for Follow-up Visit Post-Residential Treatment
- WM Readmission rates Within 30 Days of Discharge
- No-Shows

### **DMC-ODS-Reported Data**

For the FY 2021-22 EQR, the DMC-ODS reported its performance for FY 2020-21.

- Average wait time of 3.2 days from initial service request to first non-urgent SUD appointment offered.
- Average wait time of 0 days from initial service request to first non-urgent NTP/OTP appointment offered.
- Average wait time of hours from initial service request to first urgent appointment offered was not tracked.
- Follow-up services post-residential treatment were not tracked.
- There were no clients who received WM; therefore, no readmission rates were tracked.
- No-shows were tracked for the central assessment center and routine outpatient appointments.
- One concern raised with the timeliness methodology was that other than the NTP, which is required to do its own assessment and tracking of timeliness, the requests at contract agencies were not part of timeliness tracking only requests at county sites, or the Access Line started the clock running in terms of time for timeliness tracking. If contractors are designated as access sites and advertised as such, the clock for requests must begin when they are approached for services, not when they call the county for an appointment for an assessment.
- Most counties require clients contacting contractors to do a brief ASAM screening and inform the county. They also submit the screening form detail. In such models. If the client is appropriate for the LOC they obtained initial access to the LOC, steps are saved and the provider simply submits medical necessity information to the county once a full ASAM assessment is completed.

**Table 9: FY 2021-22 DMC Assessment of Timely Access**

<b>FY 2021-22 DMC Assessment of Timely Access</b>			
<b>Timeliness Measure</b>	<b>Average/Rate</b>	<b>Standard<sup>3</sup></b>	<b>% That Meet Standard</b>
First Non-Urgent Appointment Offered	3.2 Days	10 Business Days	98.42%
First Non-Urgent Service Rendered	4.07 Days	10 Business Days	94.36%
Non-Urgent MAT Request to First NTP/OTP Appointment	0 Days	3 Business Days	100%
Urgent Services Offered	n/a	48 Hours	n/a
Follow-up Services Post-Residential Treatment	-	7 Days	n/a
WM Readmission rates Within 30 Days	n/a	-	-
No-Shows	6.03%	3%	48%

### **Medi-Cal Claims Data**

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the FY 2020-21 claims.

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

San Benito has timely dosing for methadone, less than a day, for NTP clients who request the first dose after assessment.

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<sup>3</sup> DHCS-defined standards, unless otherwise noted.

**Table 10: Days to First Dose of Methadone by Age, CY 2020**

San Benito				Statewide		
Age Groups	Clients	%	Avg. Days	Clients	%	Avg. Days
Ages 12-17	-	0.00%	<1	*	n/a	n/a
Ages 18-64	*	n/a	n/a	33,027	80.4%	<1
Ages 65+	*	n/a	n/a	*	n/a	n/a
<b>TOTAL</b>	<b>14</b>	<b>100.0%</b>	<b>&lt;1</b>	<b>41,093</b>	<b>100.0%</b>	<b>&lt;1</b>

### Transitions in care

The transitions in care following residential treatment are an essential indicator of care coordination. There were 18 discharges from residential treatment; however, too few clients had a follow-up to display unsuppressed data.

**Table 11: Timely Transitions in Care Following Residential Treatment, CY 2020**

San Benito (n= 18)			Statewide (n= 49,799)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	-	-	3,757	7.54%
Within 14 Days	-	-	5,160	10.36%
Within 30 Days	-	-	6,422	12.90%
<b>Any Days (TOTAL)</b>	*	<b>n/a</b>	<b>10,112</b>	<b>20.31%</b>

### Residential WM Readmissions

There were no WM clients in San Benito for CY 2020.

**Table 12: Residential WM Readmissions, CY 2020**

San Benito		Statewide		
Total DMC-ODS admissions into WM	0	11,647		
	#	#	#	%
WM readmissions within 30 days of discharge	n/a	n/a	1,291	11.1%

## IMPACT OF FINDINGS

San Benito only tracks timeliness data for the first request to first offered and first rendered appointment for county-run programs (outpatient treatment) and the NTP

tracks its own data. Timeliness for outpatient treatment met standards over 90 percent of the time (98.42 percent for first offered, 94.36 percent for first rendered). Timeliness is tracked for the few NTP clients who are served by the DMC-ODS and met standards 100 percent of the time. Urgent requests were not tracked. There were a small number of clients who went to residential, and so post-residential transitions were small numbers, but those served did transition to outpatient at a much higher percentage than other counties. There is a contract in place for WM 1.0 and 3.2 Perinatal which includes WM. No WM Medi-Cal residential units of service for CY 2020 were provided. Thus, Medi-Cal readmissions were not applicable.

## QUALITY OF CARE

### BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

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

### QUALITY IN SAN BENITO COUNTY

In the DMC-ODS, the responsibility for QI is part of the integrated QI/QA team, and it is divided between MH and SUD with approximately 6.5 total staff. The lead SUD QI Manager has clinical credentials in substance use and extensive experience from a methadone program and was aware of requirements in the Special Terms and Conditions (STCs). She was tracking compliance requirements such as NA, quality metrics such as reviewing TPS results, ASAM assessment findings, timeliness of services, and LOC placements. It was positive to see San Benito has such an experienced SUD QI leader for its substance use programs.

The DMC-ODS monitors its quality processes through the QI Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of providers, persons with lived experience, analysts, and stakeholders, meets monthly other than two months for holidays. Since the previous review of San Benito County, the DMC-ODS QIC has met ten times. Of the nine identified FY 2020-21 QAPI workplan goals, the DMC-ODS identified the percentage of goals met or improved related to their plan on all nine of the goals. The primary concern expressed by CalEQRO was that the integrated plan has only two goals directly focused on SUD issues. In future years, the program needs to be more balanced in focus areas related to the quality of care on SUD.

## QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SUD services healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These Key Components include an organizational culture that prioritizes quality, utilizes data to inform and make decisions, engages in QI activities, matches beneficiary needs to appropriate services, coordinates care with other providers, routinely monitors outcomes, satisfaction, and medication practices, and promotes transparent communication with focused leadership and strong stakeholder involvement.

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

**Table 13: Key Components – Quality**

KC #	Key Component – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Partially Met
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of an ASAM Continuum of Care	Partially Met
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	Partially Met
3F	ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Clients Served	Partially Met
3H	Utilizes Information from Client Perception of Care Surveys to Improve Care	Not Met

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

- San Benito hired a professional consultation to augment staff in quality data analytics. They are using this resource to improve their care system in both MH and SUD clinically, to improve data integrity, for development of PM data,

productivity data, costs of care, timeliness data, for prevalence data, and assisting them with planning for CalAIM.

- While San Benito is now getting some assessment data, the SUD staff are still learning how to utilize the data to understand ASAM findings and dimensions. This includes working to utilize providers across the continuum to meet client needs, especially in different counties, and use the data to educate staff on important changes related to evidence-based practices (EBPs). Ideally, the new data system will be shared across the network of providers, not just for county outpatient for communication. Also, client clinical profiles should be shared and worked on together by both county and contracts as a care system.
- CalEQRO encouraged San Benito to use the TPS which can provide valuable feedback to different programs on critical quality of care measures. Expanded participation of clients and sharing results would be recommended, mainly results from youth programs, Spanish-speaking clients, at all LOCs. Each sector on the continuum needs feedback on performance from the clients' view. UCLA identifies high-low charts and outliers, and they can be used to improve quality.

## PERFORMANCE MEASURES

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

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

## Diagnosis Data

Table 14 compares the breakdown by diagnostic categories of San Benito and statewide by the number of beneficiaries served and total approved claims amount, respectively, for CY 2020. The most common diagnostic categories for DMC-ODS clients in San Benito were Alcohol Use Disorder (AUD) (54.2 percent), Other Stimulant Abuse (17.6 percent), and Cannabis Abuse (15.3 percent). These percentages differ from statewide diagnostic code distributions. Most strikingly, Opioid Use Disorders comprise only 10.6 percent of clients served compared to 47.4 percent statewide. This



is most striking when the rate of overdose attempts is high, but utilization of services is low.

**Table 14: Percentage Served and Average Cost by Diagnosis Code, CY 2020**

Diagnosis Codes	San Benito		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	54.2%	\$2,191	17.6%	\$5,936
Cannabis Use	15.3%	\$2,427	8.0%	\$2,921
Cocaine Abuse or Dependence	0.5%	\$1,828	1.8%	\$5,769
Hallucinogen Dependence	0.0%	\$0	0.2%	\$6,112
Inhalant Abuse	0.0%	\$0	0.0%	\$8,581
Opioid	10.6%	\$3,397	47.4%	\$4,788
Other Stimulant Abuse	17.6%	\$3,522	23.1%	\$5,269
Other Psychoactive Substance	0.0%	\$0	0.1%	\$7,114
Sedative, Hypnotic Abuse	0.9%	\$1,614	0.5%	\$6,077
Other	0.9%	\$573	1.2%	\$2,923
<b>Total</b>	<b>100.0%</b>	<b>\$2,567</b>	<b>100%</b>	<b>\$4,962</b>

Table 15 summarizes the number and percentage of clients who received at least one dose and the percentage who received three or more doses of non-methadone MAT. There are small numbers of clients in San Benito who had at least one dose of non-methadone MAT. During a review session, medical providers noted the lack of any current X-waivered prescribers in the county, a challenge that will need to be addressed so that clients in need of MAT have more access to opioid treatment medications which can only be prescribed by X-waiver providers. In addition, the closest NTP is in Monterey County. Driving to Monterey on a daily basis to access NTP services was reported as difficult by clients and the probation staff.

### Non-Methadone MAT Services

**Table 15: DMC-ODS Non-Methadone MAT Services by Age, CY 2020**

Age Groups	San Benito				Statewide			
	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	-	-	-	0.0%	*	n/a	*	n/a
Ages 18-64	*	n/a	-	0.0%	6,698	7.6%	3,227	3.7%
Ages 65+	*	n/a	-	0.0%	*	n/a	*	n/a

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
<b>TOTAL</b>	*	n/a	-	0.0%	7,146	7.0%	3,397	3.3%

### Residential WM with No Other Treatment

Table 16 identifies clients who enter WM multiple times without ever engaging in follow-up treatment. This measure is a proxy for lack of effective discharge planning and case management follow-up to ensure that clients engage in treatment after WM. There were no WM clients in San Benito for CY 2020. They only recently signed a contract for WM 3.2 but had WM 1.0 since FY 2019-20.

**Table 16: Residential WM with No Other Treatment, CY 2020**

San Benito			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
<b>TOTAL</b>	0	0.0%	8,824	3.34%

### High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High-cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries' receiving services. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

There were no clients in San Benito who met or exceeded the threshold to be considered HCBs.

**Table 17: High-Cost Beneficiaries by Age, DMC-ODS, CY 2020**

<b>San Benito</b>						
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages 12-17	*	-	-	-	-	-
Ages 18-64	199	-	-	-	-	-
Ages 65+	*	-	-	-	-	-
<b>TOTAL</b>	<b>221</b>	-	-	-	-	-

**Table 18: High-Cost Beneficiaries by Age, Statewide, CY 2020**

<b>Statewide</b>					
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims
Ages 12-17	3,980	53	1.33%	\$19,547	\$1,036,014
Ages 18-64	89,545	5,355	5.98%	\$20,688	\$110,786,886
Ages 65+	10,277	217	2.11%	\$20,676	\$4,486,743
<b>TOTAL</b>	<b>103,802</b>	<b>5,625</b>	<b>5.42%</b>	<b>\$20,677</b>	<b>\$116,309,644</b>

**ASAM Level of Care Congruence**

Table 19 shows the congruence between the ASAM criteria-based findings at screenings and assessments and where the prospective client was referred. San Benito only recently have ASAM-based assessment criteria in the EHR. Thus, no data was reported to UCLA that could be displayed in Table 19. San Benito reports doing ASAM evaluations on paper but not submitting them electronically. With the recent addition of ASAM to the EHR, they can now be submitted.

**Table 19: Congruence of Level of Care Referrals with ASAM Findings, CY 2020**

San Benito ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
<b>CY 2020</b>						
<b>If assessment-indicated LOC differed from referral, then reason for difference</b>						
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

San Benito ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
CY 2020						
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 Level of Care Missing	n/a	n/a	n/a	n/a	n/a	n/a
<b>TOTAL</b>	n/a	n/a	n/a	n/a	n/a	n/a

### Initiation and Engagement

For adults in San Benito, 79.8 percent initiated treatment (had at least one session within 15 days after their initial visit), which is lower than the statewide percentage of 89.1 percent. For engagement (two more sessions with 30 days after the initiation visit), 71.0 percent of adults continued to engage in services, also lower than the statewide rate of 78.9 percent. The numbers of youth served was much smaller than adults; however, initiation and engagement were low compared to statewide for this age group. Initiation into services for youth was 80.0 percent.

**Table 20: Initiating and Engaging in DMC-ODS Services, CY 2020**

	San Benito				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	203		15		98,320		3,904	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	162	79.8%	12	80.0%	87,609	89.1%	3,179	81.4%
Clients who then engaged in DMC-ODS services	115	71.0%	*	n/a	69,099	78.9%	2,230	70.1%

## Length of Stay

The mean (average) LOS for San Benito clients was 122 days (median 86 days), comparable to the statewide mean of 142 (median 88 days). Of all clients, 49.1 percent had at least a 90-day LOS; 23.8 percent had at least a 180-day stay, and 12.1 percent had at least a 270-day LOS. The percentages for 180-day and 270-day LOS were slightly lower in San Benito compared to statewide, likely due to a majority of clients receiving services in the outpatient service LOC rather than other modalities that typically have a longer LOS, such as NTPs. (Table 21)

**Table 21: Cumulative LOS in DMC-ODS Services, CY 2020**

San Benito			Statewide	
Clients with a discharge anchor event	265		110,817	
LOS for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50 <sup>th</sup> percentile)	Mean (Average)	Median (50 <sup>th</sup> percentile)
	122	86	142	88
	#	%	#	%
Clients with at least a 90-day LOS	130	49.1%	54,782	49.43%
Clients with at least a 180-day LOS	63	23.8%	32,644	29.46%
Clients with at least a 270-day LOS	32	12.1%	20,256	18.28%

### CalOMS Discharge Ratings

Slightly more clients in San Benito have positive discharge ratings compared to the statewide average (61.2 percent vs 49.8 percent). This suggests that San Benito providers are engaging clients in treatment and providing quality care that is helping clients recover. However, contract providers are currently unable to enter their CalOMS into the EHR thus this data is incomplete.

**Table 22: CalOMS Discharge Status Ratings, CY 2020**

Discharge Status	San Benito		Statewide	
	#	%	#	%
Completed Treatment – Referred	*	n/a	16,988	17.80%
Completed Treatment - Not Referred	55	38.70%	5,541	5.80%
Left Before Completion with Satisfactory Progress - Standard Questions	*	n/a	13,830	14.50%
Left Before Completion with Satisfactory Progress – Administrative Questions	22	15.50%	7,566	7.90%
<i>Subtotal</i>	<b>87</b>	<b>61.2%</b>	<b>43,925</b>	<b>46.0%</b>
Left Before Completion with Unsatisfactory Progress - Standard Questions	*	n/a	13,918	14.60%
Left Before Completion with Unsatisfactory Progress - Administrative	45	31.70%	36,618	38.30%
Death	-	-	341	0.40%
Incarceration	*	n/a	722	0.80%
<i>Subtotal</i>	<b>55</b>	<b>38.7%</b>	<b>51,599</b>	<b>54.1%</b>
<b>TOTAL</b>	<b>142</b>	<b>100.0%</b>	<b>95,524</b>	<b>100.0%</b>

## IMPACT OF FINDINGS

There was a high percentage of clients with positive discharge ratings on the CalOMS compared to statewide; however, contract providers are unable to enter CalOMS into the EHR so data reflected in Table 22 is incomplete.

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

## BACKGROUND

Each DMC-ODS is required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330<sup>4</sup> and 457.1240(b)<sup>5</sup>. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create improvement at a member, provider, and/or DMC system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested individually by the DMC-ODS, hosting quarterly webinars, and maintaining a PIP library at [www.caleqro.com](http://www.caleqro.com).

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

## CLINICAL PIP

### General Information

Clinical PIP Submitted for Validation: Reducing Drop-Out Rates & Improving Continuity of Care

Date Started: December 2020

Aim Statement: Will a streamlined assessment process, linked to evidenced-based treatments, and transitions to RSS groups reduce dropouts to 65 percent over the next 24 months?

Target Population: All clients, all ages, appropriate for outpatient SUD treatment services regardless of diagnosis based on their ASAM assessment needing treatment and support for their SUD needs.

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<sup>4</sup> <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf>

<sup>5</sup> <https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf>



### Validation Information:

The DMC-ODS's clinical PIP is in the first remeasurement phase and considered active and ongoing.

### **Summary**

The PIP included several interventions: (1) shortening the assessment process and putting the ASAM into the EHR, (2) adding new modules into their treatment program in outpatient, and (3) beginning RSS (February 2022). RSS includes individualized recovery services including groups, case management, and individualized support services transitioning clients into community networks of support. These three interventions were designed to enhance engagement and continuity of care. A positive result was expected, since the having more intensive one on one counselor relationships from outpatient through to recovery support would strengthen the therapeutic alliance. However, based on the first measurement, the impact has not had the desired results.

### **TA and Recommendations**

As submitted, this clinical PIP was found to have low confidence, because of disruptions related to COVID-19 surges, staff and client illness, and challenges with telehealth and ability to develop clinical support systems, and for some clients' lack of technology and transportation access, and lack of access to MAT to assist with cravings related to alcohol or opioids. More analysis of the barriers to successful engagement and treatment components need examination.

The TA provided to the DMC-ODS by CalEQRO consisted of:

- Two sessions with the Quality Assurance (QA) Director provided feedback on draft PIPs. One set of feedback came from CalEQRO lead reviewer, and a second set was provided by a national PIP consultant; both on key questions to answer to enhance the PIP analysis and design.

CalEQRO recommendations for improvement of this clinical PIP include:

- Suggest more thorough root cause analysis regarding dropouts, lack of engagement, and use clients on QA committee or obtain consumer input via surveys to explore these key issues. Timeliness of assessment may be only one factor related to dropouts, per staff and clients in feedback sessions.
- Putting ASAM in to the EHR will help with timeliness of admission process so that is helpful for engagement but other activities to assist with making it to the first appointment are often also needed such as transportation assistance, case management support and outreach, childcare, etc. per your own summary of barriers.

- Also, if the primary diagnostic group is AUDs and the program has no access to MAT for AUD, this is a barrier that should be overcome to assist those with chronic cravings. With Medi-Cal, coverage of medication and clinical service is available for beneficiaries with a medical provider.

## NON-CLINICAL PIP

### General Information

Non-Clinical PIP Submitted for Validation: Text Message Appointment Reminders

Aim Statement: Will text message appointment reminders reduce no-shows for assessments and routine appointments to no more than 10% overall.

Target Population: All assessment and routine outpatient appointments done by the county (contractors are not using the EHR appointment system).

Validation Information:

The DMC-ODS's non-clinical PIP is in the first remeasurement phase and considered active and ongoing with a moderate confidence level.

### Summary

San Benito added a text messaging software system linked to its appointment module so all appointments could get reminders twice before the actual visit, both for assessments and routine scheduled appointments. If the client canceled or did not show, the staff were asked to call the client to reschedule.

The PIP tracked improvement rates of clients who had assessments and who had routine appointments. They also did a satisfaction survey related to the text software, which 70 percent of clients said they liked. There was one remeasurement following the launch of the text messaging software with several indicators.

The assessment no-show rate improved from 4.5 to 2.2 percent, but the routine appointment improvement was much more modest, from 22.6 to 22.5 percent.

Clinical staff did not control their own schedules, and the clerical staff had to do all the re-scheduling of canceled appointments with the clinical team. There was concern with the efficiency of the re-scheduling process by phone by the clerks versus letting clinical staff follow-up as soon as they got the text of cancellation. One suggestion was the possibility of allowing the clinician to text the client back and arrange a time for the new appointment, which could be considered as a modified intervention. The PIP is still being considered for some possible re-design and continuation. Clients discussed that text messaging is their client focus group as needing improvement but not a bad idea.

Clients identified by other issues as well such as no identifier on the phone when a call comes in which currently shows as SPAM or unknown, and they often do not pick up.

## TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because the design was sound in terms of the PIP principles and research related to this issue and was using data and client feedback. Also, text communication is a primary communication tool for persons in many communities. It is also key to engagement and retention in care and appointment coordination. There are more avenues for the development of this tool for treatment and telehealth.

The TA provided to the DMC-ODS by CalEQRO consisted of:

- The lead reviewer provided early feedback on the draft. Discussed other counties with similar PIPs and barriers and challenges.
- National PIP expert reviewed and asked additional questions related to client role in root cause analysis, why assessments were included since these clients are not yet in treatment, so it was not a no-show issue of an existing client, more of an engagement issue from a quality perspective, and other TA comments.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- Explore in more depth the root causes for no-shows (transportation, childcare, illness, etc.) and directly address these as well as reminding clients of the appointments themselves and being flexible about changes in appointment re-scheduling process, hours of services, provision of free transportation, better or easier telehealth options, childcare, combining appointments with a health clinic, etc.
- Consider refining the text model in one clinic with clinicians doing all their own appointment management using direct text messaging re-scheduling to be efficient and, if successful, expand to other clinics and contractors.
- Set up a system to allow clinic numbers or identifiers to be visible per client feedback allowing them to know the clinic is calling.
- Gather more direct feedback from clients in similar to focus groups.

# INFORMATION SYSTEMS

## BACKGROUND

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

## IS IN SAN BENITO COUNTY

California DMC-ODS EHRs fall into two main categories, those that are managed by county IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the DMC-ODS is Cerner Community Behavioral Health, hosted by the ASP vendor, Kings View, which has been in use for 15 years. Cerner's product is sunsetting, and Kings View is partnering with Credible. Thus, the DMC-ODS is actively implementing a new system (Credible) which requires heavy staff involvement to fully develop, as well as the partnership with Kings View.

Approximately 2.5 percent of the DMC-ODS budget is dedicated to supporting the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving DMC-ODS control and another county department or agency.

The DMC has 55 named users with logon authority to the EHR, all county-operated staff. Support for the users is provided by 0.4 full-time equivalents (FTE) IS technology positions, as well as contracted IT support from Kings View. Currently, all positions are filled.

As of the FY 2021-22 EQR, no contract providers have access to directly enter data into the DMC's EHR. Line staff that has direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the DMC-ODS IS as reported in the following table:

**Table 23: Contract Providers’ Transmission of Beneficiary Information to DMC-ODS EHR**

Submittal Method		Frequency	Submittal Method Percentage
<input type="checkbox"/>	Health Information Exchange (HIE) between DMC IS	<input type="checkbox"/> Real Time <input type="checkbox"/> Batch	0%
<input type="checkbox"/>	Electronic Data Interchange (EDI) to DMC IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
<input type="checkbox"/>	Electronic batch file transfer to DMC IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
<input type="checkbox"/>	Direct data entry into DMC IS by provider staff	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
<input checked="" type="checkbox"/>	Documents/files e-mailed or faxed to DMC IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly	95%
<input checked="" type="checkbox"/>	Paper documents delivered to DMC IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly	5%
			100%

### Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a personal health record (PHR) enhances beneficiaries’ and their families’ engagement and participation in treatment. San Benito does not have a PHR and does not have plans to implement at this time.

### Interoperability Support

The DMC is not a member or participant in an HIE. DMC staff uses secure email, and DocuSign is used for secure HIE with password protection.

### IS KEY COMPONENTS

CalEQRO identifies the following Key Components related to DMC system infrastructure that are necessary to meet the quality and operational requirements required to promote positive beneficiary outcomes. Technology, 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 the overall quality of the SUD delivery system and organizational operations.

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

**Table 24: Key Components – IS Infrastructure**

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Partially Met
4F	Interoperability	Not Met

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

- The dashboards that San Benito has created in partnership with Kings View are clear and customizable. They are pushed out to leadership and managers to assist with system monitoring and decision-making.
- San Benito has a contract with Nancy Callahan Consulting to assist with data analytics, among other implementation activities.
- San Benito has an opportunity to engage contract providers in the planning process for the new EHR implementation of Credible. With CalAIM’s focus on integration, interoperability will be critical for the DMC-ODS to establish, particularly with its own provider partners.

## IMPACT OF FINDINGS

As discussed above, interoperability is a vital component of IS infrastructure. With a new EHR implementation beginning in February 2022, there is an opportunity to engage with contract provider stakeholders and enhance their ability to directly enter data into the system and/or use electronic batch file transfer into the EHR. The new EHR may also help facilitate other areas, such as the PHR, which is another critical component of California Advancing and Innovating Medi-Cal (CalAIM).

# VALIDATION OF CLIENT PERCEPTIONS OF CARE

## BACKGROUND

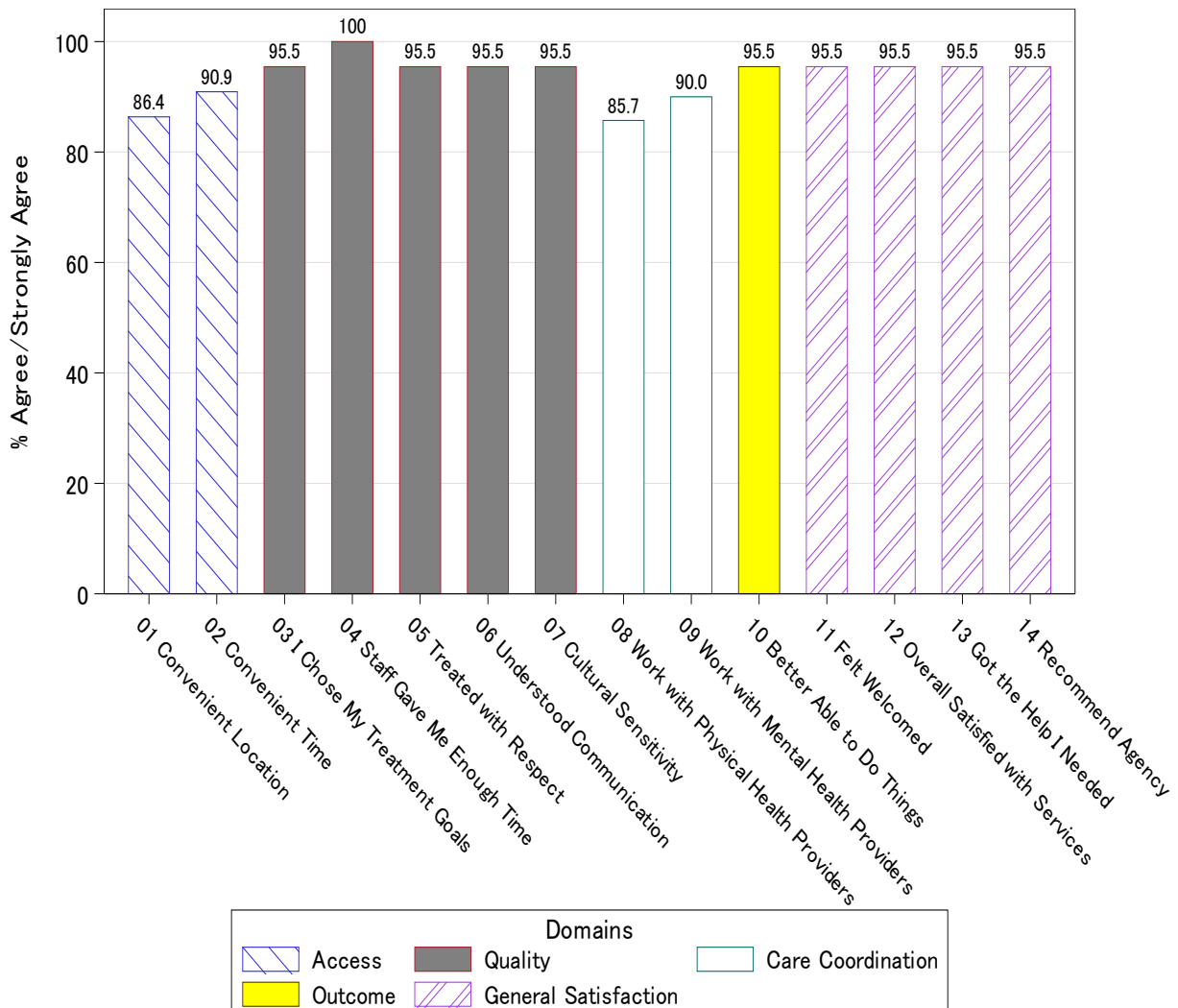
CalEQRO examined available client satisfaction surveys conducted by DHCS, the DMC-ODS, or its subcontractors.

## TREATMENT PERCEPTION SURVEY

The TPS consists of ratings from the 14 items that yield information regarding 5 distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. DMC-ODSs administer these surveys to beneficiaries once a year in the fall and submit the completed surveys to DHCS. As part of its evaluation of the statewide DMC-ODS Waiver, the University of California, Los Angeles (UCLA) evaluation team analyzes the data and produces reports for each DMC-ODS.

The DMC-ODS did not appear to have any specific use for the TPS other than sharing results with staff and programs. All the results collected were from county-run outpatient programs and were remarkably high. The numbers of surveys collected were small, and the goal for next year is to increase the number of participants, increase Spanish speakers, and include persons participating in contract agencies.

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



## CONSUMER FAMILY MEMBER FOCUS GROUP

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



As part of the pre-site planning process, CalEQRO requested one adult focus group with adults from their outpatient and intensive outpatient programs, both recently admitted and longer-term clients.

### Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult clients who initiated services in the preceding 12 months and some who had been in the program longer. The focus group was held at virtually and included seven participants; no interpreter was needed for the group. All clients participating receive clinical services from the DMC-ODS at the Hollister campus or virtually through the county outpatient programs.

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement.

Participants Described Their Experience As the Following:

**Table 25: CFM Focus Group One**

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

There were five males and two females in the group, four Caucasians and three Latino/Hispanic clients. All reported positive experiences with their counselors, and particularly the support they received in crisis situations and in dealing with court and legal challenges and improving their access to services to they could work towards reunification with their children, find help getting into the workforce, reconcile with families.

They did report that having residential programs out of the county discouraged them from wanting to participate even when they needed their help.

They did not like one aspect of the text message system because it did not let them know it was the clinic calling them or their counselor, so they often did not pick up. The clients stated that it needs to show the name or county number, so they recognize who is calling. Also, participants noted it would be more helpful if they could arrange appointments directly right after they cancel because the schedule can change so fast with their counselor.

Recommendations from focus group participants included:

- Add more services closer to home and transportation, especially for those who need methadone or residential.
- Add a name or recognizable number to text messaging, so clients know who is calling and make it easy to quickly reschedule with counselors.
- Add more counselors, so they have more time for clients and are not so busy. Add night and weekend social support activities like other programs when COVID-19 impacts are not so bad.
- Add more help from case managers with housing and jobs.

## IMPACT OF FINDINGS

San Benito quality findings indicate progress over the prior year in terms of expanded services and capacity through several new contracts, and DMC-ODS Medi-Cal certifications and clients served. San Benito had high scores on the TPS for outpatient care and engagement of clients leaving residential into outpatient care, though few clients accessed residential treatment being out of the county. The Quality Plan needed more focus on SUDs in its goals and objectives, but the program and its structure were sound and had informed leadership. The Cultural Competence Plan was in-depth in its analysis of ethnic groups, penetration rates, and prevalence, as well as the use of services across the ASAM continuum. Currently, outpatient is the primary service being delivered in the county. There is also a perinatal residential, and a new contract for residential and WM should be available for more utilization in the coming year. Additionally, San Benito said it was working with the Salinas methadone provider to try

to develop a satellite site within the county to provide care. DMC-ODS also considering a regular van daily to and from Salinas for access.

The need for a permanent MAT provider in the county was also voiced by many in the client group as well as in the San Benito Opioid Task Force. In addition, challenges in tracking urgent conditions and access to services other than just the emergency department were very high across the community, the stakeholder group shared.

## CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the DMC-ODS's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective DMC-ODS managed care system.

## STRENGTHS

San Benito DMC-ODS exhibited the following strengths in its second year of delivering services:

1. DMC-ODS expanded access in new LOCs of the ASAM continuum, including two contracts for youth residential, one contract for intensive outpatient, county addition of intensive outpatient for youth and adults, and one WM contractor for women and residential contractor who became Medi-Cal certified.

(Access)

2. The Cultural Competence Plan evaluation reflected a quality review of key issues. It thoroughly evaluated the prevalence, penetration rates, and utilization by LOC for clients using the ASAM continuum. While this second year was primarily outpatient, more services are being added to complete the continuum.

(Quality, Access)

3. Clients in focus groups shared positive therapeutic alliances and successful benefits from counseling services, indicating a quality experience. San Benito added a new therapy module to their treatment program this year.

(Quality)

4. The first offered appointments from the call center were within state guidelines 98.4 percent of the time for first appointments with clinician staff for assessments appointments.

(Timeliness)

5. San Benito integrated ASAM assessment tools into their EHR to enhance quality and improve clinician workflows.

(Quality, Timeliness, IS)

## OPPORTUNITIES FOR IMPROVEMENT

San Benito DMC-ODS exhibited the following opportunities in its second year of delivering DMC-ODS services:

1. San Benito could not track urgent appointment requests in the Access Call Center during or after business hours and does not have a current definition. This is a state required timeliness measure.  
(Timeliness)
2. The county does not have local access to MAT site to address rising opioid overdose crises impacting the community, as reflected by data and opinions in the Opioid Overdose Task Force and Prevention Coalition.  
(Access, Quality)
3. The QI Plan contained only two goals focused primarily on SUDs.  
(Quality)
4. The after-hours call service providing DMC-ODS access to services is a MH crisis line and does not conduct SUD screening or provide SUD information for callers.  
(Access, Quality)
5. Contractors reported infrequent communication and coordination with San Benito SUD leadership, which impairs data information exchange and coordination of care efforts. This is especially true on submission of required CalOMS data and TPS data for San Benito residents. This is also important for planning with CalAIM, transfers between LOCs, and quality of care in general. San Benito states they meet every two months and are available by phone and email.  
(Access, Quality, IS)

## RECOMMENDATIONS

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

1. Develop a definition for and track urgent appointments through the Access Call Center, including after-hours service on night and weekends.  
(Timeliness, Access)
2. San Benito has a contract for WM services for female clients but also needs to add a contract for access for male clients as well. It is recommended a contract be added to address the need for male access to WM services level 3.2 residential which is a Medi-Cal entitlement.  
(Timeliness, Access)
3. Develop a plan to solicit providers for MAT, both methadone and non-methadone, in coordination with surrounding counties and DHCS to see if there could be a collaborative solution to bring on-site services into San Benito County

on a regular basis to address this critical need for MAT within the county at least three days per week and possibly on-call during other days.

(Access, Quality)

4. Increase the focus and number of SUD quality measures to balance the QI Work Plan related key issues such as timeliness, ASAM, MAT, screening, transitions in care, the new treatment module San Benito purchased, etc. TA is available if needed. CalAim should also provide many options for new quality goals as well.

(Quality)

5. Expand after-hours access call services to include SUD screening and provide SUD information for callers.

(Access, Quality)

6. Improve coordination of care efforts and data information exchange between contractors and DMC-ODS leadership. Consider establishing routine, formalized meetings. This will be particularly important with the transition to a new computer system and the full implementation of CalAIM.

(Quality, IS)

## SITE REVIEW BARRIERS

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

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the DMC-ODS. Consequently, some areas of the review were limited.

## **ATTACHMENTS**

ATTACHMENT A: CalEQRO Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT E: County Highlights



## ATTACHMENT A: CALEQRO REVIEW AGENDA

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

**Table A1: CalEQRO Review Sessions – San Benito DMC-ODS**

<b>Table A1: CalEQRO Review Sessions - San Benito DMC-ODS</b>
Opening session – Changes in the past year, current initiatives, the status of previous year’s recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of PM
QI Plan, implementation activities, and evaluation results
ISCA/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards, and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: Cultural Competence Plan, implementation activities, evaluation results
PIPs
Health Plan, primary, MH, health care coordination with DMC-ODS
MATs
Criminal justice coordination with DMC-ODS
Clinical line staff group interview – county and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

## ATTACHMENT B: REVIEW PARTICIPANTS

### **CalEQRO Reviewers**

Rama K Khalsa, Ph.D., Lead Reviewer

Melissa Martin, Ph.D. Information Systems Review

Jon Santoyo, Consumer Family Consultant

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

Sites for San Benito's DMC-ODS Virtual Review

### **DMC-ODS Location:**

San Benito County Behavioral Health and Recovery Services

1131 San Felipe Road

Hollister, California 95023

### **Contract Provider Sites**

No visits: contractors participated via zoom.

All sessions were held via video conference.

**Table B1: Participants Representing the DMC-ODS**

<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>Agency</b>
Yamamoto	Alan	Director	San Benito County Behavioral Health
White	Rachel	Assistant Director	SBCBH
Lopez	Elizabeth	Substance Abuse Program, Clinical Supervisor	SBCBH
Cendana	Maxe	QI Supervisor	SBCBH
Saikia	Rumi	QI Supervisor	SBCBH
Rios-Gonzalez	Grizelle	Director of Administrative Services	SBCBH
Garcia	David	Substance Abuse Counselor	SBCBH
Ramirez	Jason	Substance Abuse Counselor	SBCBH
Greer	Greg	Substance Abuse Counselor	SBCBH
Callahan	Nancy	Consultant	IDEA Consulting
Tobra	Sabrena	Probation	Probation Officer
Johnson	Veronica	Public Health	Epidemiologist
White	Mary	Health	Pharmacist
Aguilera	Ezmerelda	Hazel Hawkins	Social Worker
Hankla	Renee	Detention	Jail Re-entry

## ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

### Clinical PIP

**Table C1: Overall Validation and Reporting of Clinical PIP Results**

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> →High confidence <input type="checkbox"/> →Moderate confidence <input checked="" type="checkbox"/> →Low confidence <input type="checkbox"/> →No confidence	<p>There is a certain lack of clarity related to measurement strategy and intervention and root cause analysis related to the stated problem. The measurements focus on the LOS in treatment which does link to better outcomes. Still, the intervention is primarily a shorter assessment tool versus continuity of care tools with the bridge the therapeutic alliance from assessment to treatment to RSS and enhanced continuity.</p>
<b>General PIP information</b>	
<b>Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: San Benito DMC-ODS</b>	
<b>PIP Title:</b> Reducing Drop-Out Rates & Improving Continuity of Care	
<b>PIP Aim Statement:</b> Will a streamlined assessment process linked to evidenced-based treatments and transitions to RSS groups reduce dropouts to 65 percent over the next 24 months?	
<b>Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (Check all that apply)</b> <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
<b>Target age group (check one):</b> All clients, all ages, appropriate for outpatient SUD treatment services regardless of diagnosis	

based on their ASAM assessment needing treatment and support for their SUD needs.

- Children only (ages 0–17) \*       Adults only (age 18 and over)       Both adults and children

\*If PIP uses different age threshold for children, specify age range here:

**Target population description, such as specific diagnosis (please specify): All SUD diagnoses- none are excluded**

**Improvement Strategies or Interventions (Changes in the PIP)**

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)  
Member must agree to participate in assessments and treatment processes.

Provider-focused interventions  
Clinical staff will provide a shorter ASAM assessment integrated into the EHR and then transition the client into the outpatient program with EBPs provided by SUD-trained staff in the new Matrix module and other individualized treatments appropriate to that person’s plan. If clinically appropriate, will transition the individual into RSS with case manager peer support with an individual RSS plan.

MHP/DMC-ODS-focused interventions/System changes Administration will pay the vendor to put ASAM into the EHR, train staff in this workflow, and the new modules in Matrix. Also, provide training in RSS services to provide this care, enhance continuity of care and facilitate smooth transitions between LOCs, including providing intensive case management as needed.  
Click or tap here to enter text.

PM (be specific and indicate measure steward and National Quality Forum (NQF) number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (If applicable)	Most recent remeasurement sample size and rate (If applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No)  Specify P-value
Increase LOS for SUD if clinically appropriate to 90 days or more for 65 percent or more of clients who are admitted to SUD treatment	19-20	76/187=40.6%	<input checked="" type="checkbox"/> Not applicable— PIP is in the Planning or implementation phase, results not available	20-21  121/191=63.4%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

PM (be specific and indicate measure steward and National Quality Forum (NQF) number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (If applicable)	Most recent remeasurement sample size and rate (If applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No)  Specify P-value
Increase LOS for SUD if clinically appropriate to 90 days or more for 65 percent or more of clients who are admitted to SUD treatment	19-20	76/187=40.6%	<input type="checkbox"/> Not applicable— PIP is in Planning or implementation phase, results not available	20-21 111/191=58.1%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Sixty Percent will complete goals and are in care for 90 days or more	19-20	57/112=50.9%	<input type="checkbox"/> Not applicable— PIP is in Planning or implementation phase, results not available	21-21 49.5%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Sixty Percent will complete goals and are in care for 90 days or more	19-20	57/112=50.9%	<input type="checkbox"/> Not applicable— PIP is in Planning or implementation phase, results not available		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

### PIP Validation Information

**Was the PIP validated?**  Yes  No

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

**Validation phase (check all that apply):**

PIP submitted for approval  Planning phase  Implementation phase  Baseline year

First remeasurement  Second remeasurement  Other (specify):

Validation rating:  High confidence  Moderate confidence  Low confidence  No confidence

“Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to the accepted 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:** Consider adding intensive case management from the assessment through to RSS with one primary case manager so the client has an “anchor” for their SUD support and continuity throughout this process. Many counties call these staff substance use “navigators.” They are SUD counselors who take the clients from access, often bring them to their first appointment through to treatment. Sometimes they continue to see them as core support staff, and then assist in the final transfers to RSS. Suggest consultation with Marin and Contra Costa on their PIPs with similar themes.

## Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> →High confidence <input checked="" type="checkbox"/> →Moderate confidence <input type="checkbox"/> →Low confidence <input type="checkbox"/> →No confidence	New software to reduce no-shows for new assessments and routine outpatient appointments for adults and youth. Used a survey to clients on satisfaction and county phone system.
<b>General PIP Information</b>	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: San Benito County DMC-ODS	
PIP Title: Text Messaging Appointment Reminders	
<b>PIP Aim Statement:</b> Will text message appointment reminders reduce no-shows for assessments and routine appointments to no more than 10 percent overall	
<b>Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (Check all that apply)</b> <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)	

<input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)						
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17) * <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:						
<b>Target population description, such as specific diagnosis (please specify): All SUD diagnoses and all ages</b>						
<b>Improvement Strategies or Interventions (Changes in the PIP)</b>						
<b>Member-focused interventions</b> Respond to text message reminders related to assessment appointments or treatment appointments to confirm, or cancel, or ask to reschedule						
<b>Provider-focused interventions</b> Send out two reminder text messages prior to the appointments in the week prior to appointments, and if the client responds to cancel or ask to reschedule, then respond and set up a new appointment that meets their needs and change in circumstances. Clinical staff has to work through clerical as they do not control their own schedules. Also, phone calls do not show the specific number for the county, so many clients reported they did not know who it was and did not answer.						
<b>MHP/DMC-ODS-focused interventions/System changes</b> Implement text message software attached to appointment module and county phone system (not cell phones desk phones), train staff on responsibilities to call clients back and coordinate new appointments with clerical), test, and collect and analyze data for results.						
PM (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year  (If applicable)	Most recent remeasurement sample size and rate	Demonstrated performance improvement (Yes/No)	A statistically significant change in performance (Yes/No)  Specify P-value
PM 1. Percent of no-shows/cancelations for routine SUD appointments	19-20	2032/9001=22.6%		20-21  2174/9974=22.5%	<input checked="" type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):



PM (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (If applicable)	Most recent remeasurement sample size and rate	Demonstrated performance improvement (Yes/No)	A statistically significant change in performance (Yes/No) Specify P-value
PM 2. Percent of no-show cancelations of assessments for SUD	19-20	14/309		20-21 7/322=2.2%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
PM 3. Percent of clients who were sent messages and responded	NA	NA	June-Dec 2021	366/1309=28%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
PM 4. Percent of clients sent messages and confirmed	NA	NA	June-Dec 2021	324/366=88.5%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
PM 5 percent of clients who responded and canceled appointment	NA	NA	June-Dec 2021	42/366=11.5		<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05
PM 6 was the percent of clients who rated the application excellent or very good on the survey	NA	NA	June-Dec 2021	7/10=70 %		<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05
<b>PIP Validation Information</b>						
<p><b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>“Validated” means that the EQRO reviewed all relevant parts of each PIP and decided as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)</p>						

**Validation phase (check all that apply):**

PIP submitted for approval  Planning phase  Implementation phase  Baseline year

First remeasurement  Second remeasurement  Other (specify):

Validation rating:  High confidence  Moderate confidence  Low confidence  No confidence

“Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to the accepted 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 PIPs** submitted, this non-clinical PIP was found to have moderate confidence because the design was sound in terms of the PIP principles and research related to this issue and was using data and client feedback.
- Also, text communication is a primary communication tool for persons in many communities. It is also key to engagement and retention in care and appointment coordination. There are more avenues for the development of this tool for treatment and telehealth.

The TA provided to the DMC-ODS by CalEQRO consisted of:

- The lead reviewer provided early feedback on the draft. Discussed other counties with similar PIPs and barriers and challenges.
- National PIP expert reviewed and asked additional questions related to client role in root cause analysis, why assessments were included since these clients are not yet in treatment, so it was not a no-show issue of an existing client, more of an engagement issue from a quality perspective, and other TA comments.

CalEQRO recommendations for improvement of this non-clinical PIP include.

- Consider refining the text model in one clinic with clinicians doing all their own appointment management using direct text messaging re-scheduling to be efficient and, if successful, expand to other clinics and contractors.
- Set up a system to allow clinic numbers or identifiers to be visible per client feedback to know the clinic is calling.
- Gather more direct feedback from clients similar to focus groups.

## ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

**Table D1: CalOMS Living Status at Admission, CY 2020**

Admission Living Status	San Benito		Statewide	
	#	%	#	%
Homeless	*	n/a	25,577	27.9%
Dependent Living	*	n/a	22,882	25.5%
Independent Living	143	88.8%	43,711	46.6%
<b>TOTAL</b>	<b>161</b>	<b>100.0%</b>	<b>92,170</b>	<b>100.0%</b>

**Table D2: CalOMS Legal Status at Admission, CY 2020**

Admission Legal Status	San Benito		Statewide	
	#	%	#	%
No Criminal Justice Involvement	60	37.3%	58,971	64.0%
Under Parole Supervision by CDCR	-	-	1,849	2.0%
On Parole from any other jurisdiction	*	n/a	1,305	1.4%
Post release supervision - AB 109	90	55.9%	23,836	25.9%
Court Diversion California (CA) Penal Code 1000	*	n/a	1,382	1.5%
Incarcerated	-	-	442	0.5%
Awaiting Trial	*	n/a	4,348	4.7%
<b>TOTAL</b>	<b>161</b>	<b>100.0%</b>	<b>92,133</b>	<b>100.0%</b>

**Table D3: CalOMS Employment Status at Admission, CY 2020**

Current Employment Status	San Benito		Statewide	
	#	%	#	%
Employed Full-Time - 35 hours or more	20	12.4%	10,461	11.3%
Employed Part Time - Less than 35 hours	23	14.3%	6,784	7.4%
Unemployed - Looking for work	51	31.7%	28,853	31.3%
Unemployed - not in the labor force and not seeking	67	41.7%	46,072	50.0%
<b>TOTAL</b>	<b>161</b>	<b>100.0%</b>	<b>92,170</b>	<b>100.0%</b>

**Table D4: CalOMS Types of Discharges, CY 2020**

Discharge Types	San Benito		Statewide	
	#	%	#	%
Standard Adult Discharges	60	42.2%	40,731	42.6%
Administrative Adult Discharges	76	53.5%	45,247	47.4%
Detox Discharges	*	n/a	7,946	8.3%
Youth Discharges	*	n/a	1,600	1.7%
<b>TOTAL</b>	<b>142</b>	<b>100.0%</b>	<b>95,524</b>	<b>100.0%</b>

## ATTACHMENT E: COUNTY HIGHLIGHTS

This section provides an opportunity for the reviewed county to highlight in their own presentation slides any special initiatives and results for which there was not appropriate space in the main body of the report. The emphasis is on graphs and charts that highlight data results, and it is a county's choice to include a presentation. San Benito did not submit highlights for inclusion in this report.