Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

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

SAN LUIS OBISPO DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
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SAN LUIS OBISPO DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2017-18 — 768
San Luis Obispo Threshold Language(s) — Spanish
San Luis Obispo Size — Medium
San Luis Obispo Region — Southern
San Luis Obispo Location — south of Monterey County, west of Kern County, north of Santa Barbara County
San Luis Obispo Seat — San Luis Obispo
Site Review Process Barriers — None

Site Review Special Characteristics

External Quality Reviews (EQRs) were conducted separately but conjointly for both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) during the same time period. Separate EQRO teams were responsible for each review. Five of the 16 sessions were conducted jointly, and the other 11 were separate.

Introduction

The County of San Luis Obispo officially launched its DMC-ODS in January 2018 for Medi-Cal recipients as part of California's 1115 DMC Waiver. San Luis Obispo was the third to launch in California's Southern Region and eighth statewide. In this report, "San Luis Obispo" shall be used to identify the County of San Luis Obispo DMC-ODS program unless otherwise indicated.

The County of San Luis Obispo County borders Monterey County to the north, Santa Barbara County to the south, Kern County to the east, and is 100 miles of Pacific coastline to the west. It is a medium-sized county that covers 3,316 square miles with a total population estimate of 287,863 residents (California Census estimate July 2018), making it the 23rd largest county in the State. It includes seven cities as well as many unincorporated communities. The county seat is the City of San Luis Obispo, which is also the headquarters of the county's DMC-ODS.

The mainstays of the economy are the California Polytechnic State University with its almost 20,000 students, tourism and agriculture. The county is the third largest producer of wine in California and this creates a direct economic impact and a growing wine country vacation industry. The nationally known Hearst Castle in San Simeon attracts over one million visitors each year.

San Luis Obispo is relatively high in income compared to other California counties, at the 76th percentile in per capita income and with a median home value of approximately

$600,000. Approximately 15.7 percent (45,009) of its residents are Drug Medi-Cal (DMC) eligible, which is a relatively low percentage compared to other California counties.

The county population is 71.4 percent Caucasian, 208 percent Hispanic/Latino, 3.3 percent Asian American, and 2 percent African American. Spanish is the only threshold language.

The Population Health Institute ranks San Luis Obispo as the 13th healthiest county in California. This includes indicators for mortality, health behaviors, and social and economic factors. However, San Luis Obispo has a higher rate of excessive drinking and of alcohol impaired driving deaths than the California average, and a significantly lower ratio of available mental health clinicians per capita.

Access

San Luis Obispo Medi-Cal beneficiaries may access substance use disorder (SUD) treatment services in a variety of ways within the DMC-ODS. The most common are: direct self-referrals to the county-operated walk-in clinics, referrals from the criminal justice system to treatment programs, caller self-referrals to the Access Line, and self-referrals to the narcotic treatment program (NTP).

Most new clients access services by calling for an appointment or directly walking into any one of the county-operated walk-in clinics located in each of the four major geographic regions of the county. They receive what begins as a brief screening based upon American Society of Addiction Medicine (ASAM) Criteria that could result in a referral elsewhere, but usually results in admission into outpatient treatment services at the clinic. Depending upon the ASAM Criteria-based assessment findings, they may also be admitted into the medication-assisted treatment (MAT) program adjunctive to outpatient treatment at the same clinic. Clinic assessments are easily accessible and most walk-in clients can be accommodated the same day. Those clients who call for an appointment receive one within a short wait time, according to San Luis Obispo. However, because they do not record the time of first request, irrespective of whether by phone or by walk-in, they cannot track the timeliness of first appointment for these callers and will need to develop this capability in the coming year.

Another common way that beneficiaries access DMC-ODS services is through referrals from the criminal justice system. These referrals come with input from behavioral health counselors who work with agencies in the criminal justice system and help to make ASAM Criteria-based referrals. The clients are then referred directly to the weekly scheduled registration and orientation sessions for specific programs.

A less common way for clients to first access the DMC-ODS is through the Behavioral Health Department Access Line; approximately ten percent of clients begin through this

route. The phone number is well advertised and easily accessed. The Line staff who receive calls conduct a brief screening with a prearranged script and will either: 1) provide information if it is just an informational inquiry; 2) refer to an appropriate provider for acute services if the need is emergent; 3) refer to one of the walk-in clinics that is most geographically convenient for the caller, so that a full ASAM Criteria-based assessment can be conducted and a referral made to appropriate services. If the caller is requesting MAT, then he or she may be 1) referred directly to the county-operated MAT program intake coordinator for the full assessment and possible admission into both the MAT program and outpatient treatment, or 2) referred to the contracted NTP, especially if the caller is requesting methadone MAT.

Another way for clients to enter treatment is through directly calling the contracted NTP provider for an appointment, or walking into the NTP with a request for a same-day admission. The NTP operates one site in San Luis Obispo for county residents, and a second site in northern Santa Barbara County that also serves some San Luis Obispo residents who live in the southern region of the county. The NTP specialized in methadone MAT but also offers other types of MAT including buprenorphine, naltrexone and disulfiram. San Luis Obispo management are under the impression that the NTP services are easily accessible, but the NTP does not yet enter data that would enable tracking wait times from first request to first appointment.

The Access Line does not have call center software to monitor accessibility data such as call wait time, call abandonment rate, and call talk time. They are awaiting the installation of voice-over internet protocol (VOIP) technology and Cerner Millennium electronic health record (EHR) software, so they can be sure that whatever call center software they purchase will interface well. However, since call center software can function without VOIP and does not need to interface with the EHR, they might consider selecting and installing a product soon if VOIP is delayed. San Luis Obispo management can foresee the likelihood of calls to the Access Line increasing and acknowledged how useful the logjam alert functionality in call center software could be.

San Luis Obispo's continuum of care has several gaps which limit referral options, including residential treatment facilities for 3.1, 3.3 and 3.5, and residential withdrawal management (WM) facilities for WM 3.2. San Luis Obispo is progressing with plans to build those facilities, contract with a provider to operate it, and begin services within 18 months. Until then, they are contracting with two residential facilities in Los Angeles for those levels of care, and are arranging a van service with them for the three-hour drive each way. Some clients who qualify by ASAM Criteria for either of those levels of care but do not want to be treated out of county will instead opt for a recovery residence bed arranged by San Luis Obispo and a different treatment in the county. Depending upon medical necessity, the alternative treatment might be ambulatory intensive outpatient treatment, ambulatory WM, or inpatient medically managed WM.

During the first year of its DMC-ODS Waiver implementation, partial year data indicated that San Luis Obispo was providing SUD treatment to 1.7 percent of its DMC eligible population. This penetration rate is many times higher than similar partial year data

indicates for the combined average of other DMC-ODS counties. The same positive comparisons were demonstrated in more detailed analyses by age, gender, race/ethnicity, and levels of care. More complete data will be available in the EQRO's annual report after a data refresh at the end of Fiscal Year (FY) 2018-19.

The Hispanic/Latino segment of San Luis Obispo's DMC eligible is secondary only to Caucasians in numbers, yet the percent of that segment of the eligible population who receive substance use treatment services (.83 percent) is much lower than Caucasians (2.26 percent) and African Americans (1.79 percent). San Luis Obispo might consider outreach inquiries to the Hispanic/Latino communities to understand better the meaning of these statistics and learn what barriers might exist to service accessibility for this community.

San Luis Obispo made progress in addressing service gaps in their continuum of care. In preparation for implementation of the DMC-ODS, the Board of Supervisors approved a request for funds to hire 26.5 full-time employees (FTEs), construct a residential treatment and WM facility, expand intensive outpatient treatment and several other types of services, and expand the outpatient treatment facility in Paso Robles. Since then, San Luis Obispo has nearly completed the staff hiring, expanded their intensive outpatient treatment programs, increased and began billing for case management and recovery support services, and is about to begin construction of the residential facility. While the construction ensues, San Luis Obispo contracted with two out of county providers for residential treatment and WM services. Additionally, they have over 100 recovery residence beds to offer in combination with intensive outpatient treatment as a stepdown from or alternative to residential treatment. The recovery residence beds began with criminal justice system funding years ago, and are now an essential component of the DMC-ODS continuum of care although not covered by DMC funds.

San Luis Obispo was proactive in developing its MAT treatment initiatives more than ten years before the implementation of the DMC-ODS. An X-waivered (trained to prescribe buprenorphine) nurse practitioner helped design and directs the program, prescribes buprenorphine for opiate addictions and vivitrol for chronic alcoholism, and develops the clinical protocols that include both MAT dosing and required lifestyle change counseling through outpatient SUD treatment. The program is county-operated, and is well-known and well-regarded in the community. San Luis Obispo also contracts with several local X-waivered physicians to see clients by telehealth and prescribe buprenorphine to manage the workload and bill through the program along with the nurse practitioner. The counselors who conduct screenings and assessments are trained in the criteria that warrants referrals to the MAT program. With the advent of the DMC-ODS, the program is able to bill DMC for payments, and current billings are at approximately 10 times the penetration rate of the statewide average for DMC-ODS counties.

In addition to this non-methadone MAT program, a contractor operates an NTP in northern San Luis Obispo and also in northern Santa Barbara. In addition to methadone, the contractor offers the other types of MAT medications required by the DMC-ODS Waiver Special Terms and Conditions (STCs). The Federally Qualified

Health Clinics (FQHCs) do not yet provide MATs for addiction, but recently applied for a Health Resources and Services Administration (HRSA) grant to train physicians and build the infrastructure to provide the medications. San Luis Obispo also has an active Opioid Safety Coalition that focuses on tracking and preventing overdose deaths. Naloxone kits are widely distributed to police, first responders, and families and friends of individuals with a SUD.

Timeliness

As part of the preparation for the Waiver implementation, San Luis Obispo began enhancing its capabilities to track timeliness data. Staff worked with their EHR software vendor to enable entry of prospective client i.d. numbers for callers screened and referred by the Access Call Line, so the time of first call request could be linked to a later full assessment session. This connectivity enables efficient tracking of timeliness from Access Line screening to first clinic intake assessment.

In most instances of prospective client self-referrals, they bypass the Access Line and request services directly through assessments in the walk-in clinics. Most clients simply walk into a clinic and usually get a same-day assessment that is entered into the Anasazi EHR. However, when prospective clients initially contact the clinic by phone for an appointment, the clinic does not enter the date and time of that request so timeliness cannot be tracked.

Another common entry point into the DMC-ODS is through the contracted NTP, which has yet to begin recording time of first request for treatment per prospective client. San Luis Obispo is communicating with the NTP about the new data entry responsibilities for tracking timeliness that are now required, has explained the rationale for them, and is considering incorporating the new responsibilities into their provider contracts.

San Luis Obispo modified its previous definition of “urgent” requests for treatment to conform to DHCS’ Information Notice 18-011. However, they found this definition to be too broadly worded to satisfactorily operationalize. They will be refining the definition further, and will track timeliness systematically from first request to first appointment using their new definitions beginning in FY 2019-20 if not sooner.

San Luis Obispo set a timeliness standard of three business days from initial MAT request to first MAT appointment. They are challenged to track whether processes meet this standard at the NTP sites because the NTP has not been entering the time of first requests. In addition, the county-operated MAT program does collect the necessary data. Prospective clients are able to get an assessment appointment easily and quickly, but the time from first request to first medication evaluation appointment for dosing is 9.75 days. Staff had set as a condition for medication dosing that clients must commit to also entering outpatient treatment for lifestyle changes, and decided to slow the intake and assessment processes so that only those clients ready to make that commitment would be given a medication evaluation appointment. They note that only

37 percent of those who receive an intake for MAT end up showing for the medication evaluation and initial dosing. Staff are reconsidering their approach and returning to a more streamlined intake and assessment process. The County is likely to make this the focus of their clinical performance improvement project (PIP).

Authorization of residential treatment is a new and central component of the DMC-ODS Waiver's blueprint for an organized delivery system. Prior authorizations have the potential to add quality to the system of care referrals, but also to create barriers to access. Per the DMC-ODS STCs, the response time to requests for treatment authorizations should be no longer than 24 hours. San Luis Obispo delegated authorization responsibility and authority to the Walk-in Clinic Assessment Coordinators. In situations where the referral is to residential treatment, the Coordinator does both the authorization and the referral at the same, immediately following the assessment. A residential treatment referral committee meets weekly to review recent cases and performs a quality monitoring function to make sure that authorizations and referrals are made in a timely and appropriate manner.

San Luis Obispo recognizes the importance and monitors the timeliness of follow-up transfers from residential treatment. They set a standard of seven days post-discharge for transfers to be completed. They reported that all clients who completed residential treatment with a transfer plan were successfully transferred within the seven days. However, the number of clients tracked for these transfers are very small because of the lack of residential beds in county except for perinatal women and the high rate of client dropouts from out of county residential treatment. These small numbers are expected to change substantially once the residential treatment facility is built in county and begins operating.

Quality

A fundamental premise of the DMC-ODS Waiver, based upon ASAM Criteria, is that quality of treatment is founded in a client-centered approach that includes matching treatment to a client's situation. The current Alcohol and Drug Program (ADP) Administrator conveyed this premise to San Luis Obispo management, clinical staff and other system of care stakeholders more than ten years ago and advocated for its implementation. However, the implementation of ASAM Criteria presupposes a somewhat robust continuum of care which San Luis Obispo lacked at that time when the DMC State Plan covered very few services. The ADP Administrator advocated for building out other levels of care, and seized opportunities as they arose throughout an extensive period preceding the Waiver. In 2008, San Luis Obispo began a medication-assisted ambulatory WM program using buprenorphine, which grew over the years into a flourishing MAT program using several evidence-based MATs to support persons in recovery from several types of addictions. In 2011, with the advent of major criminal justice reform through AB109, San Luis Obispo used AB109 funding to substantially expand sober living environments (SLEs) and case management. In 2015, after California formally incorporated Intensive Outpatient Treatment (IOT) into the DMC State Plan, San Luis Obispo hired new staff to substantially grow several IOT programs

throughout the county. The ADP Administrator also arranged for the incorporation of data fields into their EHR system to track utilization of case management, sober living environments (SLEs, now called recovery residences under the DMC-ODS) and IOT, and to document notes for those levels of care. Each of these steps prepared the groundwork for the implementation of the DMC-ODS Waiver in San Luis Obispo, which then enabled further expansion of these and other levels of care.

San Luis Obispo stills needs other levels of care to fully implement the DMC-ODS Waiver, and was not able to begin them prior to and without the help of the Waiver. Except for a small residential treatment facility for perinatal women, San Luis Obispo lacks in-county residential treatment and residential withdrawal management. Using the advent of the Waiver as impetus, the county forged partnerships with the criminal justice system, a non-profit contractor for homeless shelters, and donors to raise substantial funds for building and operating residential treatment and WM levels of care. They are on target for having the new facility become operational in approximately 18 months.

San Luis Obispo incorporated into their Anasazi EHR software the fields for collecting the necessary data to complete the required ASAM Level of Care (LOC) Referral Data spreadsheet. The data is entered for every in-person initial assessment and in-person re-assessment, and these data are then uploaded to the state DHCS for analysis and report-writing by UCLA. These data are used to document the congruence between ASAM findings for prospective clients and the level of care to which they are referred for treatment. In their monitoring results, they report that as of the EQRO review, 75 percent of all initial provider assessments and 83 percent of all follow-up assessments include a concordance between the initial findings and the recommendation. The primary reason cited for incongruent referrals is client preference.

San Luis Obispo had not entered data into the ASAM LOC Referral Data spreadsheet on results of initial screenings. They considered most of the screenings from the Access Line to be incomplete considerations of ASAM Criteria that were insufficient for LOC determinations and mostly useful for referral to a clinic for a full assessment. They considered most of the screenings from the walk-in clinics to be the initial part of a full assessment that would occur subsequently, and similarly not warranting a separate entry into the ASAM LOC Referral Data spreadsheet. However, since both the Access Line and the walk-in clinics do some ASAM Criteria-based screenings that lead to level of care determinations and referrals, CalEQRO suggested they enter the data from those screenings into the ASAM LOC Referral Data spreadsheet and submit that data to DHCS as they would with their initial full assessments and reassessments.

DMC Waiver principles strongly encourage coordination of care between SUD treatment and physical health care services. San Luis Obispo management meets with representatives of the health care system on a monthly basis to discuss client care and coordinate services. San Luis Obispo would like the in-county FQHCs to provide screening, brief intervention, referral and treatment (SBIRT) and MAT services. The FQHCs did decide to treat persons with mild to moderate symptoms due to mental health disorders who need medication maintenance and minimal treatment

intermittently. However, they have yet to undertake care for SUD treatment. After the onsite EQRO review of the San Luis Obispo DMC-ODS, the FQHCs asked San Luis Obispo to assist them in responding to a HRSA grant to help launch MAT services for addictions within their primary care settings.

Like most counties, San Luis Obispo had a history of stigma within its SUD treatment continuum against those receiving methadone and other addiction treatment medications. This attitude was mitigated by the influence of the well-received MAT program and by active interventions from the county behavioral health department. However, the attitude still persists among a few of the contracted recovery residences who will not admit clients on MATs, reportedly because they do not want the liability. This is especially problematic for perinatal women, who have a great need for recovery residences to support their recovery and few recovery residences set up to accommodate them. San Luis Obispo does not have contracted organizations other than the ones with whom they already contract who were willing to operate recovery residences. They are considering support for the Oxford House model as a way to build out their recovery residences further, including for population segments with special needs such as those needing concurrent MAT treatment and especially perinatal women.

San Luis Obispo is unusual in its lengthy history pre-waiver of operating a thriving MAT program distinct from its NTP. The lengthy history gave San Luis Obispo the opportunity to learn what works and to develop clinical protocols for people with opioid addictions and chronic alcoholism. Among the protocols are an insistence that beginning clients must commit to outpatient treatment for lifestyle change along with taking medication. The MAT program and outpatient treatment program are each provided in the same walk-in clinics, so the providers for each program can coordinate care closely together. As an example, when a client sets a goal of ending medication support when they complete their outpatient treatment, the counselors from the two programs work together with the client to make sure that happens in an effective manner. However, both programs also encourage clients to continue their medication after they complete their outpatient treatment.

Outcomes

San Luis Obispo participated actively in the Treatment Perception Survey (TPS) and received analyses of their results from UCLA. The individual domains and overall results were uniformly high, averaging about 80 percent agreement with positive perceptions of care across the five domains of access (77.4 percent), quality (84.8 percent), care coordination (68 percent), outcomes (75.6 percent), and general satisfaction (82.7 percent). San Luis Obispo received the results from UCLA during the same week as the EQRO onsite review, and had yet to study the results by program and look for quality improvement opportunities.

San Luis Obispo has long been accustomed to using their California Outcomes Management System (CalOMS) data for quality improvement purposes. To ensure the

data integrity is high, every counselor is trained to properly score and enter the data, using a modification of California's Department of Health Care Services (DHCS) Training Manual that is customized to support data entries into Cerner's Anasazi EHR. They also have designated responsibility to an administrative services officer to check each discharge summary for data integrity. San Luis Obispo was proactive in using CalOMS reports from the DHCS-hosted Information Technology Web Services (ITWS) for a long time. They used over twenty automated CalOMS reports from ITWS and found them to be regularly useful. They remarked that the migration to the new platform called Behavioral Health Information Services (BHIS) reduced the number of reports from over twenty to only four, so they have not been able to conduct as many analyses as previously.

EQRO shared data analyses from the first five months of San Luis Obispo's 2018 CalOMS data compared to averages for other DMC-ODS counties statewide. San Luis Obispo's incidence of homelessness (16.3 percent) is significantly lower than the statewide average (26.6 percent). Their unemployment rate is slightly lower at 71.1 percent compared to 78.6 percent statewide, but it is noteworthy that 60 percent of the unemployed clients in San Luis Obispo are looking for work in contrast with only 36 percent statewide. A much higher percent (64.5 percent) of San Luis Obispo's clients are involved in the criminal justice system, mostly AB109, as compared to statewide (40.1 percent).

The MAT program administers a Quality of Life measure to its clients on a monthly basis and plans to use it for measuring client change over time and program success. The program was only recently assigned a data analyst, and is anticipating the opportunity to analyze the data and use it for program evaluation. They also recognize the value of using the data on an individual client basis for feedback-informed care, especially since they already collect it, and are considering this as a project for the future.

Client Family Impressions and Feedback

CalEQRO conducted three diverse client focus groups during the onsite review: one for perinatal women clients in residential treatment, one for youth clients, and one for a mixed group of adult clients. The purpose of the focus groups was to obtain first-hand perceptions from those receiving treatment services regarding the accessibility, timeliness and quality of those services.

The focus group for perinatal women reported widely varying experiences with access to treatment, some stating they were admitted within days and others stating they waited months. Once admitted, they appreciated the staff skills, sensitivity, and delivery of personalized care. Several expressed the wish for some programming for the dads. Their main concerns were about preparations for discharge, especially more time and help needed to find housing and employment. Several on MAT complained that the perinatal women's recovery residence would not admit anyone on MAT because they did not want the liability.

The mixed adult focus group remarked that access into the system was generally easy except for residential treatment because there is no facility in the county. Several thought it was especially easy to access treatment if coming from the criminal justice system, and stated their impressions that the criminal justice system is helpful in getting clients into treatment sooner. However, those involved in the criminal justice system also remarked about the many types of appointments they have to keep, and said public transportation can make it challenging to get around and always be on time. Many remarked about the high cost of living and problems finding affordable housing. Most participants remarked that their counselors were helpful and even “amazing”. All participants felt their counselors had informed them effectively about the potential benefits of MAT.

The youth focus group was comprised primarily of participants who were in treatment due to court and/or probation requirements. Some acknowledged how harder drugs kept them from effective functioning, but most expressed ambivalence about maintaining abstinence from drugs, especially from marijuana. They complained about the pressures in their lives to meet varied commitments. They all agreed that when they reach out to their counselors for help, the counselors are there for them.

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has received 40 implementation and fiscal plans for California counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act. DHCS has approved and contracted thus far with 31 of those counties, and EQRO has scheduled each of them for review.

This report presents the FY 2018-19 EQR findings of San Luis Obsipo's FY 2017-18 by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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

- Total beneficiaries served by each county DMC-ODS;
- Number of days to first face-to-face DMC-ODS service after referral;
- Total costs per beneficiary served by each county DMC-ODS;
- Cultural competency of DMC-ODS services to beneficiaries;
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors are validated for access;
- Coordination of Care with physical health and mental health;
- Timely access to medication for narcotic treatment program (NTP) services;

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

- Timely access and numbers of beneficiaries accessing non-methadone MAT;
- Timely transitions in levels of care (LOC) after residential treatment in year one of the Waiver;
- 24-hour access call center line availability to link prospective clients to ASAM assessments and treatment;
- Identification and coordination of the special needs of high-cost beneficiaries (HCB);
- Percentage of clients with three or more Withdrawal Management (WM) episodes and no other treatment to improve engagement.

Performance Improvement Projects[2]

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

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

DMC-ODS Information System Capabilities[3]

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

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

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

Validation of State and County Client/Consumer Satisfaction Surveys

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

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

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

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

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

This means looking at the research-linked programs and STCs of the Waiver as they relate to best practices, enhancing access to MAT, and developing and supervising a

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

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

During the last year, the County of San Luis Obispo hired Michael Hill as its new Health Care Agency Director. He brings considerable leadership experience from high level health care positions in other states, and with it his fresh perspectives and creative ideas.

The county is in the process of making a major change from county-operated to contracted jail health services. The jail had the sixth highest death rate of all California county jails during the past five years. The Board of Supervisors is committed to bring its inmate care up to levels that meet national standards, as well as help address problems with staffing, recruitment, and retention of medical personnel at the jail. They believe these goals can be met through outsourcing more quickly, and at less than current costs.

In December, the union representing 1700 of the county's 3000 employees initiated its first strike in history. Approximately 900 employees participated in the strike during at least one of the strike days. The negotiations, largely regarding wages, were resolved and the strike ended after three days.

Two ongoing changes in the county seemed salient during the past year. In local elections, debates emerged about the desired pace of population and housing growth, and with it came discussions of the insufficient availability of affordable housing. Another ongoing issue is the gradual closing of Diablo Canyon nuclear plant, still with years to go, which raises a mixed set of concerns among residents regarding population safety, alternative energy sources, employment challenges, and anticipated reductions in local tax revenues.

Past Year's Initiatives and Accomplishments

- San Luis Obispo's Behavioral Health Department launched implementation of the DMC-ODS Waiver on January 1, 2018. In preparation, the county Board of Supervisors approved a request for an additional 26.5 full-time employees (FTEs) and a one-time infusion of $3.7 million to cover start-up costs not initially coverable by service claims. The DMC-ODS nearly completed its full hiring into the requested positions.
- San Luis Obispo made progress in addressing their insufficient residential treatment and residential withdrawal management (WM) capacity. They obtained the land and raised $1 million to construct a residential withdrawal management and treatment facility, scheduled for completion in 18 months.

As an interim solution, they contracted with two providers in other counties to provide those services.

- After Intensive Outpatient Treatment (IOT) became a DMC covered benefit under the State Plan, San Luis Obispo quickly began these services. The continued to grow them throughout the first year of the Waiver Implementation.
- San Luis Obispo began an innovative non-methadone ambulatory WM program ten years ago, using buprenorphine. It quickly developed into an ambulatory non-methadone MAT program with a broad array of addiction medicines including buprenorphine, Naltrexone, Disulfiram, and long-acting injectable Naltrexone (Vivitrol). The program continued to expand under the Waiver and is DMC certified.
- San Luis Obispo reclassified its Drug and Alcohol Services positions so the salary schedules are on a more equal footing with similar ones for mental health. This was done in recognition of their importance, and to improve San Luis Obispo's ability to recruit and retain Drug and Alcohol Services staff.
- San Luis Obispo developed case management and recovery support services prior to the Waiver. Under the Waiver they began documenting and billing for these services according to DMC requirements. They also expanded the amount of these services provided to clients.
- San Luis Obispo reorganized their entire billing and EHR systems to accommodate the different levels of care, billing modifiers, specific populations, and new billing rates.
- San Luis Obispo created a comprehensive documentation guideline document and training system for regular annual trainings and for new employees. They also established monitoring and quality assurance functions for DMC-ODS documentation.
- San Luis Obispo continues to administer CalOMS as its primary data source, and added two new measurement systems required under the DMC-ODS—the TPS for client's perceptions of their care, and the ASAM LOC Referral Data for congruence of assessor's ASAM findings for indicated LOC with their referral LOC. For more information about CalOMS and about the two new measurement tools, go to:
  1. CalOMS Treatment Data Collection Guide: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf
  2. TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf
  3. ASAM Level of Care Data Collection System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

San Luis Obispo's Goals for the Coming Year

- Increase the capacity for residential treatment and withdrawal management. As an interim step, the county is increasing the residential treatment capacity through contracts with two out of county providers, and improve post-discharge hand-offs to other levels of care. For a longer-term solution, the county will work towards completion of the construction and licensing of a new in-county residential treatment and WM center.
- Increase MAT with improved timeliness of access, including hand-off from hospitals and primary care physicians.
- Increase network adequacy by expansion of the Paso Robles Clinic. In support of this goal, find an additional or a larger replacement building.
- Increase billing and revenue generation through a decrease in errors and disallowances.

PERFORMANCE MEASUREMENT

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

The first six PMs will be used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal levels of care based on ASAM assessments, and outcomes. The additional six measures could be modified in year two if better, more useful metrics are needed or identified.

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

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

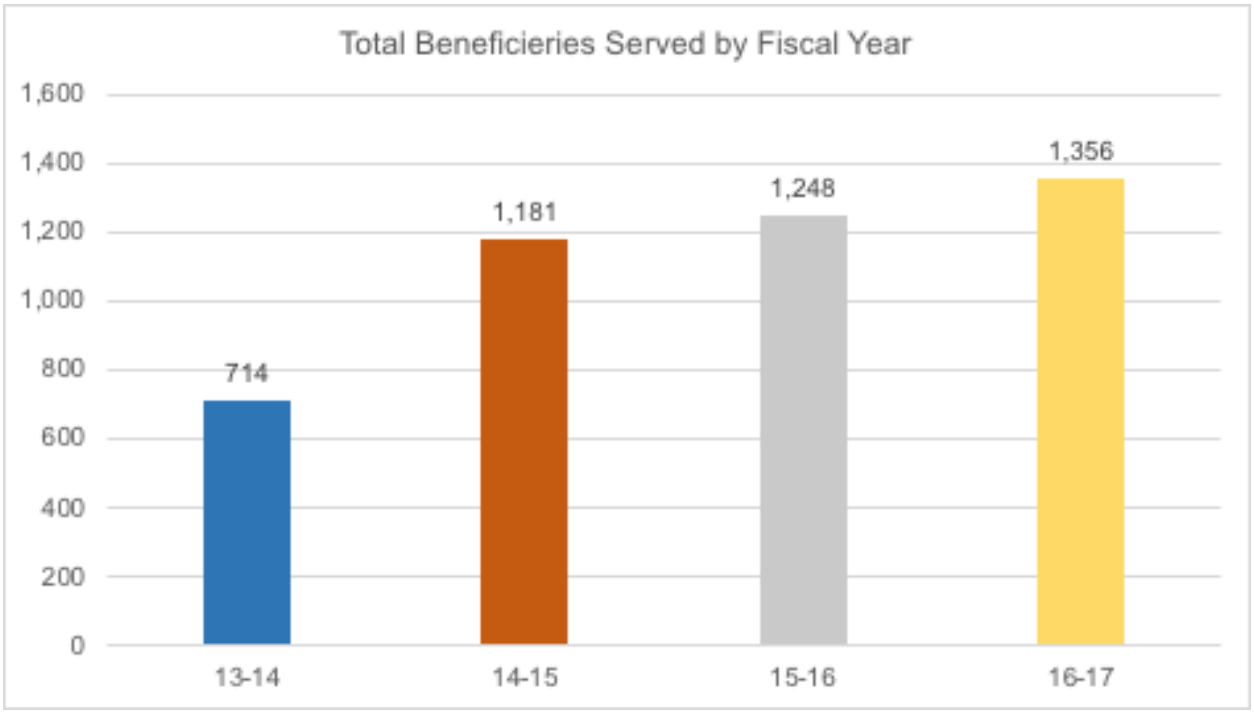
HIPAA Guidelines for Suppression Disclosure:

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

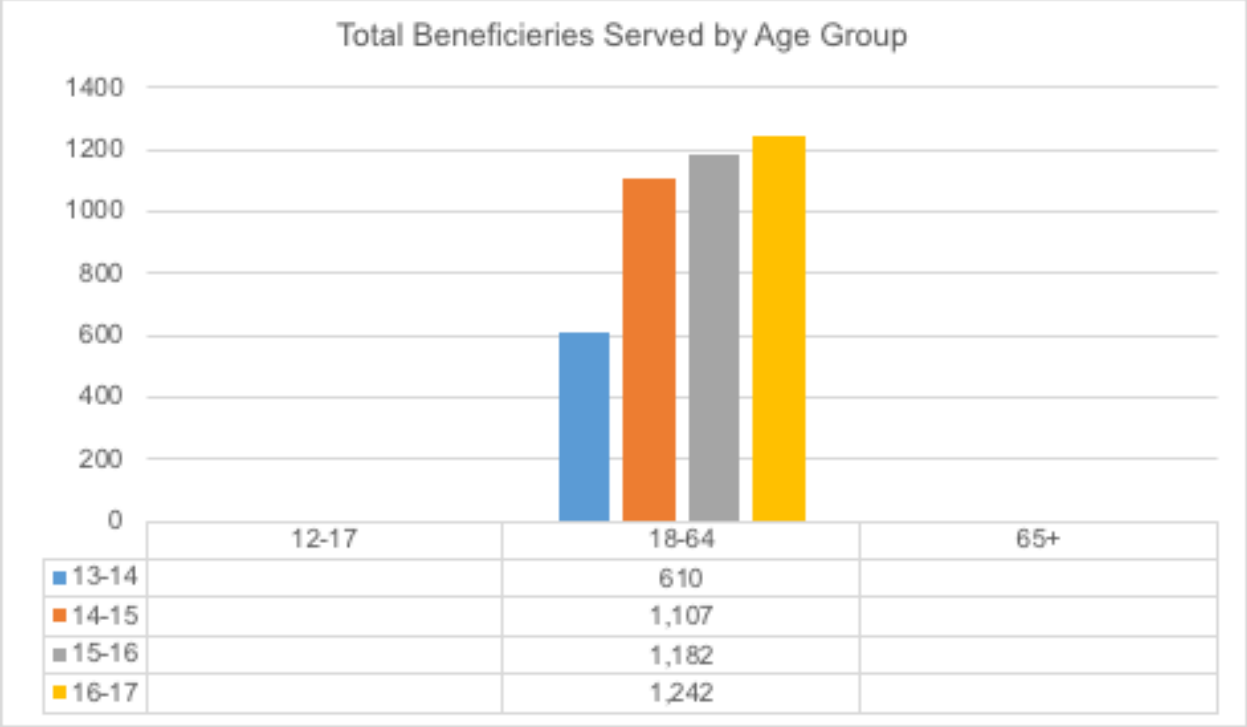
Baseline PM Data for San Luis Obispo Prior to the DMC-ODS Waiver

To evaluate the impact of the DMC-ODS Program and Waiver, baseline data for four prior FYs was analyzed both statewide and for each DMC-ODS County. The next seven graphs display several data trends for those years. Table 1 displays the total number of beneficiaries served. Tables 2-6 display number of beneficiaries served by age, by gender, by race/ethnicity, by service category, and by eligibility category. Table 7 displays the average approved claims by eligibility category.

B Table 1-Total Beneficiaries Served



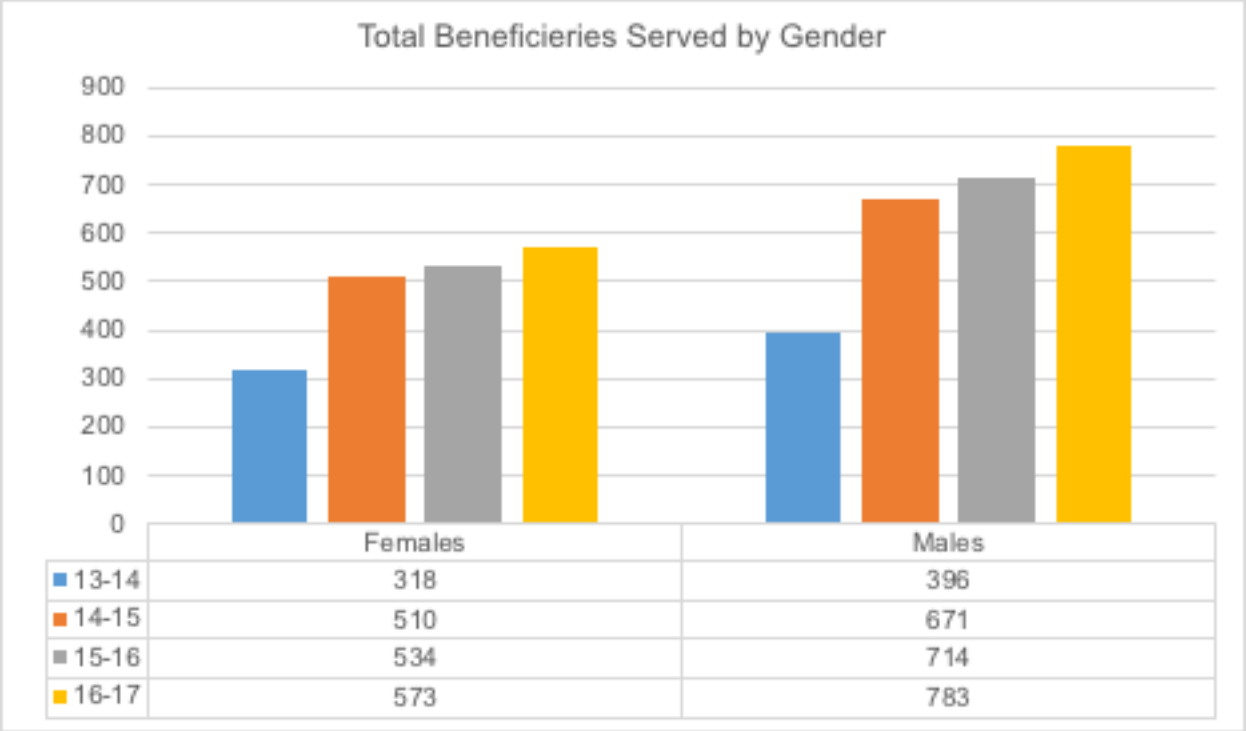
B Table 2 – Total Beneficiaries Served by Age



	12-17	18-64	65+
13-14		610	
14-15		1,107	
15-16		1,182	
16-17		1,242	

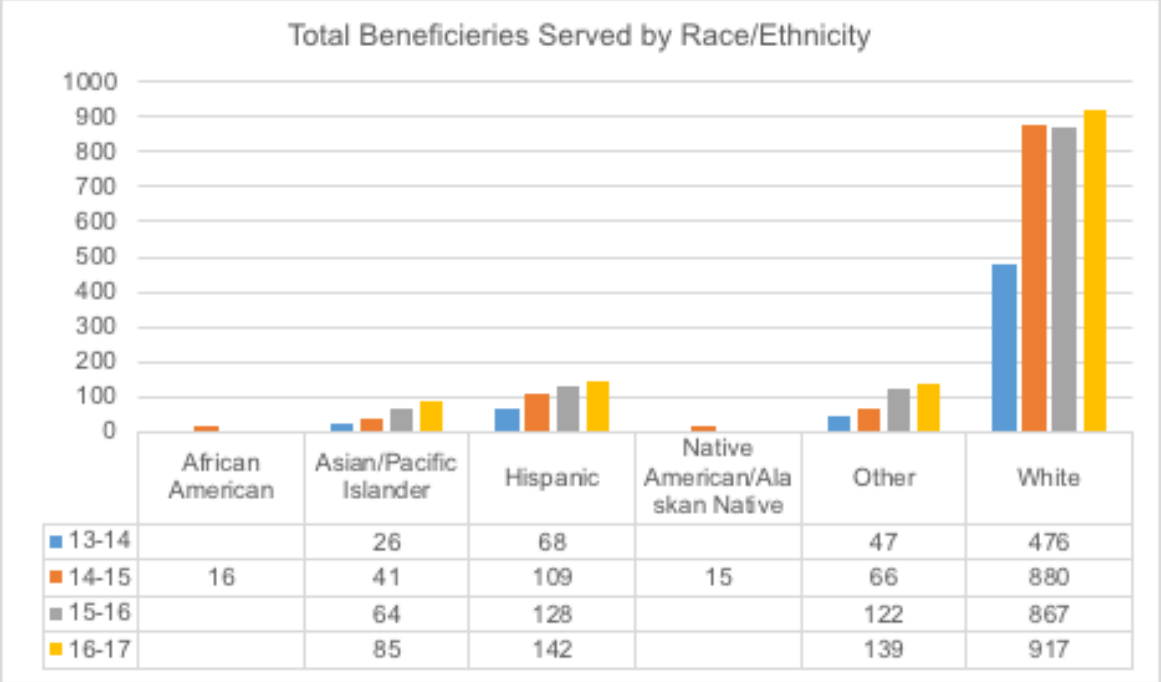
Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

B Table 3 – Total Beneficiaries Served by Gender



	Females	Males
13-14	318	396
14-15	510	671
15-16	534	714
16-17	573	783

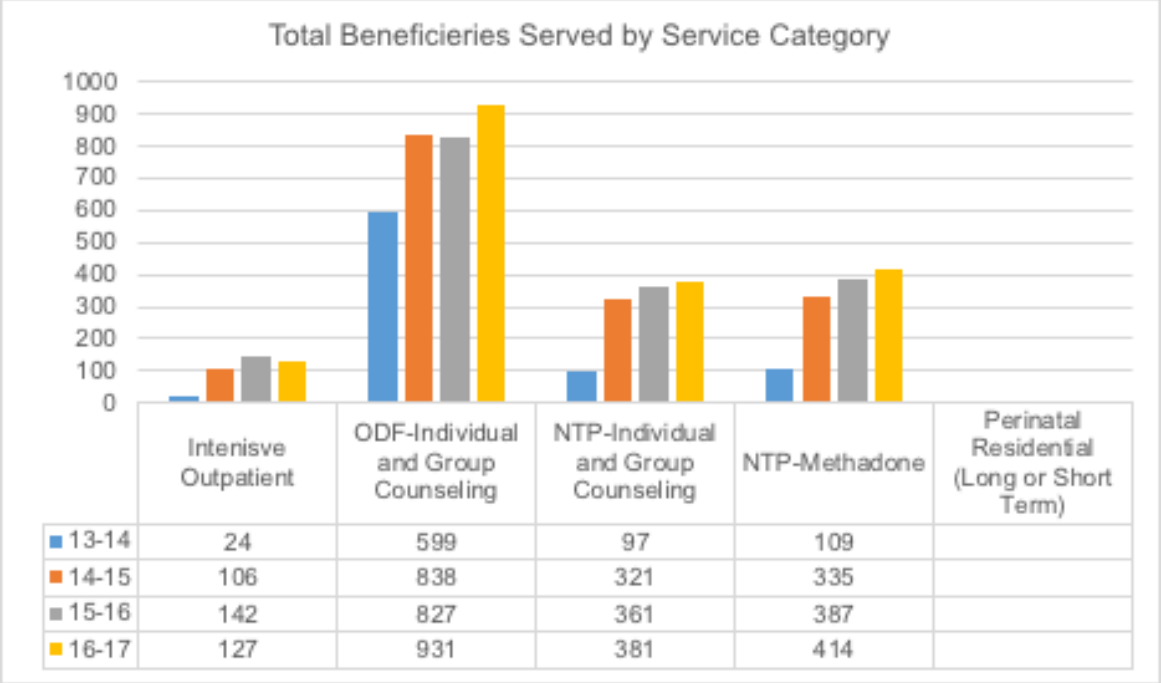
B Table 4 – Total Beneficiaries Served by Race/Ethnicity



	African American	Asian/Pacific Islander	Hispanic	Native American/Alaskan Native	Other	White
13-14		26	68		47	476
14-15	16	41	109	15	66	880
15-16		64	128		122	867
16-17		85	142		139	917

Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

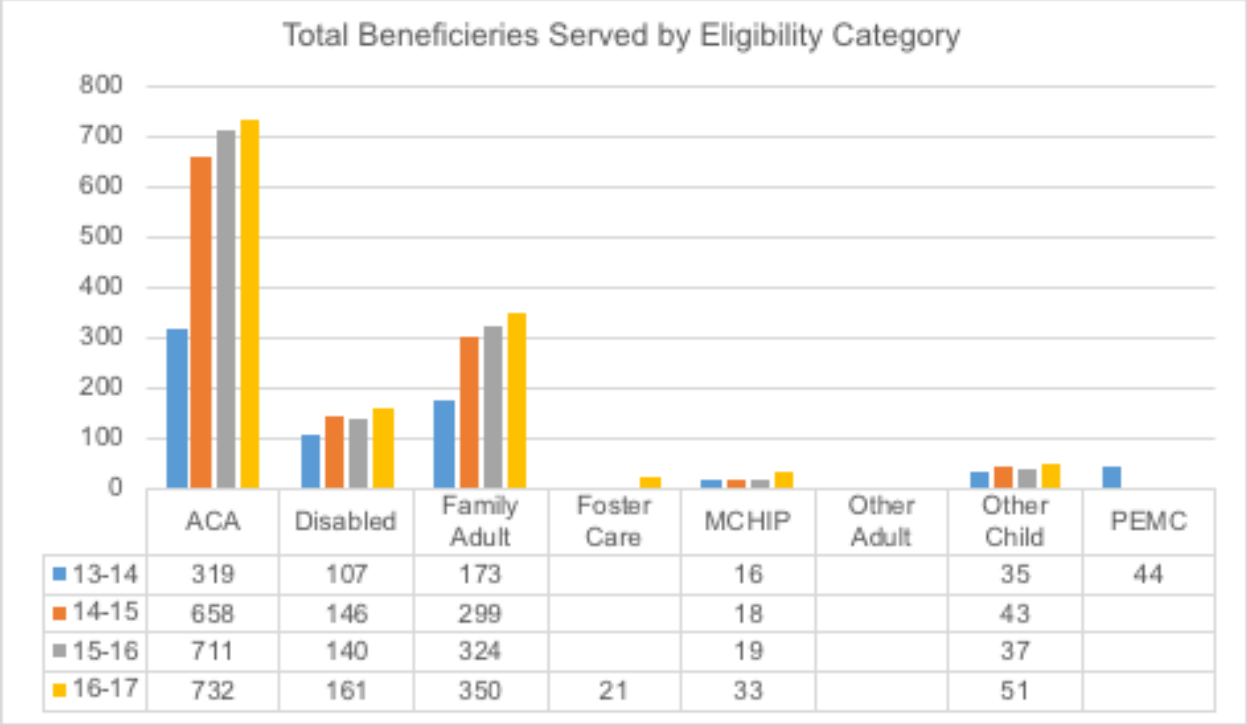
B Table 5 – Total Beneficiaries Served by Service Category



	Intenisve Outpatient	ODF-Individual and Group Counseling	NTP-Individual and Group Counseling	NTP-Methadone	Perinatal Residential (Long or Short Term)
13-14	24	599	97	109	
14-15	106	838	321	335	
15-16	142	827	361	387	
16-17	127	931	381	414	

Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

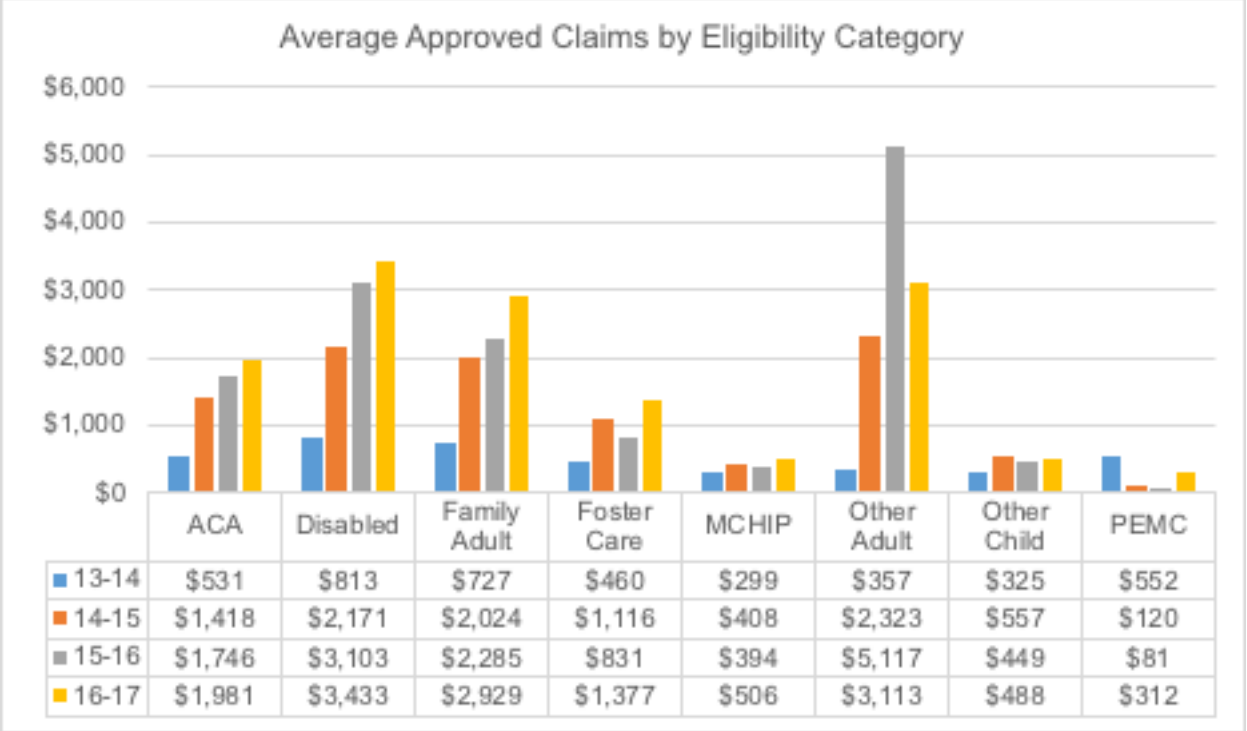
B Table 6 – Total Beneficiaries Served by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	MCHIP	Other Adult	Other Child	PEMC
13-14	319	107	173		16		35	44
14-15	658	146	299		18		43	
15-16	711	140	324		19		37	
16-17	732	161	350	21	33		51	

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

B Table 7 – Average Approved Claims by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	MCHIP	Other Adult	Other Child	PEMC
13-14	$531	$813	$727	$460	$299	$357	$325	$552
14-15	$1,418	$2,171	$2,024	$1,116	$408	$2,323	$557	$120
15-16	$1,746	$3,103	$2,285	$831	$394	$5,117	$449	$81
16-17	$1,981	$3,433	$2,929	$1,377	$506	$3,113	$488	$312

Discussion of Baseline Data Trends and Implications

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

Prior to the Waiver, SUD treatment services covered by DMC were limited to a narrow range of services including narcotic replacement therapy with counseling, outpatient group counseling, IOT, and perinatal residential treatment. Case management, recovery support, residential treatment, and WM were not covered under the state Medicaid plan.

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

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

Costs per beneficiary were highest for the Disabled and Other Adult populations, even though there were relatively lower numbers served. The average cost per beneficiary across all age groups in FY 2016-17 was $1,767.

Year One of Waiver Services

San Luis Obispo services began in January 2018 and PM data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file, and from UCLA for TPSs for the six-month period from January through June 2018. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS Counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there is a claims lag for many services in the data available at the time of the review. In addition, many DMC-ODS Counties phased in new and expanded services for billing, and thus there is not a stable set of services for the complete duration of the fiscal year after launch.

DMC–ODS Beneficiaries Served in Fiscal Year 2017-18

FY 2017-18 Table 1 – Beneficiaries Served by Race/Ethnicity

Table 1: San Luis Obispo DMC-ODS Eligibles and Client Beneficiaries Served in 2017-2018 by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated DMC-ODS Eligibles**	**% Eligibles**	**Unduplicated Annual Count of Beneficiary Clients Served**	**% Beneficiary Clients Served**
White	22,169	49.3%	500	65.1%
Latino/Hispanic	13,275	29.5%	110	14.3%
African-American	614	1.4%	*	n/a
Asian/Pacific Islander	1,202	2.7%	*	n/a
Native American	310	0.7%	*	n/a
Other	7,442	16.4%	138	18.0%
Total	**45,012**	**100.0%**	**768**	**100.0%**

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

The totals in the bottom row indicate a decrease in beneficiaries served as compared to FY16-17, but the data is incomplete and only reflects six months of claims reporting.

The race/ethnicity results in this table can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS county. If they 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. However, the table shows distinct differences. Those persons who are Caucasian accessed DMC-ODS services more readily than others. In contrast, persons who are Latino/Hispanic, African-American, or Asian/Pacific Islander were relatively less inclined to access treatment. However, the data are still incomplete and may not reflect access trends once there is a full year of reporting and claims are complete.

Penetration Rates and Approved Claim Dollars per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. San Luis Obispo uses the same method to calculate penetration rates as does CalEQRO.

FY 2017-18 Table 2 shows San Luis Obispo's penetration rates overall and by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties.

FY 2017-18 Table 2 – Penetration Rates

	San Luis Obispo			Statewide
Age Groups	**Average Number of Eligibles per Month**	**Number of Beneficiary Clients Served FY 2017-18**	**Penetration Rate**	**Penetration Rate**
Total	45,012	768	1.71%	0.37%
Age Group 12-17	7,032	24	0.34%	0.06%
Age Group 18-64	33,617	696	2.07%	0.44%
Age Group 65+	4,363	48	1.10%	0.36%

Table 3 below shows San Luis Obispo average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties.

FY 2017-18 Table 3 – Average Approved Claims

	San Luis Obispo		Statewide
Age Groups	**Total Approved Claims**	**Approved Claims per Beneficiary Clients Served per Year**	**Approved Claims per Client Beneficiary Served per Year**
Total	$523,825	$682	$3,681
Age Group 12-17	$5,561	$232	$1,451
Age Group 18-64	$476,671	$685	$3,800
Age Group 65+	$41,594	$867	$3,277

Table 4 below shows San Luis Obispo's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties.

FY 2017-18 Table 4 – Beneficiaries Served and Penetration Rates by Eligibility Category

	San Luis Obispo			Statewide
Eligibility Categories	**Average Number of Eligibles per Month**	**Number of Client Beneficiaries Served FY 2017-18**	**Penetration Rate**	**Penetration Rate**
Disabled	5,682	103	1.81%	0.73%
Foster Care	220	*	n/a	0.98%
Other Child	3,678	17	0.46%	0.06%
Family Adult	8,163	198	2.43%	0.36%
Other Adult	5,435	*	n/a	0.04%
MCHIP	3,591	*	n/a	0.06%
ACA	18,206	430	2.36%	0.57%

Table 5 below shows San Luis Obispo's approved claims per penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties.

FY 2017-18 Table 5 – Approved Claims per Client Beneficiary Served by Eligibility Category

	San Luis Obispo			Statewide
Eligibility Categories	**Average Number of Eligibles per Month**	**Number of Client Beneficiaries Served FY 2017-18**	**Approved Claims per Client Served per Year**	**Approved Claims per Client Beneficiary Served per Year**
Disabled	5,682	103	$755	$3,138
Foster Care	220	*	$514	$1,308
Other Child	3,678	17	$237	$1,363
Family Adult	8,163	198	$799	$3,121
Other Adult	5,435	*	$778	$2,948
MCHIP	3,591	*	$286	$1,723
ACA	18,206	430	$633	$4,005

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

Children 12 and under rarely access treatment for SUD. Foster Care, Other Child and Maternal and Child Health Integrated Program (MCHIP) include children of all ages with low penetration rates. Expansion of services to youth is an important focus of San Luis Obispo with their expanded residential and outpatient services.

ACA and disabled members constituted the major eligibility subgroups using the most SUD services in San Luis Obispo.

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

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

Persons seeking methadone medication are likely to have been unable to stop using through non-MAT approaches, and are also likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they are likely to go back to opiate use that can be life threatening. For these reasons, NTPs regard the request to begin treatment with methadone as urgent and requiring a timely response. Tables 6 and 7 show the average number of days from triage/assessment contact to the first dose of NTP services for opioid use disorder (OUD) diagnoses, first by age groups and then by race/ethnicity. NTPs are required to provide other addiction medicines for MATs in addition to methadone, and those services are the focus of Table 8.

Average number of days indicated below for San Luis Obispo client beneficiaries indicate they are able to access care in a timely manner, on average within one (1) day of diagnosis/assessment across age groups and race/ethnicity.

FY 2017-18 Table 6 – Number of Days to First Dose of NTP Services by Age

Age Groups	San Luis Obispo			Statewide		
	Client Beneficiaries	%	Avg. Days	Client Beneficiaries	%	Avg. Days
Total Count	243	100%	<1	15,162	100%	<1
Age Group 12-17	0	0%	n/a	*	n/a	n/a
Age Group 18-64	214	88%	<1	11,380	78%	<1
Age Group 65+	29	12%	<1	*	n/a	n/a

FY 2017-18 Table 7 – Number of Days to First Dose of NTP Services by Race/Ethnicity

Race/Ethnicity	San Luis Obispo			Statewide		
	Client Beneficiaries	%	Avg. Days	Client Beneficiaries	%	Avg. Days
Total Count	243	100%	<1	15,162	100.0%	<1
White	191	78.6%	<1	6,673	44.0%	<1
Hispanic/Latino	23	9.5%	<1	3,995	26.3%	<1
African-American	*	n/a	<1	1,929	12.7%	<1
Asian Pacific Islander	*	n/a	<1	181	1.2%	<1
Native American	*	n/a	<1	105	0.7%	<1
Other	25	10.3%	<1	2,279	15.0%	<1

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

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

Some people with opiate addictions have become interested in newer-generation addiction medicines that have increasing evidence of effectiveness. These include buprenorphine and long-acting injectable naltrexone that do not need to be taken in as rigorous a daily regimen as methadone. While these medications can be administered through NTPs, they can also be prescribed and administered by physicians through other settings such as primary care clinics, hospital-based clinics, and private physician practices. For those seeking an alternative to methadone for opiate addiction or a MAT for another type of addiction such as alcoholism, some of the other MATs have the advantages of being available in a variety of settings that require fewer appointments for regular dosing. The DMC-ODS Waiver encourages delivery of MATs in other settings additional to their delivery in NTPs. Medical providers are required to receive specialized training before they prescribe some of these medications, and many feel the need for further consultation backup once they begin prescribing. Consequently, physician uptake throughout most counties throughout the state tends to be slow.

Unlike most counties, San Luis Obispo provides MATs primarily through its own county-operated DMC-certified program. The FQHCs have yet to provide MATs for addictions although this may change in the near future if they are awarded a HRSA grant for which they are applying to support the beginning of MATs for addiction in their clinics.

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

Tables 8 and 9 display the number and percentage of clients receiving three or more non-methadone MAT visits per year provided through San Luis Obispo providers and statewide for all actively implemented DMC-ODS counties in aggregate. Three or more visits were selected to identify clients who received regular non-methadone MAT treatment versus a single dose. The numbers for this set of performance measures are based upon DMC-ODS claims data analyzed by EQRO. The numbers may not reflect the full extent of these services due to claims approval problems yet to be resolved.

The percentages in Tables 8 and 9 substantially exceed the statewide average for DMC-ODS counties, and indicate the value that San Luis Obispo places on MAT with any type of evidence-based addiction medicine as a treatment approach for substance use addictions. In addition to those beneficiaries served with non-methadone MATs, nearly twice that number were referred for MAT assessments and did not proceed with MAT (see the non-clinical PIP section of this report for more details).

San Luis Obispo's delivery system for non-methadone MATs is unusual compared to most counties. It is county-operated and DMC-certified. It began ten years ago, has grown steadily, and is thriving. San Luis Obispo explained that the relatively long history with new addiction medicines enabled the program to develop effective protocols, grow a strong reputation within the county, and build a widespread acceptance of the value of MAT as an adjunct to outpatient SUD treatment.

San Luis Obispo's contracted NTP provider also offers non-methadone MATs. San Luis Obispo reports that, because of historical patterns preceding the Waiver implementation, most prospective clients seeking methadone will go directly to the NTP provider and most seeking some other form of MAT will go through San Luis Obispo's screening and assessment processes to then enter into their county-operated MAT program. San Luis Obispo is working with their NTP provider to increase their provision of non-methadone MAT services.

FY 2017-18 Table 8 – Three or more DMC-ODS MAT Billed Visits, by Age

	San Luis Obispo					Statewide				
	# of Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits	# of Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits
Total	768	85	11.1%	24	3.1%	37,369	415	1.11%	170	0.45%
Age Group 12-17	24	*	n/a	*	n/a	876	0	n/a	0	n/a
Age Group 18-64	696	80	11.5%	22	3.2%	31,381	381	1.21%	154	0.49%
Age Group 65+	48	*	n/a	*	n/a	4,501	31	0.70%	15	0.33%

FY 2017-18 Table 9 – Three or more DMC-ODS MAT Billed Visits, by Race/Ethnicity

	San Luis Obispo					Statewide				
	# of Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits	# of Clients	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits
Total	768	85	11.1%	24	3.1%	37,369	415	1.11%	170	0.45%
White	500	57	11.4%	14	2.8%	13,442	248	1.84%	107	0.80%
Hispanic/Latino	110	*	n/a	*	n/a	13,125	76	0.58%	26	0.20%
African-American	*	*	n/a	*	n/a	4,590	*	n/a	*	n/a
Asian Pacific Islander	*	*	n/a	*	n/a	766	*	n/a	*	n/a
Native American	*	*	n/a	*	n/a	6	*	n/a	*	n/a
Other	138	17	12.3%	*	n/a	66	66	1.44%	23	0.50%

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

Transitions in Care Post-Residential Treatment – FY 2017-18

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

Table 10 and Table 11 show two aspects of this expectation — (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 10 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment. Table 11 shows similar information from the perspective of statewide data for DMC-ODS counties. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

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

FY 2017-18 Table 10 – Timely Transitions in Care Post Residential Treatment DMC-ODS, San Luis Obispo

	San Luis Obispo								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%
Within 7 days	*	*	n/a	*	*	n/a	*	*	n/a
Within 14 days	*	*	n/a	*	*	n/a	*	*	n/a
Within 30 days	*	*	n/a	*	*	n/a	*	*	n/a
Any days	*	*	n/a	*	*	n/a	*	*	n/a
Total Transfer Admits Post-Residential	*	*	n/a	*	*	n/a	*	*	n/a

The actual numbers for the above table are too low to show, due to the aforementioned HIPAA suppression rules for low numbers (see section on Clinical PIP for more details). San Luis Obispo has a small residential treatment facility for perinatal women, and otherwise no residential treatment or residential withdrawal management in the county. They contract with several providers out of county, but none are close by so driving time can be lengthy. As a result, most clients prefer not to leave the county for treatment.

San Luis Obispo addressed these issues historically by offering sober living environments (now called recovery residences under the DMC-ODS Waiver) combined with IOT. They aggressively developed these alternatives using criminal justice and other county funds to contract for over 100 recovery residence beds and capacity for many IOT slots across several IOT programs. San Luis Obispo is in the midst of building a residential treatment and withdrawal management facility that they anticipate will be fully operational in late 2020.

FY 2017-18 Table 11 – Timely Transitions in Care Post-Residential Treatment DMC-ODS, Statewide

	Statewide								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%	Total Clients	Transfer Admits	%
Within 7 Days	105	*	n/a	5,133	388	7.6%	106	*	n/a
Within 14 Days	105	*	n/a	5,133	128	2.7%	106	*	n/a
Within 30 Days	105	*	n/a	5,133	125	2.7%	106	*	n/a
Any days	105	12	11 %	5,133	817	15.9%	106	*	n/a
Total Follow-Up, Post Residential	105	12	11 %	5,133	817	15.9%	106	*	n/a

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

Statewide numbers of youth clients in residential treatment are low relative to their statewide numbers of Medi-Cal enrollees. DHCS and DMC-ODS counties, including San Luis Obispo, are making efforts to increase the number of youths treated in residential and other levels of care.

Regarding post-residential follow-up, the statewide statistics indicate similarly low percentages of clients across all age groups receiving timely follow-up care after discharge from residential treatment. This reflects pre-Waiver patterns with program-driven care, and is expected to change gradually with the more client-centered approach to treatment in the Waiver.

Access Line Quality and Timeliness

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

Table 12 shows Access Line critical indicators from January 1st, 2018 through October 25th, 2018. For the Access Line Key Indicator form, please refer to Attachment F.

FY 2017-18 Table 12 – Access Line Critical Indicators

San Luis Obispo Access Line Critical Indicators January 1st, 2018 through October 25th, 2018	
Average Volume	2,398 calls per month
% Dropped Calls	Not tracked*
Time to answer calls	Not tracked*
Monthly authorizations for residential treatment	12
% of calls referred to a treatment program for care, including residential authorizations	Not tracked
Non-English capacity	4.0 FTE Access Line staff are bilingual (English/Spanish) and San Luis Obispo utilizes the Language Line.

* In March the county is installing a voice-over IP software system. Once that is done, the Access Call Center can lease and install a Call Center software system to track call wait time, dropped calls, etc. They plan to do this by the end of FY2018-19.

High-Cost Beneficiaries

Table 13a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $8,351 in approved claims per year. The table lists the average approved claims costs for the year for San Luis Obispo HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes.

While the statewide tables below show HCB data, those for San Luis Obispo do not. The primary reason is that San Luis Obispo makes few referrals to higher cost DMC-ODS services—residential treatment and residential withdrawal management—for reasons mentioned in the narrative for Table 10. This will likely change once San Luis Obispo brings its new in-county residential facility into full operation. A second reason is that the billing for its high-cost out-of-county residential treatment was problematic until the new Waiver-related coding rules were understood and implemented. A third reason is that San Luis Obispo claims data used for this table was only for partial year, and there may well be HCBs after a full year of approved claims data.

FY 2017-18 Table 13a – HCBs at 90th percentile or higher, San Luis Obispo by Age

San Luis Obispo						
HCBs by Age Group	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	768	*	n/a	n/a	n/a	n/a
Age Group 12-17	24	*	n/a	n/a	n/a	n/a
Age Group 18-64	696	*	n/a	n/a	n/a	n/a
Age Group 65+	48	*	n/a	n/a	n/a	n/a

FY 2017-18 Table 13b – HCBs at 90th percentile or higher, Statewide by Age

Statewide						
HCBs by Age Group	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	36,763	2,992	8%	$16,543	$49,497,265	36%
Age Group 12-17	876	23	3%	$12,223	$281,119	22%
Age Group 18-64	31,376	2,851	9%	$16,654	$47,481,607	39%
Age Group 65+	4,500	117	3%	$14,742	$1,724,864	12%

FY 2017-18 Table 14a – HCB Claims per Beneficiary, San Luis Obispo by Race/Ethnicity

San Luis Obispo						
HCBs by Race/Ethnicity	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Total	768	*	*	*	*	*
White	500	*	*	*	*	*
Hispanic/Latino	110	*	*	*	*	*
African-American	*	*	*	*	*	*
Asian Pacific Islander	*	*	*	*	*	*
Native American	*	*	*	*	*	*
Other	138	*	*	*	*	*

FY 2017-18 Table 14b – HCB Claims per Beneficiary, Statewide by Race/Ethnicity

Statewide						
HCBs by Race/Ethnicity	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Total	36,763	2,992	8%	$16,543	$49,497,265	36%
White	13,439	1,198	9%	$18,511	$22,175,952	40%
Hispanic/Latino	13,124	1,046	8%	$14,451	$15,115,525	34%
African-American	4,590	373	8%	$17,132	$6,390,053	36%
Asian Pacific Islander	766	67	9%	$12,759	$854,836	34%
Native American	252	19	8%	$17,634	$335,053	34%
Other	4,592	289	6%	$16,006	$4,625,845	29%

Withdrawal Management with No Other Treatment

This PM intends to measure engagement after WM for beneficiaries with no other DMC-ODS treatment services for their SUDs. The goal is to track levels of engagement for a high-risk group of clients who are using only WM.

San Luis Obispo's numbers for WM were too low to include, because of HIPAA Suppression Guidelines. As explained in the narrative for Table 10, San Luis Obispo contracts out of county for residential WM and does not expect to operate an in-county facility for residential WM until late 2020 or early 2021. To further complicate matters, the billing for this service out of county was initially challenging so the data is incomplete. Thus, the above tables are not an accurate reflection of the total numbers of clients served in residential WM. A data refresh in the annual report will include more data on treatment engagement after a WM episode.

FY 2017-18 Table 15 – WM by Age

	San Luis Obispo		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	*	n/a	2,047	0.93%
Age Group 12-17	*	n/a	*	n/a
Age Group 18-64	*	n/a	1,938	0.83%
Age Group 65+	*	n/a	105	2.9%

FY 2017-18 Table 16 – WM by Ethnicity

	San Luis Obispo		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	*	n/a	2,047	0.93%
White	*	n/a	1,027	1.27%
Hispanic/Latino	*	n/a	621	0.97%
African-American	*	n/a	152	0%
Asian Pacific Islander	*	n/a	22	0%
Native American	*	n/a	10	0%
Other	*	n/a	215	0%

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

Diagnostic Categories

Table 17 summarizes the diagnostic billing codes used statewide by DMC-ODS counties to identify diagnostic groups with SUDs.

FY 2017-18 Table 17 – Diagnosis Codes

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

Table 18 compares the breakdown by diagnostic category of the San Luis Obispo and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2017-18. Opioids, alcohol, and stimulants were the most prominent types of SUDs addressed by San Luis Obispo's DMC-ODS treatment providers.

FY 2017-18 Table 18 – Percentage Served and Average Cost by Diagnosis Code

Diagnosis Codes	San Luis Obispo		Statewide	
	% Served	Average Cost	% Served	Average Cost
Total	100%	$682	100%	$3,734
Alcohol Use Disorder	16.9%	$500	14.4%	$4,989
Cannabis Use	9.0%	$412	7.3%	$2,042
Cocaine Abuse or Dependence	0.7%	$237	2.3%	$4,471
Hallucinogen Dependence	0.0%	$0	0.5%	$3,731
Inhalant Abuse	0.0%	$0	0.0%	$6,031
Opioid	49.2%	$913	48.5%	$3,380
Other Stimulant Abuse	24.1%	$454	25.3%	$4,097
Other Psychoactive Substance	0.0%	$0	1.1%	$3,224
Sedative, Hypnotic Abuse	0.1%	$133	0.5%	$5,926

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

Use of ASAM Criteria for Level of Care Referrals

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

San Luis Obispo's data in the table below indicates they had not been conducting full ASAM Criteria-based screenings but instead referred prospective clients to a full assessment after a very brief screening. After the initial full assessment, there was high congruence (75 percent) between the ASAM Criteria indicated LOC referral and the actual referral, with the primary reason for any difference being patient preference. At reassessments, usually done when there is question about extending length of stay or stepping down from residential treatment, the congruence was even higher (83 percent) with the same primary reason for differences being patient preference.

FY 2017-18 Table 19: Congruence of Level of Care Referrals with ASAM Findings

January to April, 2018	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	NA	NA	63	75.0%	710	83.0%
Patient Preference	NA	NA	7	8.3%	35	4.1%
Level of Care Not Available	NA	NA	3	3.6%	30	3.5%
Clinical Judgement	NA	NA	2	2.4%	28	3.3%
Geographic Accessibility	NA	NA	1	1.2%	2	0.2%
Family Responsibility	NA	NA	0	0.0%	2	0.2%
Legal Issues	NA	NA	0	0.0%	6	0.7%
Lack of Insurance/Payment Source	NA	NA	0	0.0%	1	0.1%
Other	NA	NA	8	9.5%	41	4.8%
Total	NA	NA	84	100.0%	855	100.0%

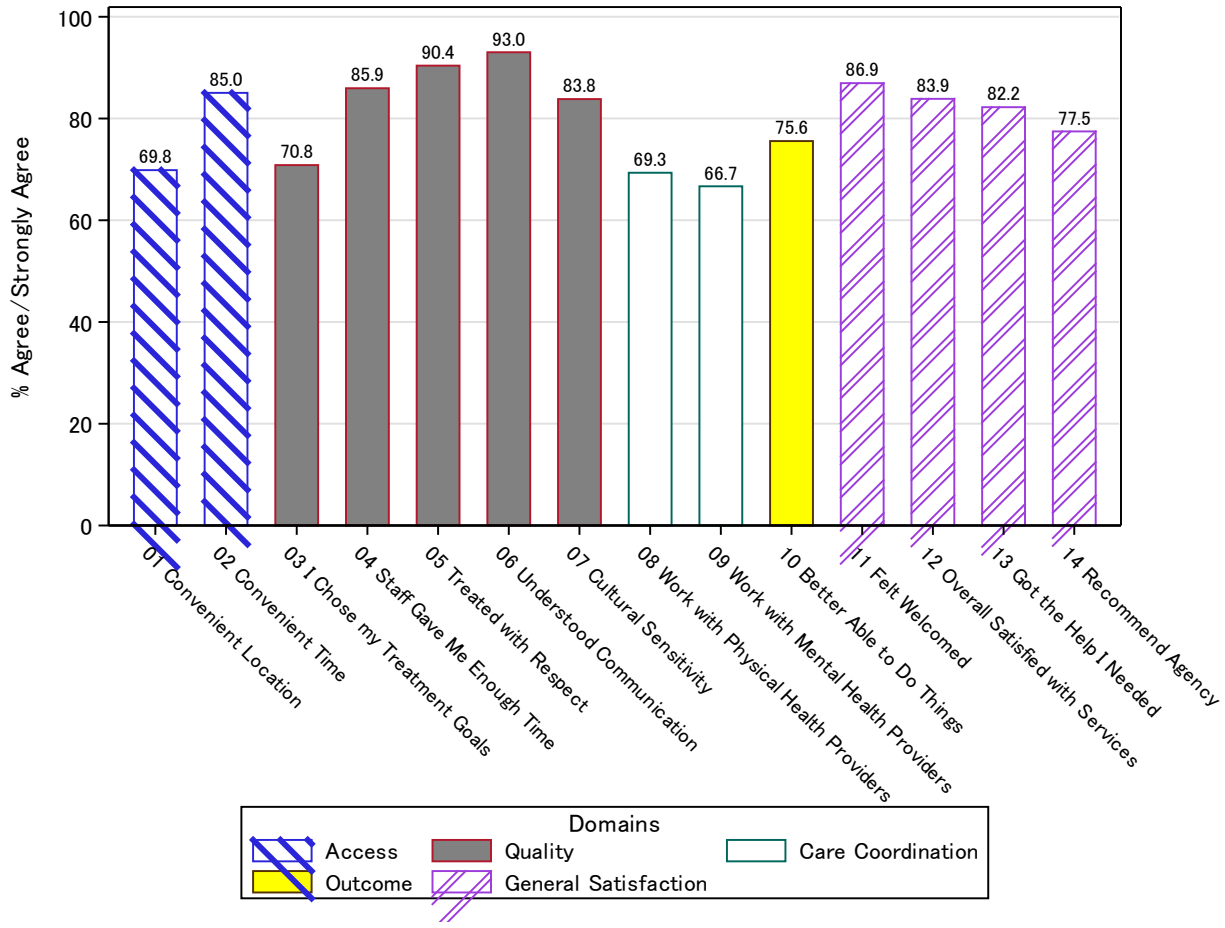
FY2017-18 Figure 1: Percent in agreement with Treatment Perception Survey items and by domains

Client Perceptions of Their Treatment Experience

CalEQRO regards the client perspective as an essential component of the External Quality Review. In addition to obtaining qualitative information on that perspective from focus groups during the onsite review, CalEQRO uses quantitative information from the Treatment Perception Survey (TPS) they administer to clients in treatment. They upload the data to DHCS, it is analyzed by the UCLA Team evaluating the statewide DMC-ODS Waiver, and UCLA produces reports they then send to each DMC-ODS County. Ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction.

Client ratings for San Luis Obispo were high across all domains. The ratings for the Care Coordination domain were somewhat lower than those for the other four domains, which parallels results in all the other DMC-ODS counties reviewed thus far. This difference points to opportunities for quality improvements that San Luis Obispo can pursue. There are additional quality improvement opportunities when San Luis Obispo reviews the program-specific results, which show differences in performance not apparent when reviewing the overall results.

FY2018-19 Figure 8 - Percent of Participants with Positive Perceptions of Care



CalOMS Data Results for Client Characteristics at Admission

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

The information displayed in Tables 20 - 22 indicate important characteristics of San Luis Obispo's clients at the time of admission to treatment. Table 20 data show that, compared to the other active DMC-ODS counties statewide, a relatively lower percentage of San Luis Obispo's clients are homeless (16.3 percent vs. 26.6 percent). Table 21 data show that a relatively higher percentage of San Luis Obispo's clients are involved in the criminal justice system. Table 22 data show that a substantially lower percentage of Marin's clients are NOT in the criminal justice system (35.5 percent vs. 59.9 percent). Table 22 shows that San Luis Obispo's clients may also be more resilient with a greater percentage either employed or actively looking for employment (2l.9 percent vs. 21.4 percent) and fewer are long-term unemployed and no longer looking for work (28 percent vs. 50.3 percent).

FY2017-18 Table 20: Current Living Arrangement, San Luis Obispo and Statewide

Current Living Arrangement	San Luis Obispo		Statewide	
	#	%	#	%
Homeless	131	16.3%	19,283	26.6%
Dependent Living	58	7.2%	19,991	27.6%
Independent Living	617	76.6%	33,171	45.8%
Total	806	100.0%	72,445	100.0%

FY2017-18 Table 21: Legal Status Last 30 Days, San Luis Obispo and Statewide

Legal Status-Past 30 Days	San Luis Obispo		Statewide	
	#	%	#	%
No Criminal Justice Involvement	286	35.5%	43,361	59.9%
Under Parole Supervision by CDCR	4	0.5%	1,962	2.7%
On Parole from any other jurisdiction	3	0.4%	709	1.0%
Post release supervision - AB 109	473	58.7%	22,380	30.9%
Court Diversion CA Penal Code 1000	20	2.5%	1,035	1.4%
Incarcerated	0	0.0%	351	0.5%
Awaiting Trial	20	2.5%	2,641	3.6%
Total	806	100.0%	72,439	100.0%

FY2017-18 Table 22: Current Employment Status, San Luis Obispo and Statewide

	San Luis Obispo		Statewide	
Current Employment Status	#	%	#	%
Employed Full Time - 35 hours or more	136	16.9%	9,661	13.3%
Employed Part Time - Less than 35 hours	97	12.0%	5,860	8.1%
Unemployed - Looking for work	347	43.1%	20,476	28.3%
Unemployed - not in the labor force and not seeking	226	28.0%	36,448	50.3%
Total	806	100.0%	72,445	100.0%

CalOMS Data Results for Client Progress in Treatment at Discharge

The information displayed in Tables 23-24 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 23 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those did notify their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment.

The data in Table 23 has important for measuring outcomes and understanding Table 24. San Luis Obispo has a substantially higher number of administrative discharges than the statewide average for all DMC-ODS counties (59.3 percent vs. 39.4 percent), indicating challenges in following up with clients as the time approaches for them. This impedes San Luis Obispo's capability to collect valid discharge data and make valid and reliable ratings on their progress in treatment. It suggests San Luis Obispo might explore what can be done to improve meetings with clients as they approach treatment discharge and obtaining discharge status information from them. It is also a crucial time to assist client's in discharge planning for post-treatment recovery support services.

FY2017-18 Table 23: Discharge Types, San Luis Obispo and Statewide

	San Luis Obispo		Statewide	
Discharge	#	%	#	%
Standard Discharges	429	36.3%	51,470	42.1%
Administrative Discharges	700	59.3%	48,129	39.4%
Detox Discharges	6	0.5%	19,068	15.6%
Youth Discharges	46	3.9%	3,610	3.0%
Total	1,181	100.0%	122,277	100.0%

Table 24 displays the types of rating options in the CalOMS discharge summary form that counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs. The first four rating options are positive. "Completed Treatment" means the client met all their treatment goals and/or the client learned what the program intended for clients to learn at that level of care. "Left Treatment with Satisfactory Progress" means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options are negative with clear meaning.

San Luis Obispo counselors rated the discharge status of their clients less positively than the statewide average for all DMC-ODS counties (35.5 percent vs. 48.7 percent). The biggest contributor to this difference was the rating "Completed Treatment –

Referred" and the next biggest contributor was "Left Before Treatment Completion-Unsatisfactory Progress--Administrative". San Luis Obispo might want to explore the reasons. It may be that more clients are making progress than the ratings would indicate, but are not being referred when ready to a less intensive level of care or to recovery support services.

FY2017-18 Table 24: Discharge Status, San Luis Obispo and Statewide

Discharge Status (Type of Form = Discharge)	San Luis Obispo		Statewide	
	#	%	#	%
Completed Treatment - Referred	5	2.0%	7,063	22.8%
Completed Treatment - Not Referred	28	11.4%	2,080	6.7%
Left Before Completion with Satisfactory Progress - Standard Questions	31	12.7%	3,609	11.6%
Left Before Completion with Satisfactory Progress – Administrative Questions	23	9.4%	2,374	7.6%
Left Before Completion with Unsatisfactory Progress - Standard Questions	26	10.6%	5,739	18.5%
Left Before Completion with Unsatisfactory Progress - Administrative Questions	116	47.3%	9,689	31.2%
Death	2	0.8%	38	0.1%
Incarceration	14	5.7%	432	1.4%
Total	245	100.0%	31,034	100.0%

Performance Measures Findings—Impact and Implications

Overview

Data in many sectors showed robust launch of SUD programs, but claims lag resulted in partial year data at the time of the review.

Access to Care PM Issues

- Claims data from baseline to fiscal year 2017 reflect a steady expansion of services for Medi-Cal DMC-ODS and an increase in beneficiaries served to 1,356 in FY 2016-17. From January 2018 to June 2018, the number of beneficiaries served was 768, reflecting only six months of data. Thus, the data are on trend to surpass the FY 2016-17 number of beneficiaries served.

- San Luis Obispo is achieving a substantially higher penetration rate than the statewide average, and this is also reflected in most of the race/ethnicity, age group, and gender analyses. Comparing subgroups within San Luis Obispo, the Caucasian enrollees had a relatively higher rate of access to services than did the Latino/Hispanic, African-American, and Asian/Pacific Islander enrollees. Across age groups, the 18-64 age group had the highest penetration rate for age groups (2.07 percent).

- The average approved claims cost per beneficiary is much lower than the statewide average ($682 compared to $3,681). This in part reflects the early stage implementation for San Luis Obispo with only partial year data that is further complicated by lag time in submission and approval processes. In addition, and perhaps most salient, San Luis Obispo contracted for its most expensive services—residential treatment and residential WM—to be delivered out of county. As with most DMC-ODS counties, the beginning of Waiver implementation involved challenges in learning the new billing procedures for out of county services. These challenges especially impacted San Luis Obispo and affect its initial data. The new billing has since gone more smoothly but doesn't show on these initial reports.

- San Luis Obispo offers two types of DMC-certified MAT programs. One is a contracted NTP that specializes in methadone but also offers other addiction medicines including buprenorphine, naltrexone (including injectable long-acting), disulfiram and naloxone kits (the kits are offered to all clients, and freely given to whomever request one). The other program is a county-operated MAT that specializes in buprenorphine but also offers other non-methadone addiction medicines such as long-acting injectable naltrexone. In aggregate, the intakes provided by the two programs comprise more than half the total number of intakes for SUD treatment in San Luis Obispo. Also, in aggregate, those client beneficiaries who continue from intake to an addiction medication regimen comprise 37 percent of all beneficiaries receiving some

form of SUD treatment. The county-operated non-methadone MAT program accounts for 11.1 percent of all beneficiaries receiving SUD treatment, which is ten times the average rate in the other DMC-ODS counties. In part, this dramatic difference is due to the program being DMC-certified and therefore able to bill through the DMC-ODS, while in most other counties the non-methadone MAT is delivered through FQHCs outside the DMC-ODS and therefore difficult to track. Nonetheless, the differences are so substantial as to still be noteworthy.

- San Luis Obispo currently has no residential treatment or residential WM in the county, aside from a small perinatal program. They are constructing a new facility in county and anticipate startup of residential programs there in late 2020. Until then, they contracted with a facility in northern Los Angeles County and another in Santa Barbara County. However, most clients prefer to try a combination of IOT and recovery residence in county rather than go out of county.

- The Access Call Center serves as the entry point to the DMC-ODS service system for about 10 percent of beneficiaries, and the remaining 90 percent access services through any of the five walk-in outpatient clinics or through the contracted NTP. The Call Center tracks call volume.

- Among San Luis Obispo's DMC-ODS clients, the most common substance use diagnosis is Opiate Use Disorder at 49.2 percent, followed by Other Stimulants at 24.1 percent, followed by Alcohol at 16.9 percent, followed by others at much lower percentages. This distribution is similar to most counties and in part reflects the impact of the opioid epidemic that pervades California and the United States. However, the distribution is also affected by the types of services offered--until the advent of the DMC-ODS, NTP services were among the few covered by DMC and still account for a high proportion of the treatment services delivered. The NTP, and San Luis Obispo's non-methadone MAT program, primarily treat clients with opiate addictions. As utilization of other services newly covered by the DMC-ODS Waiver grow, the percent of clients served with non-opiate addictions may increase somewhat.

Timeliness of Services PM Issues

- The Access Call Center does not currently track call wait time, call abandonment rate, and call talk time. These basic tracking mechanisms serve as early warning systems for logjams, and enable managers to make suitable staffing adjustments when needed. San Luis Obispo is in the process of procuring Voiceover IP (VOIP) call center technology to be able to track these other key indicators.

- The Access Line staff enter the date and time of their initial call screenings when they refer to a provider for a full assessment, and give the prospective client a number in the EHR system that can later be linked to a client i.d. number when they are first seen for an intake. In this way the DMC-ODS county is able to monitor timeliness from first contact at the Call Center to first appointment (usually at one of the five outpatient clinics}.

- San Luis Obispo's clients who receive methadone from an NTP received timely dosing following their first request for NTP treatment. The average time to first dose at NTP is less than one day for all age groups and race/ethnicities.

- San Luis Obispo has a PIP focused on improving the timeliness of first dosing for non-methadone MATs. For more details, please see the PIP section of this report.

- San Luis Obispo is tracking the timeliness of transitions from residential treatment to non-residential treatment in the community, but the numbers are small. As mentioned, aside from a small residential treatment facility for perinatal women, San Luis Obispo has no residential treatment or residential WM within county.

- San Luis Obispo's WM numbers were small and there is little data on timely linkage to continuing treatment services following discharge from WM. As mentioned, San Luis Obispo contracts out of county for residential WM and does not expect to operate an in-county facility until late 2020 or early 2021.

Quality of Care PM Issues

- San Luis Obispo is unique in that it has run a county-operated MAT clinic for ten years, with the same nurse practitioner as the primary prescriber. She is joined by several X-waivered physicians in the community who are contracted to also serve some MAT clients, primarily through telehealth means. The program developed effective protocols over the years with newer addiction medicines and a set of best practices for intake and dosing combined with outpatient treatment for addiction lifestyle change.

- San Luis Obispo is distinct among most other DMC-ODS counties in that is has provided to the community a MAT program for ten years through a county-operated program that is DMC-certified. The program is under the consistent leadership of a nurse practitioner who established the program and who has more recently arranged program contracts with several physician prescribers of buprenorphine in the community to share the caseload. Those who receive MAT through this program are required to also participate in a DMC-certified IOT or outpatient program to explore changing other elements of their addiction lifestyle. The program has a strong reputation within the county

which has helped to reduce stigma around MAT as an adjunct to outpatient SUD treatment.

- San Luis Obispo uses CalOMS data for multiple purposes including service planning and discharge planning. They train all individual providers in how to complete the CalOMS forms so that inter-rater reliability is high. They also designated to an Administrative Service Officer the responsibility for checking the submitted CalOMS data to monitor data integrity. The CalOMS admission data suggests that, compared to the averages for other DMC-ODS counties, San Luis Obispo's SUD clients have significantly lower rates of homelessness (16.3 percent vs. 26.6 percent), significantly higher rates of criminal justice involvement (64.5 percent vs. 40.1 percent), and significantly higher rates of clients actively looking for work among the unemployed (43 percent vs. 28 percent). These statistics are strongly suggestive of case management services and program elements to incorporate into many clients' treatment plans.

- There is no data on high cost beneficiaries because of the partial year data and the lack of more expensive residential facility services in county.

- The DMC-ODS uses the TPS to measure several domains, including clients' perception of the quality of care they received. San Luis Obispo received overall high ratings for its services across treatment programs. The ratings for coordination of care with physical health and with mental health were still were noticeably lower than the ratings in other domains, although still high.

- There is no data entered by San Luis Obispo for congruence between ASAM-indicated recommendations for LOC referral and the actual referral made at screening. Most Access Call Center screenings do not include consideration of the full ASAM Criteria dimensions, but the clinic screenings do include those considerations and often result in treatment referrals. When these ASAM Criteria-based screenings do occur, the data for them should be entered into the ASAM LOC Referral Data spreadsheet as screening results. When the referrals result in full assessments by providers to whom the clients are referred, the results of those assessments should also be entered into the ASAM LOC Referral Data spreadsheet—as results of assessments.

- San Luis Obispo entered ASAM LOC Referral Data on congruence between ASAM-indicated recommendations for LOC referral and the actual referral made during the initial assessment and also at follow-up reassessments. The staff entering the data report a 75 percent rate of congruence at initial assessments and 83 percent at reassessments. These rates are comparable to those from other DMC-ODS counties. When the actual referrals are incongruent with the ASAM Criteria-indicated ones, the primary reason given is "patient preference". These rates the desired balance according to ASAM

philosophy of client-centered care—tending strongly towards ASAM Criteria indications, but also honoring client wishes and motivations.

Client Outcomes PM Issues

- San Luis Obispo uses CalOMS discharge summary data to monitor treatment success. The data is compromised by the high rate of administrative discharges as compared to other counties (59.3 percent vs. 39.4 percent). This is an indicator that clients leave without a termination interview, so their status cannot be accurate rated. It may also be an indicator that cases overdue for closure are allowed to accumulate due to inattention and those closing them simply enter more data-limited administrative discharges. There could be other reasons as well. CalEQRO recommends that San Luis Obispo look into their high rate and both plan and implement strategies to lower it.

- San Luis Obispo's percentage of positive ratings for their client's discharge status is lower than the combined average for all DMC-ODS counties statewide--26.1 percent with treatment completion or at least some satisfactory progress for San Luis Obispo vs. 41.1 percent in other DMC-ODS counties. There tend to be many problems with the reliability and validity of this particular rating across California. Nevertheless, with this degree of difference and low rating, CalEQRO recommends that San Luis Obispo look into provider rating patterns and determine whether they truly reflect their client's treatment outcomes. Depending upon what is learned, there may be quality improvement steps to take in improving data integrity or in improving treatment program quality.

- San Luis Obispo has tracked successes of its MAT model in an anecdotal manner, but have not conducted statistical analyses. They collect data on their clients' quality of life and could analyze the change scores to measure the effectiveness of their unique model.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment Information Provided by the DMC-ODS

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

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

Table 1: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	99%
Contract providers	1%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 2.5 percent.

The budget determination process for information system operations is:

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

DMC-ODS currently provides services to clients using a telehealth application:

☒ Yes ☐ No ☐ In Pilot phase

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported technology staff changes in Full-time Equivalent (FTE) staff since the previous CalEQRO review are shown in ISCA Table 2.

ISCA Table 2 – Summary of Technology Staff Changes

Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
4	0	0	0.75

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

ISCA Table 3 – Summary of Data and Analytical Staff Changes

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

The following should be noted regarding the above information:

- San Luis Obispo does not have separate positions for data analysis. Data analytics are incorporated as part of several different Administrative Service Officer and Division Manager positions in the Mental Health Plan, Mental Health Service Act, and DMC-ODS divisions.
- Without dedicated clinical QI data analytics staff, San Luis Obispo will not have capacity to accomplish routine analyses or requests from stakeholders.

Current Operations

- San Luis Obispo utilizes the Cerner Anasazi and will migrate to Cerner's Millennium product as soon as the contract has been finalized. San Luis Obispo Health Agency support the EHR across its health, mental health, and substance use divisions.

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

ISCA Table 4 – Primary EHR Systems/Applications

Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
CCBH Anasazi EHR	Clinical Documentation and Billing	Cerner Community Behavioral Health	8.5	SLO County

Priorities for the Coming Year

- Prepare for transition from Cerner-Anasazi to Cerner's Millennium product.
- Add external PHI messaging through an Ultra-Sensitive Exchange and finalize partnership in a regional Health Information Exchange (OCPRHIO).
- Continue electronic prescribing of controlled substances.
- Continue to improve security management – 2FA, RFID
- Plan for disaster recovery planning with Central Information Technology.
- Improve reporting capabilities around service data for all client attributes captured in assessments, including ASAM.

Major Changes since Prior Year

- Finalized move from 2X Remote Access Server to Enterprise Remote Access.
- Redesigned and launched County Website, including a comprehensive list of services. Google translator allows instant translation in 110 languages.
- Implementing Secure Print.
- Implementing RFID chips in badges.

Other Significant Issues

- San Luis Obispo is in the process of upgrading to VoiceOver IP (VOIP) call center software to track dropped calls, average call time, etc.

Plans for Information Systems Change

- San Luis Obispo has no plans to replace the current system. However, the County is preparing for the transition from Cerner Anasazi to Cerner's Millennium product. This project is expected to initiate in the last quarter of 2019 with a go-live date currently anticipated for some time in 2020. This upgrade should radically improve the MHP's reporting environment and empower the creation of more robust data analyses and dashboards.

Current Electronic Health Record Status

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

Table 5: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Cerner	X			
Assessments	Cerner	X			
Care Coordination	Cerner	X			
Document imaging/storage	Cerner	X			
Electronic signature—client/consumer	Cerner	X			
Laboratory results (eLab)	Cerner		x		
Level of Care/Level of Service	Cerner	X			
Outcomes	Cerner	X			
Prescriptions (eRx)	Cerner	X			
Progress notes	Cerner	X			
Referral Management	Cerner	X			
Treatment plans	Cerner	X			
Summary Totals for EHR Functionality:		**11**	**1**		

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

- Other than DMC-ODS necessary changes, there have been no EHR enhancements over the past year.

Clients' Chart of Record for county-operated programs (self-reported by DMC-ODS):

☐ Paper ☐ Electronic ☒ Combination

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

Summary of Findings	Yes	No	%
ASAM Criteria is being used for assessment for clients in all DMC Programs.	x		
ASAM Criteria is being used to improve care.	x		
CalOMS being administered on admission, discharge and annual updates.	x		
CalOMS being used to improve care. Track discharge status. Outcomes.	x		
Percent of treatment discharges that are administrative discharges.	x		59.3%
TPS being administered in all Medi-Cal Programs.	x		

Highlights of use of outcome tools above or challenges:

- San Luis Obispo made extensive use of CalOMS data for profiling client needs and monitoring outcomes. The Administrative Service Offices are assigned the responsibility of training staff in obtaining and entering the client data into the required forms, monitoring the data submissions for data integrity, and using reports through ITWS (now BHIS) for quality management.
- TPSs have been administered to all levels of care. San Luis Obispo received their first set of analyzed results from UCLA during the same week of the EQRO review.
- San Luis Obispo administers ASAM Criteria through initial and follow-up assessments. The assessors enter the data regarding congruence of referrals with ASAM findings and upload it through BHIS. They received their first set of results from these spreadsheets from UCLA during the same week of the EQRO review.

Drug Medi-Cal Claims Processing

- San Luis Obispo has successfully submitted claims for MAT services (methadone and other addiction medications), residential treatment, intensive outpatient and outpatient treatment service categories during FY 2017-18.
- San Luis Obispo is implementing the Dimensions suite of tools which should assist in addressing denials.

Special Issues Related to Contract Agencies

- Almost all DMC-ODS services are delivered through county-operated programs. Exceptions to this are contractors for: perinatal residential

treatment and out of county residential treatment programs, and the narcotic treatment program.

Overview and Key Findings

Access to Care

- San Luis Obispo uses Cerner-Anasazi as its EHR and will begin migrating to Cerner's Millennium product in 2019, with a migration completion date of 2021.
- San Luis Obispo is in the process of finalizing a partnership with the regional Health Information Exchange (OCPRHIO). This participation in the HIE will enable San Luis Obispo to pull information from local hospitals and FQHCs.

Timeliness of Services

- San Luis Obispo tracks the timeliness of first offered appointments, first MAT appointment, and timeliness of follow-up appointments after discharge from residential treatment. However, San Luis Obispo does not currently track first contact to first offered appointment when a client walks into the clinic. This was noted to the county as an important action item and included in the Recommendations section of this report.
- San Luis Obispo has a PIP to increase access to MAT by, in part, streamlining the intake and assessment processes of the county-operated MAT program.

Quality of Care

- San Luis Obispo does not currently have the capacity to track critical indicators for their access call center, such as dropped calls and average wait time. They are in the process of procuring VoiceOver IP (VOIP) in order to track these important indicators.
- San Luis Obispo is using CalOMS consistently and as a primary data collection mechanism. They have an audit process in place to review all CalOMS discharge data to ensure accuracy. However, since the changeover in technology platforms from ITWS to BHIS, they no longer have access to automated data analytic reports from DHCS that they used to obtain aggregated information on client outcomes.
- Additional IS data analytics staff are needed to convert more of the available data into reports with useful information and move the QI plan from compliance-based to reflect more of a quality improvement learning agenda.

Client/Consumer Outcomes

- San Luis Obispo collects a significant amount of data but does not currently have data visualization and analytics in place to tell the story of the data, so others can more easily understand the strengths and opportunities of treatment programs and plan improvements.
- San Luis Obispo administers the TPS to clients during the required time periods, enters the data and sends it to DHCS and UCLA for scoring and reporting, and reviews the results from UCLA for use in quality improvement.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

San Luis Obispo PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs submitted by San Luis Obispo, as shown below.

PIP Table 1 lists the number and titles of the PIPs submitted by San Luis Obispo, as required by the PIP Protocols: Validation of PIPs.[4]

PIP Table 1

Table 1: PIPs Submitted by San Luis Obispo		
PIPs for Validation	**# of PIPs**	**PIP Titles**
Clinical PIP	one	Care Transitions from Residential Treatment Center (RTC) to Outpatient Services
Non-clinical PIP	one	Improving Retention in Medication Assisted Treatment

PIP Table 2, on the following page, is intended to provide the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially M, Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR). Since neither PIP is active, no ratings could be made.

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

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

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

PIP Table 3

Table 3: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	NR	NR
Number Partially Met	NR	NR
Number Not Met	NR	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	NR	NR
Overall PIP Rating Clinical: ((M*2)+(PM))/(AP*2) Non-clinical: ((M*2)+(PM)/(AP*2)	NR	NR

Clinical PIP—Care Transitions from Residential Treatment or Withdrawal Management to Outpatient Services

San Luis Obispo presented its study question for the clinical PIP as follows:

"*Will implementing case management services to assist/support clients that transition from residential treatment center (RTC) to outpatient services increase client retention and engagement*?"

Date PIP Began: Study Phase Initiated 6/27/2018

Status of PIP: This was a reasonable PIP proposal for an important clinical process, but the pre-study findings rendered it not viable for San Luis Obispo to pursue further. They will instead be working on development of a new PIP.

Brief Description: San Luis Obispo currently has no in-county DMC-ODS residential treatment other than a small program for perinatal women. The goal of this PIP was to enhance case management interventions to assist clients discharged from out-of-county residential treatment and withdrawal management providers re-enter the county and engage in step-down outpatient treatment services. During the study period to establish baselines for the effectiveness of these case management interventions, San Luis Obispo found that all clients who returned to the county post discharge from residential treatment and WM and received case management interventions were able to successfully engage in treatment--there was no room for improvement. In contrast, all the clients who did not successfully complete residential treatment did not return to San Luis Obispo, did not receive case management, and did not begin stepdown services.

San Luis Obispo is working with the contracted residential treatment and WM providers to improve treatment engagement for the clients sent there, but they did not want their work with those out of county providers to become the focus of a PIP. Within two years they plan to complete the construction of an in-county residential treatment and WM facility and contract with a provider to begin operating it.

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

Technical Assistance Provided: The technical assistance provided to San Luis Obispo by CalEQRO for this PIP consisted of a conference call between the EQRO Lead Reviewer and some of the members of the San Luis Obispo PIP team on July 27, 2018 to brainstorm the PIP; a conference call between the Lead Reviewer and the EQRO PIP Consultant on December 3, 2018 to review and critique the written PIP proposal from San Luis Obispo; and an in-person meeting with the PIP team onsite in San Luis Obispo on December 5, 2018 to review and critique the proposal.

Non-Clinical PIP—Improving Retention in Medication Assisted Treatment

San Luis Obispo presented its study question for the non-clinical PIP as follows:

"*We are working to identify interventions we can implement to improve retention and engagement in services as evidenced by percentage of clients who receive their initial post walk-in MAT service*"

Date PIP Began: The Conceptual/Study Phase began 7/27/18

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

Brief Description: The goal of this PIP is to implement procedures to improve timely linkage to non-methadone MAT services in the county-operated MAT program following an initial intake and assessment for MAT. The MAT program has been operating for ten years. Among its protocols are a requirement for clients to participate in outpatient treatment for addiction lifestyle change adjunctive to MAT. The program developed more cumbersome and lengthy admission processes to ensure that clients understand and make a commitment to the outpatient treatment requirement. Staff are under the impression that the combination of this requirement and the lengthier admission process contribute to a high dropout rate before MAT begins. The PIP study phase will help define what pre-MAT processes should be changed during the PIP with the goals of improving the percentage of clients who start MAT (engagement) and continue with MAT for at least a predefined minimum period of time (retention).

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

Technical Assistance Provided: The technical assistance provided to San Luis Obispo by CalEQRO consisted of a conference call between the Lead Reviewer and the EQRO PIP Consultant on December 3, 2018 to review and critique the written PIP proposal from San Luis Obispo; an in-person meeting with the PIP team onsite in San Luis Obispo on December 5, 2018 to review and critique the proposal; and several brief follow-up suggestions by phone and email from the Lead Reviewer to the San Luis Obispo ADP Administrator during December 2018.

PIP Findings—Impact and Implications

Overview

San Luis Obispo proposed two PIPs, each in a concept phase. Both were selected to focus upon important facets of the DMC-ODS. The Clinical PIP proposed improvements in newly established case management interventions that are designed to support clients in successfully transferring when ready from out-of-county residential treatment and WM into less intensive in-county outpatient services. The Non-Clinical PIP proposes a streamlining of intake and assessment processes for clients requesting MAT so that more of them successfully engage in MAT conjoined with outpatient treatment. The intent of both PIPs is to increase the number of individuals at high risk for relapse to engage successfully in their next steps of treatment. San Luis Obispo's goal for the MAT program PIP is to finalize the design during the third quarter of FY2018-19 and get it started in the fourth quarter of FY2018-19, and this is encouraged by CalEQRO. For the other PIP, Cal EQRO offered technical assistance and is encouraging San Luis Obispo to complete the redesign of that PIP by the end of the fourth quarter of FY2018-19 and begin the PIP on active status at the start of FY19-20.

Access to Care Issues related to PIPs

Both PIPs are designed to improve access to outpatient treatment services so that clients can establish and sustain a drug- and alcohol-free lifestyle. The Clinical PIP would engage more clients in intensive outpatient services and other supports as a stepdown after they stabilized in an out of county residential treatment or WM program. These clients are at high risk for relapse during the time immediately following discharge from residential treatment or WM, and particularly vulnerable when having to travel from treatment in another county and navigate the system of care when re-entering San Luis Obispo.

The Non-Clinical PIP would engage more clients in MAT services, combined with outpatient SUD treatment. Clients seeking a MAT solution to their addictions have usually tried other methods previously without lasting success. They are often ambivalent about changing their addiction-oriented lifestyle. It can be a challenge to motivate clients seeking MAT to also commit to treatment that encourages lifestyle change. If through the PIP the DMC-ODS can bring clients into both MAT and outpatient treatment conjointly, the clients have a much better chance of recovering from their addiction lifestyle.

Timeliness of Services Related to PIPs

San Luis Obispo clinical staff and management recognize the importance of timely access to outpatient treatment services during some particularly critical junctures in a person's treatment and recovery journey from addiction. One such type of critical juncture is during stepdown from a protected environment such as residential treatment or WM when timely entry into outpatient services is vital. Another critical juncture is when someone with a severe addiction that has been intractable to other types of treatment reaches out for MAT as a solution. In either case, San Luis Obispo found with years of experience that the client is likely to be ambivalent about treatment that focuses them on the substantial challenges of changing addiction-related habits and lifestyles. Timely entry into outpatient services is vital during these critical junctures in a person's life. It can mean the difference between life, health and hope on the one hand, and relapse with intense suffering and possible death on the other hand.

Quality of Care Related to PIPs

The clinical PIP focuses on the timeliness and quality of case management interventions as a solution to the problem of clients failing to enter into stepdown services after residential treatment and WM discharges. The interventions were so successful that they left no room for further improvement—everyone who received the case management successfully entered outpatient treatment. Those clients who were not successful left residential treatment or WM before completion, did not return to San Luis Obispo, and did not receive case management services. There would seem to be room for improvement in the quality of residential treatment or WM delivered by the out of county providers, and San Luis Obispo is working with them to improve outcomes. However, they do not want to make this aspect of quality care the focus of the PIP for a variety of reasons, including that they will soon be contracting with a provider to manage an in-county residential treatment and WM facility. Consequently, San Luis Obispo will begin exploring a new focus for their clinical PIP.

The non-clinical PIP also focuses on the confluence of timeliness and quality of care. Those persons requesting MAT as a solution to their addiction are often ambivalent about the difficult recovery work of changing their habits and addiction lifestyle. The MAT program somewhat slows down the intake and assessment process to ensure that prospective clients are committed to engaging in outpatient treatment conjointly with MAT. The staff are in a dilemma of how to streamline the intake and assessment processes, so they are timelier, but not to the extent that prospective clients can avoid committing to the effort of outpatient treatment for lifestyle change. They are still exploring how best to accomplish this, and translate it into a non-clinical PIP.

Client/Consumer Outcomes Related to PIPs

The Clinical PIP case management interventions resulted in a 100 percent success rate for clients completing residential treatment or withdrawal management who then

received case management services and engaged in outpatient treatment. San Luis Obispo will explore another process within the DMC-ODS that might lend itself to more room for improvement.

The Non-Clinical PIP began with an observation that a high rate of clients requesting entry into the non-methadone MAT program did not meet the requirement to concurrently enter outpatient treatment to address lifestyle change. These clients learned of the requirement early in the process but did not seem to fully recognize it until confronted with the requirement at the time of their medication evaluation. They dropped out at that point. To avoid the waste of time, the program staff decided to slow the initial intake and assessment processes. It is unclear whether this change increased the dropout rate, or merely induced those who would drop out to do so earlier in the admissions process. San Luis Obispo is going to do more exploration, comparing the dropout rates as a result of the differing approaches to the initial screening processes and also making certain to obtain input from clients. Once they have more information, they can begin an active PIP during this FY 2018-19 that deploys one or more approaches to balancing timeliness and quality considerations.

CLIENT/CONSUMER FOCUS GROUPS

CalEQRO conducted three 90-minute client focus groups during the San Luis Obispo DMC-ODS site review. As part of the pre-site planning process, CalEQRO requested three focus groups with eight to ten participants each, the details of which can be found in each section below.

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

Focus Group One: Perinatal Women

CalEQRO requested a group of perinatal women clients including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

The group met on December 4, 2018 at one of the client meeting rooms in the Bryan House Perinatal Women's Residential Treatment Center at 2000 Traffic Way, San Luis Obispo. The participants were all adults 25 years of age or over who were SUD clients. All were admitted into treatment at Bryan House within the previous 12 months, one of whom had not been in other treatment previously. They all spoke English, so no interpreter was needed. The participants were all Caucasian/White and female.

Number of participants: Five
Interpreter used for focus group: No

Participants were first facilitated through a group process to rate each of eight items on a survey, and discussion is 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. Clients are told there are no wrong answers, and that feelings are important. The group facilitators explain that the information sharing is regarded as confidential and reflects the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	3.4	2-5
2. I got my assessment appointment at a time and date I wanted.	3.4	2-5
3. It did not take long to begin treatment soon after my first appointment.	2.8	1-5
4. I feel comfortable calling my program for help with an urgent problem.	4.0	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.0	2-4
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.4	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	3.9	2-5
8. Because of the services I am receiving, I am better able to do things that I want.	3.0	1-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.2	3-5

The following comments were made by some of the five participants who entered services within the past year and who described their experiences as follows:

- Several said it was relatively easy to enter Bryan's House. Others waited from 5-11 months.
- If a client is coming from jail or has an active child welfare case, then they are bumped up on the priority list to enter Bryan House.
- One participant came from jail and is pregnant.

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

- All participants said it is easy to talk to staff. One said that staff are like "life coaches". Another said, "Here in this program there are necessary supports to get our needs met".
- All participants who were also in the MAT program were informed of the benefits and risks of medication. Although one of them had not wanted to be on medication, she "understood the necessity."
- All participants who were also in the MAT program were concerned that would have to stop their medication upon discharge from residential treatment to move to a recovery residence because of the recovery residence house rules prohibiting use of MAT. They said it was because the recovery residences "don't want to be responsible" for the liability of people on medications.

- All participants said they received and appreciated the personalized care they received in the residential treatment program, which they attributed in part to the facility and program being small.

Recommendations for improving care included the following:

- One participant said she and her child have video visits with the child's father who is in jail, but thinks it would be more beneficial if she were able to take her child to visit the child's father in jail.
- Many of the participants would like to look for housing earlier in recovery since the housing market is so bad. The clients in residential treatment feel the stress of looking for housing and work in the last couple weeks of their stay before discharge. This is especially stressful because they have their children to care for as well as themselves. One of the participants is pregnant and has a young child.
- The residential treatment program's policy is unclear if a client tests positive for drugs. Some felt it would be better if the counselors explained the policies upfront when clients first enter the house as a resident.
- Clients want classes that include dads and/or are for dads. Clients also want classes with dads, child/children, and moms.
- All the participants agreed there needs to be more places like Bryan's House --more beds for more women in need.
- Clients have access to only one laptop in the residential treatment facility. They all need it to search for housing and for employment.

Focus Group Two: Youth Focus Group

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

The group met on December 4, 2018 in the County Behavioral Health Building at 277 South St. in San Luis Obispo, California. Six participants attended, three of whom were under 18 years old and three of whom were 18-24 years old. All participants spoke English, so no interpreter was needed. Two participants were Caucasian/White, two were Hispanic/Latino, one was African American/Black, and one identified as mixed race. Four were male and one was female.

Number of participants: Six
Interpreter used for focus group: No

Participants were first facilitated through a group process to rate each of eight items on a survey, and discussion is encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five for best and one for worst experiences. Clients were told there are no wrong answers,

and that feelings are important. The group facilitators explained that the information sharing is regarded as confidential and reflects the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvements. See Attachment E for tools.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.3	3-5
2. I got my assessment appointment at a time and date I wanted.	4.2	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.5	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.5	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.3	3-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.0	1-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.2	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.2	2-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.5	4-5

The following comments were made by some of the six participants who entered services within the past year and who described their experiences as follows:

- Participants thought they received services in a timely manner
- Four of the six participants were on probation and were court ordered; they received services immediately. One client said his attorney and his mother sent him to treatment.
- Several participants expressed puzzlement that they were not allowed to just "smoke weed" and repeatedly expressed that sentiment. It seemed they did not really want to get off drugs.
- None of the clients thought they would call a counselor if they had an urgent matter. However, several thought the counselors would be responsive if they did call.

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

- Access to services was easy

- Some felt the program kept them out of trouble, while others felt the program was too lengthy.
- Logistics was an issue. Some clients wished the program was located closer to their house. They do not drive and found transportation to and from the sessions to be challenging.
- Drug testing and group sessions area difficult to make when schedule during work hours since they take the client away from work.
- Enforced length of stay by probation is 90 days, and should be shorter.

Recommendations for improving care included the following:

- Some felt the program was fixed at 90 days and should be shorter.
- Schedule more required sessions and drug testing after hours so clients aren't required to miss work.

Focus Group Three: Adult Focus Group

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

The group met on June 5, 2018 in the Health Agency Green Room. Twelve participants attended who were adult beneficiaries receiving treatment services as clients. Eight of the participants entered treatment within the past year.

One participant was a young adult between the ages of 18-24, eight were adults between the ages of 25-59, and two were older adults over sixty. All participants spoke English as their preferred language, so no interpreter was needed. Seven of the participants were Caucasian/White, three were Hispanic/Latino, and one described themselves as of mixed race. Four of the participants were male, seven were female, and one declined to state. They participants were all adults who spoke English so that no interpreter was needed. The participants were of different races—seven were Caucasian/White, three were Hispanic/Latino, and one identified as mixed race.

Number of participants: Twelve
Interpreter used for focus group: No

Participants were first facilitated through a group process to rate each of eight items on a survey, and discussion is encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five for best and one for worst experiences. Clients were told there are no wrong answers, and that feelings are important. The group facilitators explained that the information sharing is regarded as confidential and reflects the participating group members' own experiences and feelings about the program. The facilitators further explained that the

goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvements. See Attachment E for tools.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	3.9	1-5
2. I got my assessment appointment at a time and date I wanted.	4.2	2-5
3. It did not take long to begin treatment soon after my first appointment.	3.9	1-5
4. I feel comfortable calling my program for help with an urgent problem.	4.2	2-5
4. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.6	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.1	1-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.6	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.5	2-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.5	3-5

The following comments were made by some of the twelve participants who entered services within the past year and who described their experiences as follows:

- Access to services seems to be much easier for those who were just coming from jail rather than for those who were not.
- One participant wanted a more intensive level of care and was not able to be admitted.
- One participant was sent to Oakland for a residential program and left within two days, relapsed, was charged and ended up in jail.

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

- Participants were referred for services through a variety of sources.
- Most participants received services in a timely manner. Those who did not said they received interim services while waiting.
- Participants said that case managers and counselors are helpful, "great" and "amazing".
- Participants thought their programs were positive and would recommend the programs to others.
- The cost of living his high throughout the county, and there are not enough clean and sober living arrangements.

Recommendations for improving care included the following:

- More treatment offerings, especially residential treatment.
- Provide more assistance with finding housing
- Loosen the rule that clients are sent away if more than five minutes late for a session; the bus system is not always on time.
- Make the hours for drug testing more flexible for those who come from a distance or have to work during the day.
- Offer more individual counseling.
- Provide assistance to clients for resolving conflicts with each other.
- Institute family therapy in the Adult Treatment Court Collaborative program.
- More flexible program hours—less for those who work and need/want less intense treatment, and more for those who want it.

Client Focus Group Findings and Experience of Care

Overview

CalEQRO conducted three diverse client focus groups during the onsite review: one for perinatal women clients in residential treatment, one for youth clients, and one for a mixed group of adult clients. The purpose of the focus groups was to obtain first-hand perceptions from those receiving treatment services regarding the accessibility, timeliness and quality of those services.

Access Feedback from Client Focus Groups

- In the focus group for perinatal women, participants reported widely varying experiences with access to treatment, some stating they were admitted within days and others stating they waited months. Several participants in the mixed adult focus group echoed these remarks, stating that when they had needed residential treatment it was difficult to access it because the county did not have that level of care (other than for perinatal women) in county.
- Several on MAT complained that the perinatal women's recovery residence would not admit anyone on MAT because they did not want the liability. Participants in the mixed adult and in the youth focus groups remarked that access into outpatient treatment was easy.
- Many participants remarked about the high cost of living and problems finding affordable housing.

Timeliness of Services Feedback from Client Focus Groups

- The youth and most adult participants said they were admitted into treatment fairly quickly and easily after being referred. Exceptions to this were some of the perinatal adult women and others among the mixed adult group who at

one time needed residential treatment and had the experience of lengthy wait times.
- Participants in all the focus groups expressed the impression that they could enter treatment more quickly when referred by the criminal justice system.
- The perinatal women and some of the mixed adult focus group participants complained about the shortage of affordable housing, the lengthy time it takes to find suitable housing, and the wish for more assistance from program staff to do so.
- Participants in the youth and the mixed adult focus groups complained about the public transportation system erratic schedules, and the consequent challenges they face as clients to get to their sessions and their drug testing on time. They asked for some flexibility in the "five-minute rule" so they are not automatically sent away if more than five minutes late for a session.

Quality of Care Issues from Client Focus Groups

- The participants in each of the three focus groups praised the program staff. They remarked how helpful the staff are, and commented about their skills, sensitivity, and delivery of personalized care. Some remarked about their counselors being "great" and "amazing".
- Participants in the perinatal women focus group expressed the wish for more programming that would include the dads of their children.
- All participants felt their counselors had informed them effectively about the potential benefits of MAT.
- The youth focus group acknowledged how harder drugs kept them from effective functioning, but most expressed ambivalence about maintaining abstinence from all drugs, especially from marijuana.

Client Outcomes Feedback from Client Focus Groups

- The participants from both the mixed adult and perinatal women focus groups expressed appreciation for the helpfulness of their counselors in supporting their progress towards recovery.
- The participants from the perinatal women's focus group and from some of the mixed adult focus group expressed apprehension about their progress in recovery from addiction if they were unable to find suitable clean and sober housing.
- Some of the women in the perinatal women's focus group expressed apprehension about their progress in recovery from addiction if they have to prematurely terminate their MAT in order to be admitted into a recovery residence.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1

Table 1: Access to Care Components

	Component	Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	NM
San Luis Obispo recently created a position with the sole focus of tending to cultural competence issues for both MH and SUD services, including more attention to these issues within the DMC-ODS. At the time of the review, the department's Cultural Competence Plan was focused almost entirely on mental health and San Luis Obispo should consider building out an equivalent section of the Plan for SUD services or creating a separate Plan for SUD services. The Cultural Competence Committee had little representation from substance use services and San Luis Obispo should consider adding proportional SUD representatives to the Committee or creating a separate one for focusing on SUD services. CalEQRO included in this report's recommendations that San Luis Obispo consider more systematically conducting outreach to diverse communities to understand how they perceive the strengths and weaknesses of the DMC-ODS and what they would like to have changed.		

1B	Manages and adapts its capacity to meet SUD client service needs	M
San Luis Obispo completed a thoroughgoing assessment and network capacity adjustment to meet the requirements of the 1115 Waiver and Managed Care Final Rule. They invested in the building of a long-needed residential treatment and withdrawal management facility and are planning an expansion of services in the Paso Robles region of the county.		
1C	Integration and/or collaboration with community-based services to improve access & care	M
Continued a history of close collaboration with many county agencies and community-based organizations for both strategic planning and implementation of new programs and initiatives. These collaborations increased substantially in preparation for the DMC-ODS implementation. The esteem with which the county Drug and Alcohol Services is held by others was evidenced by the Board of Supervisors approval of a plan for 26 new FTE positions and $3.7 million to launch the Waiver, and again when the Community Corrections Partnership allocated nearly $500,000 towards building the residential treatment and withdrawal management facility.		

Timeliness of Services

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

KC Table 2

Table 2: Timeliness of Services Components		
	Component	**Quality Rating**
2A	Tracks and trends access data from initial contact to first face to face appointment	NM
Initial contact date/time is entered into the EHR by some entry points (call requests to Access Call Center, walk-in requests resulting in same-day appointment at clinics). These data entries are linked with later face-to-face appointments for timeliness tracking. However, initial contact date/time is not entered by some other entry points (call requests to clinics for appointments, and call or walk-in requests for appointments to the NTP contractor). CalEQRO listed these entries as recommendations for the coming year.		
2B	Tracks and trends access data from initial contact to first MAT/NTP appointment	M
San Luis Obispo keeps thorough track of how prospective new clients proceed from initial intake in the MAT program to their first medication appointment. They track the		

Table 2: Timeliness of Services Components		
	Component	**Quality Rating**
time and the percentage of people who begin medication. They have made this the focus of one of their PIPs.		
2C	Tracks and trends access data for timely appointments for urgent conditions	NM
Not currently tracked. In addition to the challenges referred to in 2A, San Luis Obispo has not defined "urgent" consistently. This is a necessary first step it will have to take before setting timeliness standards for urgent appointments, creating procedures for data collection, and monitoring performance. CalEQRO listed this capability as a recommendation in the report.		
2D	Tracks and trends timely access to follow-up appointments after residential	M
Tracks these processes for in-county perinatal women clients leaving residential treatment for stepdown care, but does not collect and report statistics. Tracks these processes for a possible PIP with their adult clients leaving out of county residential treatment and reports the results. In either case, they deploy intensive case management follow-up for those with discharge plans. They are challenged with the clients who are treated out of county and leave treatment prematurely.		
2E	Tracks and trends data on re-admissions to residential treatment and WM	PM
San Luis Obispo does not track residential re-admissions. With the exception of a small residential treatment facility for perinatal women, San Luis Obispo does not offer in-county residential treatment or WM. When clients need a residential level of care, San Luis Obispo refers them to one of the few residential facilities out of county with which they contract and provides a time-limited authorization. These arrangements are possibly only through the DMC-ODS Waiver, and San Luis Obispo is now able to begin tracking readmission rates. In about two years they expect to establish an in-county facility which will make it even easier (and more essential) for them to track this indicator. However, San Luis Obispo is currently tracking residential follow-up and readmissions manually, implementing intensive case management to insure effective follow-ups, and documenting it within a conceptual PIP they had proposed.		
2F	Tracks and trends no shows	NM
San Luis Obispo does not currently track those clients with appointments who do not show for those appointments. This measure helps alert DMC-ODS counties to problems some programs might have with engaging its clients. San Luis Obispo has the capability of tracking this type of pattern through its EHR and should consider doing so at some future time.		

Quality of Care

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

KC Table 3

Table 3: Quality of Care Components		
Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	M
The QI Plan for the DMC-ODS is separate from the one for the MHP. The Plan is well-written, with meaningful and clearly stated goals and objectives. The QIC meetings are structured in part to monitor progress in meeting the QI Plan objectives. The evaluation addresses the end of year results for each of the objectives and action plans. The QI Plan seems more oriented to compliance than QI. It does not portray major challenges and what providers are learning, particularly concerning chart documentation. More than one person is needed for monitoring and providing technical assistance regarding chart documents. Also, San Luis Obispo would do well to engage providers in exploration of how documentation can be streamlined and still meet the new DMC-ODS Waiver requirements.		
3B	Data is used to inform management and guide decisions	M
San Luis Obispo actively uses data to monitor the accessibility and quality of its services. As an example, it sets capacity expansion and productivity goals linked to its requests for increased FTEs and reports to upper management on its achievements. Widespread use of an EHR makes data entry and reporting easier. San Luis Obispo set up its data collection and data integrity monitoring systems for CalOMS so that the data it produced would be useful for quality improvement, and management used their results for those purposes. San Luis Obispo would do well to acquire data analytic software with data visualization functionality to enhance its reporting capabilities and the effectiveness of its communication with others regarding the results it produces. They would also benefit from increasing their data analytic staff to make more use of the data they so diligently collect—for example, analyzing and reporting on the client quality of life data they collect in the MAT program.		

Table 3: Quality of Care Components		
Component		**Quality Rating**
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
Group sessions with line staff, supervisors and mid-level managers, and with clients all indicated that San Luis Obispo does an effective job of communicating well—explaining the rationale for changes to the system of care, explaining new procedures, and inviting feedback. Clinical supervisors and managers seemed particularly well prepared by management to carry out the principles and requirements of the DMC-ODS Waiver and lead their staff in how to implement effectively. Providers in more than one group complained about the added burden of documentation that came with the Waiver, and would like to be invited for input on how some of the procedures could be streamlined and still meet DMC-ODS requirements.		
3D	Evidence of an ASAM continuum of care	M
San Luis Obispo has adopted the ASAM Criteria and client-centered principles well before the DMC-ODS implementation. It established an extensive continuum of care before the Waiver, supported particularly by criminal justice funds, that included substantial numbers of SLE beds combined with IOT as an alternative to or stepdown from residential treatment. The primary structural limitation in the continuum is with the lack of in-county residential treatment and withdrawal management for the general adult population, which it is moving to correct with construction of a new building and plans for starting the programs in about two years. They area also intending to further expand their recovery residences, and are considering the Oxford model as a way to more quickly and easily achieve that expansion. A second limitation is the lack of MAT within the FQHCs, which are more challenging to influence because they are outside the control of the DMC-ODS. However, they recently asked for help from the DMC-ODS management to apply for a HRSA grant and launch some MAT capabilities in primary care. San Luis Obispo adopted an ASAM approach of individualized treatment, client-treatment matching, and stepdown transfers when appropriate to less intensive levels of care. They have adopted a range of evidence-based practices that they provide to clients when clinically appropriate, including a non-methadone MAT program that began ten years ago and is thriving.		
3E	MAT services both outpatient and NTP exist to enhance wellness and recovery:	M
San Luis Obispo is a standout among other California counties in its early pioneering work and ongoing success with providing non-methadone MAT for over ten years. This is done through a successful county-operated program that is DMC-certified, requires concurrent treatment through the IOT or outpatient programs for addiction lifestyle change, and coordinates care closely with the non-MAT treatment providers.		

Table 3: Quality of Care Components		
Component		**Quality Rating**
The program has evolved its clinical protocols over the years to provide individualized care for a wide range of clients with addictions. The ADP Administrator and the MAT Program Director have led the way in making MAT a widely accepted best practice for addictions in the county, although some recovery residences still resist admitting clients on MAT. Screening and intake staff at the major entry points into treatment are trained to include consideration of MAT in how they initial screen clients, and they make referrals that include MAT at high rates compared to other California counties. In addition to the county-operated non-methadone MAT program, San Luis Obispo contracts with an NTP to provide methadone and other addiction medicines. The county-operated MAT program collects quality of life data for each client regularly, and should consider more systematically collecting, analyzing and reporting the results for quality improvement purposes. In addition to these MAT treatment programs, San Luis Obispo has an extensive SUD prevention program. Part of the program includes widespread use of naloxone throughout the county, in cooperation with the county's Opioid Safety Coalition.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
Under the leadership of the ADP Administrator, the county sought consultation and training years before the Waiver from Dr. David Mee Lee and others. They began adopting client-treatment matching and individualized care according to ASAM Criteria principles. Although their lack of residential facilities in county limited their continuum of care, it also prompted inventiveness to create alternatives with SLEs and IOT. San Luis Obispo also began a non-methadone MAT program ten years ago and currently all screening and intake staff at entry points to treatment consider MAT as a possible service when they make referral decisions. All clinical staff receive training through workshops in ASAM principles. However, it would be useful if those in these roles would also be given regular (at least monthly) case consultation and supervision to fine-tune their use of ASAM Criteria in referring new clients. San Luis Obispo might also consider adopting a brief measure of therapeutic alliance to administer regularly to clients for use in quality improvement to strengthen treatment engagement and retention.		
3G	Measures clinical and/or functional outcomes of clients served	NM
San Luis Obispo is experiencing several challenges with use of CalOMS for measuring outcomes. Their rate of administrative discharges is relatively high, which makes it difficult to obtain sufficient data for discharge ratings on those clients who left without an interview, and San Luis Obispo will need to find ways to lower their rate of administrative discharges. Also, San Luis Obispo relied heavily on automated CalOMS reports generated by ITWS that are no longer available under the new BHIS		

Table 3: Quality of Care Components		
Component		**Quality Rating**
platform. This is especially problematic for counties like San Luis Obispo that use Cerner Anasazi software, and San Luis Obispo might check with other counties using the same software to find out what they have done to adapt. San Luis Obispo may want to consider using some additional outcome measures such as the ones used in their county-operated MAT program, or checking with other counties and considering measures they are using.		
3H	Utilizes information from client perception of care surveys to improve care	M
San Luis Obispo administers the TPS to clients as required, and the results measure several important domains in clients' experience of care: Access, Quality, Outcomes Care Coordination, and Satisfaction. UCLA scored the instruments and reported back to the counties on their results. Collectively, the DMC-ODS network received high scores with some slight variation by domain ranging between 3.9 and 4.1 (see Figure 8 in the Performance Measure chapter of this report). The results were also reported separately by treatment program, and a few outlier programs received relatively lower ratings in some of the items and item domains. San Luis Obispo staff promptly followed up with those programs about problems and, when necessary, took corrective actions.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- San Luis Obispo has several entry points into treatment: An Access Call Center, five outpatient clinics that offer advance appointments and walk-ins, and an NTP. Clients remarked during the focus groups that they find access to services to be especially welcoming and easy for outpatient treatment, IOT and MAT. These comments came from youth and adults alike.

- San Luis Obispo served a steadily increasing number of beneficiaries with SUD treatment over the four years preceding its launch of the DMC-ODS Waiver. The partial year approved claims data for the first year of its Waiver implementation indicated that San Luis Obispo is on a trajectory towards further increasing the number of beneficiaries served with SUD treatment. The positive signs of increased access are also evidence by a penetration rate of 1.46 percent that substantially exceeds the average of 0.32 percent for other DMC-ODS counties statewide. The same positive comparisons were demonstrated in more detailed analyses by age, gender, and race/ethnicity. These percentage comparisons will change over time as the approved claims data upon which they are based becomes more complete, but the differences are sufficiently significant to be noteworthy.

- San Luis Obispo has two DMC-certified MAT programs that bill through the DMC-ODS. One of the programs is a contracted NTP program that specializes in methadone but also offers other addiction medicines including buprenorphine, naltrexone (including injectable long-acting) and disulfiram. The other is a county-operated program offering non-methadone addiction medicines in combination with required participation in a DMC-certified IOT or outpatient program. The aggregated intakes for these two programs comprise over 50 percent of the total intakes for the entire DMC-ODS. The client beneficiaries who go onto starting an addiction medication regimen comprise 37 percent of the beneficiaries served by San Luis Obispo's DMC-ODS. Those served with non-methadone addiction medicines comprise 11.1 percent of all client beneficiaries served by the DMC-ODS, which is ten times the average across all other DMC-ODS counties. In part, this difference is because San Luis Obispo's non-methadone MAT program is DMC-certified, and its claims data are therefore readily accessible to the DMC-ODS and to the EQRO, while for most other DMC-ODS counties non-methadone MAT is delivered primarily through FQHCs wherein the claims data is not easily accessible. The differences are nonetheless so substantial as to be worth mentioning.

- The county is expanding access to addiction medicines when clinically necessary outside of the two DMC-ODS programs. A strong Opioid Safety Coalition has secured several grants and the cooperation of many county agencies to distribute Narcan to first responders, family and friends of addicts, and inmates with addictions upon leaving jail. While in jail, inmates who had been on a methadone regimen before incarceration will be able to continue receiving it. The Sheriff is considering making some other MAT medications available to inmates while in jail and upon release who may be helped by them.

- Counties have a huge undertaking to establish a DMC-ODS, which requires significant investment in additional staff. Many counties are reluctant to make those investments. San Luis Obispo did so, approving 26 new FTEs and significant funding. This was a testament to the esteem with which they and many other county agencies hold the behavioral health department and in particular the drug and alcohol services. A similar testament of confidence was made by the county's Community Corrections Partnership, which gave a one-time allocation of several hundred thousand dollars to help fund the new residential treatment and withdrawal management facility. These votes of confidence with funding go a long way to supporting expansions in treatment capacity where needed to maintain easy access to services.

- Under the leadership of the ADP Administrator, San Luis Obispo established an extensive network of over 100 contracted SLE beds, now called recovery residence beds under the Waiver. These beds, in combination with IOT or outpatient treatment, provide an alternative to or stepdown from residential treatment. These combinations are especially important while San Luis Obispo is still building its in-county residential treatment and withdrawal management facility.

- The county has made a strong commitment to coordinating resources for persons released from jail or prison to re-enter their communities effectively and not recycle back into jail. Criminal justice agencies recognize how significantly addictions contribute to incarcerations, and they work closely with the county's drug and alcohol services and its DMC-ODS to ensure accessibility of SUD treatment services. The county percentage of clients involved in the criminal justice system is nearly 60 percent, which is much higher than the combined average of about 40 percent for all other DMC-ODS counties.

Opportunities:

- Although the Hispanic/Latino penetration rate for San Luis Obispo was higher than the statewide average, it was proportionally lower than other subgroups based upon their population size. It would be appropriate for San Luis Obispo to reach out to the Hispanic/Latino community for feedback on how they perceive the Waiver to be proceeding, how accessible they perceive SUD

services to be, and what they think could be improved to engage more clients from their community.

- Leaders in the criminal justice system agencies and in behavioral health make the strong working relationship between them work with informal verbal understandings. In case of illnesses and retirements, it might be prudent to also formalize various collaborative policies and procedures to minimize disruptions when a key leader departs.

- Many clients in the focus groups remarked about their challenges getting to group sessions and to drug testing on time when using unreliable public transportation. They remarked that some programs are quite strict about being on time, and will turn them away if more than five minutes late. San Luis Obispo might look into what can be done to mitigate these difficulties.

- FQHCs have sought assistance from San Luis Obispo in applying for a HRSA grant to help jumpstart their effort to build MAT prescribing capacity. This would expand capacity for MAT, especially among people who are comfortable visiting their primary care clinic and not specialty behavioral health. San Luis Obispo would then do well to become informed about what works (i.e. in the Vermont pilot study) to help primary care physicians with X waivers to get more comfortable prescribing MATs.

- Perinatal women expressed several access challenges. When at first needing residential treatment, several complained that the wait time could be many months without treatment. Once in residential treatment, the length of stay is shorter under the Waiver. They expressed the need for more time and assistance in preparing for discharge, especially housing. They reported that the primary recovery residence specializing in perinatal women refuses to admit anyone using an addiction medicine for a MAT. They said the reason they were given was that the recovery residence did not “want the liability”.

Timeliness of DMC-ODS Services

Strengths:

- The Access Call Center staff are able to enter data into the Cerner Anasazi EHR regarding the date/time of first contact and the clinical content relevant to the screening. The provider who later conducts the intake/assessment can view the electronic chart opened for the person at the time of the call to the Access call center, and enter the assessment data into the same chart so it is unified and coordinated. This ability makes it possible to track timeliness from first contact through the call center to first appointment for an in-person assessment. Only 10 percent of persons accessing DMC-ODS services to so through initially calling the Access Call Center. For them, the time to first in-

person assessment at a clinic is timely, well within the San Luis Obispo standards.

- Most persons access treatment by calling one of the five county clinics for an appointment or simply walking into the clinic and requesting to be seen. Most people who walk in are seen the same day. The clinical line staff and supervisors are acutely aware of the importance of timeliness, and try to manage their caseloads so that timeliness standards are met. Teams meet with their supervisors periodically to address this issue.

- Clients accessing NTP services usually do so by walking in, and are seen for an intake and initial dosing the same day. This is in keeping with statewide averages for timely access from initial intake to firsts dosing within the same day.

- Authorization of residential treatment is a new and central component of the Waiver's blueprint for an organized delivery system. The clinicians who conduct the assessments in the clinics are county employees with delegated authority to generate authorizations for residential treatment. In this way there is no time lapse between a referral decision and an authorization.

Opportunities:

- San Luis Obispo has yet to develop and implement tracking mechanisms for several types of timeliness-related measures. These include:
  1) Time from first call to a clinic for an intake appointment to the first offered appointment and first actual appointment;
  2) Time first call for an urgent appointment to the actual appointment;
  3) Time from first call to an NTP for an appointment to the first offered and first actual appointment for an intake session;
  4) No shows

  These should be a focus of the QI Plan during Year Two of the San Luis Obispo Waiver implementation. To accomplish these steps, additional staff appear to be needed for both data operations and data analysis.

- San Luis Obispo is tracking the timeliness of transitions from residential treatment to less intensive stepdown treatments in the community. The numbers are small. Most of the residential treatment is out of county.

- The county-operated non-methadone MAT program slowed its admissions process to ensure that prospective clients made the commitment to participate in IOT or outpatient treatment conjointly with MAT to address changes to their addiction lifestyle. The admissions average 9.75 days and may be contributing to a 65 percent dropout rate prior to the first medication evaluation. San Luis Obispo is making this dilemma the focus of one of its PIPs.

- Some clients have a distance to travel from home or from other appointments to their treatment sessions and to drug testing. For those who do not drive and must use public transportation, the travel time may be somewhat unpredictable and frustratingly long. Consider ways that programs can be more flexible to accommodate unexpected delays in travel time for clients.

Quality of Care in DMC-ODS

Strengths:

- A fundamental premise of the Waiver is that quality of treatment is founded on a client-centered approach that includes matching level of care and treatment plan to a client's situation. One of the many ways that DMC-ODS counties apply this principle is to screen and assess prospective clients using ASAM Criteria and use the findings to guide referrals into treatment. Licensed clinical assessors are trained in use of ASAM Criteria and also trained to enter data for later analysis on the concordance between the ASAM Criteria-indicated Level of Care, what referral was actually made, and the reasons for lack of concordance if that was the case. Statistical reports from UCLA indicate that assessors are diligently entering the data for assessment and reassessments. The concordance rate is high between ASAM Criteria-indicated LOC and the actual referred-to LOC (75 percent for initial assessments and 83 percent for reassessments). When discordant referrals are made, the primary reason cited is client preference.

- San Luis Obispo is distinct among most other DMC-ODS counties in that is has provided to the community a thriving non-methadone MAT program for ten years that is county-operated and is now DMC-certified. The program is under the consistent leadership of a nurse practitioner who established the program and who has more recently arranged program contracts with several physician prescribers of buprenorphine in the community to share the caseload. She has worked with others to develop strong clinical protocols over the years which include the requirement that all clients must go through a DMC-certified IOT or outpatient program adjunctive to their MAT and explore making changes to their addiction lifestyle. The MAT program has a strong reputation within the county which has helped to reduce stigma around MAT as an adjunct to outpatient SUD treatment. The program is the focus of one of San Luis Obispo's PIPs.

- San Luis Obispo uses CalOMS data for multiple purposes including service planning and discharge planning. They train all individual providers in how to complete the CalOMS forms so that inter-rater reliability is high. An Administrative Service Officer is responsible for checking the submitted

CalOMS data to monitor and where needed to improve data integrity. The data indicates that, on average, clients in SUD treatment in San Luis Obispo County as compared with the average across other DMC-ODS counties have a: lower rate of homelessness, higher rate among their unemployed of persons actively seeking work, and higher rate of criminal justice involvement. These statistics suggest case management services and other program elements to incorporate into many clients' treatment plans.

- San Luis Obispo administers the TPS as required, receives later data analytic reports from UCLA and uses the results to consider quality improvement interventions. San Luis Obispo programs showed uniformly high ratings similar to most other DMC-ODS counties. Also similar were somewhat lower ratings, although still high, for care coordination with mental health and physical health services.

- Clinical supervisors seemed to be particularly well-informed about the Waiver and adept at explaining new policies and procedures to their line staff. They seemed well aware of the rationale for changes the Waiver brought. It seemed to the EQRO reviewers conducting the group sessions with these supervisors and managers that they had not only been well prepared for the Waiver by upper management, but also trusted and delegated to carry out substantial responsibilities and scope of decision making.

- The behavioral health department worked with county human resources to reclassify the county's substance use positions, so they are at parity with their counterparts in mental health. This means that salary structures are more in alignment and also that employees can transfer more easily between comparable positions in the mental health and the substance use divisions. These implications will improve San Luis Obispo's ability to recruit and retain staff, and to build upon strong quality management.

Opportunities:

- Clinical line staff expressed concerns about the increased administrative burden brought on by the Waiver implementation, especially regarding increased documentation requirements and time needed to fulfill them. San Luis Obispo has provided clinical line staff with training in how to meet the new documentation requirements, but not engaged them in how to streamline those requirements. It may be opportune for management to engage with line staff in an exploration of what documentation can be streamlined while still meeting basic requirements. This may also prompt questions to DHCS about whether certain documentation policies such as noting documentation start and stop times can be brought more in line with policies applied to mental health documentation, with a resulting reduction in administrative burden.

- Clinical assessors are trained in ASAM Criteria through workshops and webinars. However, research clearly shows that clinicians need follow-on monthly case consultation and supervision for at least a year to adopt an evidence-based practice with fidelity.

- There were no data entered by San Luis Obispo for congruence between ASAM-indicated recommendations for LOC referral and the actual referral made at screening. Most Access Call Center screenings do not include consideration of the full ASAM Criteria dimensions, and most clinic screenings quickly morphed into full assessments in the same session. However, when ASAM Criteria-based screenings do occur, the data for them should be entered into the ASMA LOC Referral Data electronic spreadsheets.

- Some clinical line staff noted an increasing incidence of co-occurring disorders among clients with serious mental illnesses. They cited some co-occurring disorder concurrent treatment but also remarked how helpful it would be if San Luis Obispo adopted more sessions within programs that were designed for concurrent mental health and substance use treatment.

- San Luis Obispo has one full-time staff to conduct utilization review. While she is effective, additional staff are needed to cover all that is needed.

- San Luis Obispo makes use of data and data reports, with the results portrayed in complex tables. Some are aware of data analytic software that can provide data visualization. They are awaiting the advent of Anasazi's new Millennium product before they decide what to do. The software would provide the double benefit of:
  1) Enabling San Luis Obispo to communicate its findings in a clear and compelling way; and
  2) Make it much easier for managers who are not experienced in data analytics to simply touch a facet of the data dashboard to drill down to other ways of looking at the data results.

Client Outcomes for DMC-ODS

Strengths:

- San Luis Obispo collects data regularly that can be useful to measure outcomes. These data include CalOMS admission and discharge summaries, TPS which has an outcome domain, and a quality of life measure administered in the MAT program. San Luis Obispo tends to be careful with processes to ensure data integrity, such as training each new staff member in how to collect the data for each type of measure. This is sound groundwork for building an outcomes management system.

Opportunities:

- San Luis Obispo should consider using the quality of life data it collects on a monthly basis from its MAT clients, analyze the results, and use it regularly for improving the quality of treatment and for measuring program effectiveness. The program should consider folding into the measure a few items that address frequency and amount of substance use.

- San Luis Obispo had used automated reports generated through ITWS from CalOMS that have been discontinued since migrating the platform to BHIS. They should join advisory committee meetings about to convene and advocate for more automated reports to make outcomes measurement easier. Since that may be a way off, they should consider how to develop their own software program subroutines that measure pre-post and time series mid-treatment progress.

- Consider using the outcome item and domain from TPS, which data they already have.

- Explore the reasons for relatively high administrative discharge rates and low positive ratings by counselors on CalOMS discharge status.

RECOMMENDATIONS FOR DMC-ODS FOR FY 2019-20

1. Continue progress towards establishment of a residential treatment and withdrawal management facility:
   A. Begin construction of the facility
   B. Begin process of obtaining a facility license.
   C. Develop an RFP with a program design and other specifications to elicit response from community-based organizations.

2. Design and begin an active clinical and active non-clinical PIP. For one of the PIPs, build upon the developmental work already begun that focused upon the county-operated MAT program. For the other PIP, begin the process of selecting one and collecting baseline data. Elicit technical assistance from CalEQRO. Bring the MAT PIP to active status by the fourth quarter of FY2018-19. For the other PIP, complete the selection process and bring it to active status by the beginning of FY19-20.

3. Refine data entry processes to support reporting on several required measures including:
   A. Time from first requested appointment to first offered appointment to first actual appointment: Walk-in clinic staff enter date/time of first request for services if by phone, and first offered appointment
   B. Time from first requested MAT appointment to first offered appointment to first actual appointment: NTP staff enter date/time of first request for services if by phone or in person to NTP, and first offered appointment by NTP in response
   C. Time from first requested urgent appointment to actual appointment: Refine the definition of “urgent” so it is more conducive to tracking, set and convey instructions for data entry to staff, and collect and monitor the data for QI opportunities.
   D. Concordance between ASAM-based LOC findings at initial screening and LOC referral: Access Line staff and Walk-in Clinic staff enter the ASAM LOC Referral Data into the required spreadsheets when an ASAM-based screening is done.
   E. Add to data analytic staff as needed to implement recommendations 3A-F.

4. Develop a cultural competence plan specific to substance use treatment that can stand alone or be embedded in an integrated behavioral health cultural competence plan. Consider including in the plan outreach including focus groups to the Hispanic community to understand their perceived barriers to accessing DMC-ODS services and to generate suggestions for solutions.

5. Address admission barriers set by some recovery residences for people using MATs, especially for perinatal women.

6. Develop a needs assessment for changes to Anasazi to meet DMC-ODS functionality needs, and inquire with Cerner as to how well the new Millennium product will address them. Then plan the best way to proceed with obtaining data analytic software functionality, including data visualization capabilities.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: County Highlights (none at this time)

Attachment E: Client Family Focus Group Forms

Attachment F: Access Call Center Key Indicators

Attachment G: Continuum of Care Form

Attachment H: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A—On-site Review Agenda

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

Table A1—CalEQRO Review Sessions – San Luis Obispo
Opening session – Changes in the past year, current initiatives, status of previous year's recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of performance measures
Quality Improvement Plan, implementation activities, and evaluation results; cultural competence plan, implementation activities; timeliness self-assessment.
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards and other reports
Perinatal women residential treatment site visit and focus group
Clinical line staff group interview
Youth client focus group
Coordination with Health Plan, primary and specialty health care, and MHP
Access Call Center site visit and staff group interview
Coordination with criminal justice system
Medication-assisted treatments (MATs)
Clinic managers and supervisors group interview
Adult focus group
DMC-specific data use: Continuum of Care Form, TPS, ASAM LOC Placement Data, CalOMS
PIPs
Exit interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Tom Trabin, Lead Reviewer and Deputy Director, Drug Medi-Cal EQRO
Patrick Zarate, Second Quality Reviewer
Melissa Martin, Information Systems Reviewer
Laura Bemis, Client and Family Member Consultant Reviewer

This was a side-by-side review with some of the sessions focused jointly on MHP and DMC-ODS issues, and others held separately with some focused solely on the DMC-ODS and others solely on the MHP. A separate CalEQRO team was present at the onsite review to conduct the MHP sessions.

Aside from the onsite review, additional CalEQRO staff members provided input into and assistance with the review process, assessments, and recommendations by participating in both the pre-site and the post-site meetings and assisting with writing the findings and recommendations within this report.

Sites for San Luis Obispo's DMC-ODS Review

County Sites

Drug and Alcohol Services
San Luis Obispo Health Agency
2180 Johnson Avenue
San Luis Obispo, CA 93401

Drug and Alcohol Services
277 South Street, Suite T
San Luis Obispo, CA 93401

Drug and Alcohol Services
2945 McMillan Suite 136
San Luis Obispo, CA 93401

Contract Provider Sites

Bryan's House
6480 North Star Lane
Paso Robles, CA 93446

Table B1 - Participants Representing San Luis Obispo			
LAST NAME	**FIRST NAME**	**POSITION**	**AGENCY**
Ackerman	Donna	BH Program Supervisor	County of San Luis Obispo/DAS
Aguilar	David	Supervising Deputy Probation Officer	County of San Luis Obispo Probation
Armendariz	Rosie	BH Specialist I	County of San Luis Obispo/DAS
Atwell	Angela	MH Nurse III	County of San Luis Obispo BH
Atwell	Brian	BH Program Supervisor	County of San Luis Obispo BH
Axelrod	Michael	BH Specialist III	County of San Luis Obispo/DAS
Bahner	Kristen	BH Program Supervisor	County of San Luis Obispo BH
Bailey	Kathy	Health Information Technician II	County of San Luis Obispo BH
Basulto	Paloma	Case Manager	County of San Luis Obispo/DAS
Biberston	Brianna	BHJ Specialist II	County of San Luis Obispo/DAS
Bolster- White	Jill	Executive Director	Transitions Mental Health Association
Bonaccino	Antoinette	Administrative Associate III	County of San Luis Obispo BH
Campraht	Darby	Deputy Probation Officer	County of San Luis Obispo Probation
Cantu	Berto	BH Specialist	County of San Luis Obispo/DAS
Carlisle	Amy	BH Clinician III	County of San Luis Obispo/DAS
Chaney	Johanna	Administrative Services Officer	County of San Luis Obispo/DAS
Cohen	Kathy	BH Program Supervisor	County of San Luis Obispo BH
Collins	Cindy	Administrative Services Manager	County of San Luis Obispo BH
Dolezal	Katie	MH Nurse Practitioner	County of San Luis Obispo/DAS
Duca	Briana	Deputy Probation Officer	County of San Luis Obispo Probation
Epps	Sara	Administrative Services Officer II	County of San Luis Obispo BH

Elisable	Julie	Deputy Probation Officer	County of San Luis Obispo Probation

Table B1 - Participants Representing San Luis Obispo

LAST NAME	FIRST NAME	POSITION	AGENCY
Frame	J.	Deputy Probation Officer	County of San Luis Obispo Probation
Ford	Patty	Division Manager MH Services	County of San Luis Obispo BH
Forgette	Gina	BH Clinician III	County of San Luis Obispo BH
Freitas	Jared	Deputy Probation Office	County of San Luis Obispo Probation
Gabuat	Hobert	Case Manager	County of San Luis Obispo/DAS
Getten	Amanda	BH Program Supervisor	County of San Luis Obispo BH
Gibson	Keith Patrick	*Deputy Public Defender	County of San Luis Obispo Public Defender's Office
Glove	Dawn	Case Manager	County of San Luis Obispo BH
Goodman	Kevin	Co-Occurring Clinician	County of San Luis Obispo/DAS
Graber	Star	Division Manager DAS Services	County of San Luis Obispo/DAS
Guest	Clark	BH Program Supervisor	County of San Luis Obispo/DAS
Gustavison-Defour	Jenny	Program Supervisor	County of San Luis Obispo BH
Hansen	Brianna	Accountant III	County of San Luis Obispo BH
Heriford	Julie	Licensed Psych Tech/LV Nurse III	County of San Luis Obispo/DAS
Hernandez	Alexander	BH Clinician II	County of San Luis Obispo BH
Hibble	Norm	Information Tech Supervisor	County of San Luis Obispo BH
Hoffman	Christine	BH Program Supervisor	County of San Luis Obispo BH
Hook	Andrew	Licensed Psych Tech/LV Nurse II	County of San Luis Obispo/DAS
Hopkins	Denise	Accountant III	County of San Luis Obispo BH
Hortillosa	Elaine	Adminstrative Services Officer II	County of San Luis Obispo BH

Ilano	Daisy	MH Medical Director	County of San Luis Obispo BH
Jenkins	Megan	BH Program Supervisor	County of San Luis Obispo/DAS

Table B1 - Participants Representing San Luis Obispo

LAST NAME	FIRST NAME	POSITION	AGENCY
King	Ben	Program Manager II	County of San Luis Obispo - DSS
Klassen	Dianna	BH Clinician II	County of San Luis Obispo BH
Koenig	Rachael	Administrative Services Officer II	County of San Luis Obispo BH
Leigan	Elisa	BH Specialist III	County of San Luis Obispo/DAS
Limon	Enrique	Accountant II	County of San Luis Obispo BH
Mason	Lydie	Administrative Services Officer I	County of San Luis Obispo BH
McGarigle	Rebecca	BH Program Supervisor	County of San Luis Obispo BH
Mello	Anthony	Deputy Probation Officer	County of San Luis Obispo Probation
Mendez	Louise	Senior Account Clerk	County of San Luis Obispo BH
Meyer	Kelly	BH Specialist I – Pre-Release Treatment	County of San Luis Obispo BH
Miller	Jackie	BH Clinician III	County of San Luis Obispo BH
Mora	Yesenia	BH Clinician II	County of San Luis Obispo/DAS
Moreno	Lynette	Deputy Probation Officer	County of San Luis Obispo Probation
Morgan	Molly	Case Manager – Jail AB109	County of San Luis Obispo BH
Nelson	Cindy	BH Clinician III	County of San Luis Obispo/DAS
Nibbio	Jonathon	COO & Director of Clinical Services	Family Care Network, Inc.
Pemberton	Teresa	BH Program Supervisor	County of San Luis Obispo BH
Peters	Josh	BH Program Supervisor	County of San Luis Obispo BH
Peters	Roger	Substance Abuse Treatment Specialist	County of San Luis Obispo/DAS

Phelps	Lauren	BH Clinician II	County of San Luis Obispo/DAS
Preciado	Briana	Deputy Probation Officer – Adult Treatment Court Collaborative	County of San Luis Obispo Probation

Table B1 - Participants Representing San Luis Obispo

LAST NAME	FIRST NAME	POSITION	AGENCY
Reynolds	Patrese	BH Clinician III	County of San Luis Obispo/DAS
Richardson	Julia	BH Program Supervisor	County of San Luis Obispo BH
Rietjens	Jill	BH Program Supervisor	County of San Luis Obispo BH
Roberts	Eugene	Deputy Probation Officer	County of San Luis Obispo Probation
Robin	Anne	Behavioral Health Administrator	County of San Luis Obispo BH
Roullo	Corman	Deputy Probation Officer	County of San Luis Obispo Probation
Russell	Brenda	Substance Use Treatment Specialist	County of San Luis Obispo/DAS
Schmidt	Julianne	BH Clinician III	County of San Luis Obispo BH
Shaparnis	Cyndy	BH Specialist	County of San Luis Obispo/DAS
Sorheim	Lillian	Supervising Deputy Probation Officer	County of San Luis Obispo Probation
Soto	Isidro	Deputy Probation Officer – Drug Court	County of San Luis Obispo Probation
Star	Lloyd	Program manager	County of San Luis Obispo BH
Tarver	Rachel	BH Clinician III	County of San Luis Obispo BH
Thiesmeyer	Mja	District Attorney	County of San Luis Obispo District Attorney's Office
Troxell	Desiree	Patient's Rights Advocate, MH Therapist III	County of San Luis Obispo BH
Veloz-Passalacqua	Nestor	Administrative Services Officer II	County of San Luis Obispo BH
Vickery	Greg	Division Manager MH Services	County of San Luis Obispo BH

White	Debbie	BH Specialist III	County of San Luis Obispo/DAS

Attachment C—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP

GENERAL INFORMATION

DMC-ODS: San Luis Obispo

PIP Title: Care Transitions from Residential Treatment to Outpatient Services

Start Date: 6/27/2018

Completion Date (MM/DD/YY): Study Phase in Progress

Projected Study Period (#of Months):18

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 12/05/18

Name of Reviewer:

Tom Trabin, Ph.D., MSM

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

Rated

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

☐ Completed since the prior External Quality Review (EQR)

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

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

☐ Inactive, developed in a prior year

☒ Submission determined not to be a PIP

☐ No Clinical PIP was submitted

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

San Luis Obispo currently has no in-county DMC-ODS residential treatment other than a small program for perinatal women, and no in-county residential withdrawal management. The goal of this PIP was to enhance case management interventions to assist clients discharged from out-of-county residential providers, so they re-enter the county and engage successfully in step-down outpatient treatment services. During the study period to establish baselines for the effectiveness of these case management interventions, San Luis Obispo found that all clients who returned to the county post discharge from residential treatment or withdrawal management and received case management interventions were able to successfully engage in treatment--there was no need or room for improvement. In contrast, all the clients who did not successfully complete residential treatment did not return to San Luis Obispo, did not receive case management, and did not begin stepdown

services. San Luis Obispo is working with the contracted residential treatment providers to improve treatment engagement for the clients sent there and thereby reduce the dropout rate, but they did not want their work with those out of county providers to become the focus of a PIP. Within two years they plan to complete the construction of an in-county residential treatment and withdrawal management facility and contract with a provider to begin operating it.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1 Was the PIP topic selected using stakeholder input? Did San Luis Obispo develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	County staff comprised the PIP team. Consumers and other stakeholders were not sought for input.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Widespread data nationally made clear that post-discharge from residential is a time of high relapse risk without stepdown to outpatient. Initial interventions to address these risks were designed with assumptions of client needs not based upon local data, and with the intent to learn more from the initial interventions.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	PIP did not become active

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	PIP did not become active
	Totals = 4	Met Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
(1) Will implementing case management services to assist/support clients that transition from residential treatment to outpatient services increase client retention and engagement?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The DMC ODS began interventions to collect baseline data and experienced 100 percent success, so they were unable to identify problems in the processes that could be improved upon.
	Totals = 1	Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☒ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☒ Referral ☒ Self-identification ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, it included all clients who were admitted to and completed residential treatment or withdrawal management out of county, and were then discharged with plans for transfer to a step-down level of care in county. The study did not include clients who dropped out of treatment or withdrawal management prematurely.
	Totals = 2	Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* (1) Number and percent of clients who entered outpatient treatment within timeliness standards post-discharge from residential treatment or withdrawal management.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client/consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	More measures would have been helpful.
	Totals 2	Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable
5.2 Were valid sampling techniques that protected against bias employed?	☐ Met ☐ Partially Met	Not applicable

Specify the type of sampling or census used: <Text>	☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable
	Totals 0	Met Partially Met **N**ot Met NA UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☒ Claims ☒ Provider ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Claims, provider ratings in CalOMS Admissions and Discharge Summaries. If the study had continued, it would have been helpful to add a client self-report rating measure such as TPS
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Study did not become an active PIP
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:*	☐ Met ☐ Partially Met ☐ Not Met	Study did not become an active PIP

☐ Survey ☐ Medical record abstraction tool ☒ Outcomes tool ☒ Level of Care tools ASAM ☒ Other: Contractor claims and utilization data	☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Only partially.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Julianne Schmidt, LMFT Title: Quality Support Team BH Clinician III Role: Collect and analyze the data *Other team members:* Names:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Need to specify data analytic qualifications of person in charge of data collection.
	Totals 6	Met Partially Met Not Met UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:* 1). Case Manager engages in discharge planning with RTC 2) Case manager coordinates or provides transportation 3) Case Manager provides services immediately upon RTC's discharge of client 4) Case manager arranges treatment services within one day of RTC discharge	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Study did not become an active PIP
	Totals 1	Met Partially Met Not Met UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Study did not become an active PIP

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Study did not become an active PIP
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors	☐ Met ☐ Partially Met	Study did not become an active PIP

that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? *Indicate the time periods of measurements*: *Indicate the statistical analysis used*: *Indicate the statistical significance level or confidence level if available/known:*	☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* Recommendations for follow-up: Discontinue the study and begin consideration of a different topic for the clinical PIP	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Study did not become an active PIP
Totals 4		Met Partially Met Not Met NA UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Study did not become an active PIP

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

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	Study did not become an active PIP

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: This PIP was in the early conceptual stage. A process was identified for interventions with resulting success. Problems were not identified with the interventions warranting improvement.		
Recommendations: Discontinue this topic and consider another one for the Clinical PIP.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

DMC-ODS:

Start Date (7/27/18):

Completion Date (study phase in progress):

Projected Study Period (12 Months):

Completed: Yes ☐ No ☒

Date(s) of On-Site Review: 12/5/18

Name of Reviewer:

Tom Trabin, Ph.D., MSM

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

Rated

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

☐ Completed since the prior External Quality Review (EQR)

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

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

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

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

The goal of this PIP is to implement procedures to improve timely linkage to non-methadone MAT services following an initial intake and assessment for MAT. The MAT program has been operating for ten years. Among its protocols are a requirement for clients to participate in outpatient treatment for addiction lifestyle change adjunctive to MAT. The program developed more cumbersome and lengthy admission processes to ensure that clients understand and make a commitment to the outpatient treatment requirement. Staff are under the impression that the combination of this requirement and the lengthier admission process contribute to a high dropout rate before MAT begins. The PIP study phase will help define what pre-MAT processes should be changed during the PIP with the goals of improving the percentage of clients who start MAT (engagement) and continue with MAT for at least a predefined minimum period of time (retention).

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did San Luis Obispo develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MAT provider team was cited as the only stakeholder group asked for their input thus far. Subsequently, the plan is to survey clients about their experiences at walk-in clinics and reasons for their pasts successful and unsuccessful MAT treatment episodes.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Local data was collected on substantial early dropout rates of 63 percent, and an average time from first intake to first MAT session of 9.75 days. National research was cited in the PIP that suggested a common cause of early SUD treatment dropouts to be lengthy intake and admissions processes However, the San Luis Obispo MAT Program had substantial dropout rates in previous years that they attributed to clients who weren't prepared to commit to outpatient treatment for addiction lifestyle change adjunctive to MAT. The MAT program lengthened the intake process to work with ambivalent clients prior to first MAT session in the hope of reducing the dropout rate or at least bringing it about prior to the first MAT session. There were no comparisons between the current dropout rate with longer intake times and the earlier one with shorter processes.

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

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The proposed PIP addresses access to and timeliness of care. It has yet to become an active PIP.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The proposed PIP addresses all enrollees who meet the medical necessity criteria for MAT.
	Totals 4	Met Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* We are working to identify interventions we can implement to improve retention and engagement in services as evidenced by percentage of clients who receive their initial post walk-in MAT service	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The question is stated in exploratory terms that match the conceptual phase of this PIP. The program generated substantial dropouts at least in part by requiring a client commitment to outpatient treatment for addiction lifestyle change adjunctive to MAT. They will need further preliminary study to identify whether this is the primary factor contributing to the dropout rate rather than lengthy intake processes. Also, they set this requirement believing it was essential for longer-term client retention in treatment and successful client outcomes. They should include in the PIP some measurement of the impact that their interventions have on client retention and on client progress in treatment.
	Totals 1	Met Partially Met Not Met UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MAT program is open to all enrollees who meet medical necessity criteria for MAT.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: ASAM Level of Care Results	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	yes
	Totals 2	Met Partially Met Not Met UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Percent of clients who begin the MAT program intake process and go onto receiving their first MAT.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is not yet active. Study indicators under consideration focus only on the percent of clients who were seen for an intake session and later had a first MAT session. Some of the PIP's possible interventions will undo previous changes made to the intake and admissions process that were originally designed to strengthen client retention and outcomes. Undoing these changes might inadvertently compromise lengthier retention in the program and success in treatment. It would be advisable for the PIP to include data on retention and on client progress mid-treatment in substance use, daily functioning and quality of life.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client/consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☐ No Are long-term outcomes implied? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is not yet active. The MAT Program already collects data on quality of life that can be used for measuring client progress in treatment, but they do not analyze the data nor include it in the PIP. They should consider this, as well as a measure of changes in client substance use.
	Totals 2	Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable. The proposed PIP considers several types of interventions, which can be explored through a QI PDSA design or an experimental design with random assignment to two or three experimental groups. The latter is not currently under consideration, so the issues of sampling do not pertain.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable (see comment in 5.1)

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable (see comment in 5.1)
	Totals 3	**Met** **Partially** Met **Not** Met Not Applicable UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes—basically encounter data for first intake and first MAT session. However, given the issues of retention and of other assumed factors contributing to clinical progress, it would be advisable if the PIP included encounter data for retention and other client data reflecting changes in substance use and quality of life.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ASAM ☒ Claims ☒ Provider ☐ Other: Client data from EHR	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, for the minimal data specified in the study. More data should be analyzed relevant to client retention and outcomes (see 6.1)

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ASAM ☒ Other: Claims/encounter data	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is not yet active, so data instruments are not yet finalized for routine data collection.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Only partially, it being premature to specify completely while still in the conceptual phase working out details. The person in charge of the data analysis is specified along with her qualifications. Some of the measures are specified but not others yet to be added. The eventual data analysis plan should describe the sequence of data collection, extraction, analysis, and reporting, and it should also describe the periodicity (monthly or at least quarterly) for reporting so that quality improvement opportunities can be used for further learning and PIP design refinements.
6.6 Were qualified staff and personnel used to collect the data? *Project co-leaders:* Name: Amanda Getten. LMFT Title: Managed Care Program Supervisor Role: PIP Lead *Other team members:* Names:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Ms. Getten is described as having studied research methods and statistics during her undergraduate and graduate studies and has been the lead on previous PIPs. She will consult with a Research Methods professor at Col Poly for assistance with some of the statistical calculations.
	Totals 6	Met Partially Met Not Met UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is not yet active
Totals 1		Met Partially Met Not Met NA UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? *Indicate the time periods of measurements:* *Indicate the statistical analysis used:* *Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interventions:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
	Totals 4	Met **Partially** Met Not Met NA UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? *Was there:* ☐ Improvement ☐ Deterioration *Statistical significance*: ☐ Yes ☐ No *Clinical significance*: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP is not yet active.
	Totals 5	Met Partially Met Not Met NA UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	The PIP is not yet active.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions:		
Recommendations:		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	

Attachment D—County Highlights

None submitted.

Attachment E—Client Focus Group Forms

Client focus group forms
Parents/ Guardians of Adolescent Clients Focus Group Feedback

Program/Clinic Name: _____ Date: _____

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

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

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

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

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

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

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

---

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


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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





Strongly Disagree Disagree Undecided Agree Strongly Agree

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





Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

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

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

Client focus group forms
Transitioning Age Youth (TAY) Focus Group Feedback

Program/Clinic Name: _____ Date: _____

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

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

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

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

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

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

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

---

1. I easily found the treatment services I needed.


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

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


Strongly Disagree


Disagree


Undecided


Agree


Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

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

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

Client focus group forms
Adult Client Focus Group Feedback

Program/Clinic Name: _____ Date: _____

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

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

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

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

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

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

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

---

1. I easily found the treatment services I needed.





Strongly Disagree Disagree Undecided Agree Strongly Agree

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





Strongly Disagree Disagree Undecided Agree Strongly Agree

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





Strongly Disagree Disagree Undecided Agree Strongly Agree

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





Strongly Disagree Disagree Undecided Agree Strongly Agree

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





Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

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

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

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

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

Attachment F—Summary of Access Call Center Key Indicators

Access Line Performance Measure

Overview/ Analysis

Average Monthly Call Volume in Last 12 months:
Average Monthly Calls: **2398 from** 1/1/2018 **to** 10/25/2018

Average Dropped Calls Per Month: Not yet tracked

Average Wait Time on the Phone until Answered: Not yet tracked

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

Software/Vendor for Tracking Call Metrics:
Software Name: AT&T (to be installed and operational March 2019)
Software Version: Voice Over Internet Protocol (VOIP)
Or ☒ *DMC-ODS Data Not Available*

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

Attachment G—Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Capacity

County: San Luis Obispo Review Date(s): 12/4/2108 – 12/5/2018

Persons Completing Form: Clark Guest, Program Supervisor and Star Graber, Division Manager

County Role for Access and Coordination of care for persons with SUD requiring social work/linkage/peer supports to coordinate care and ancillary services.

Describe County Role and Functions linked to access and coordination of care:

The County of San Luis Obispo handles access and coordination internally throughout the entire county with four (4) adult and one (1) youth access point. We have established a continuous flow of services between hospitals, outpatient services, MAT, and residential care. Beneficiaries access our services by coming to the walk-in clinics (see Attachment A—Walk-In Schedules) or our local hospitals will call our agency requesting services for their patients. Once a beneficiary has accessed one of our county access points for services, they come in to contact with our access team and a provisional level of care determination will be made while using the ASAM assessment instrument. During this initial access, they will meet with an Intake Clerk, Assessment Coordinator (LPHA for ASAM Determination), Licensed Psychiatric Technician (LPT), and an Assessment Case Manager to help ensure that their initial needs are met at one time and one spot and subsequent appointments are made prior to exiting the clinic during this crucial initial contact. When available, Peer Support Volunteers are present for hospital outreach as well as within our walk-in clinics.

Intake Clerk (IC)—Greets and welcomes the beneficiary, explains and helps to fill out the initial paperwork and various Consents and required forms. Notifies the Assessment Coordinator that the beneficiary is ready for their initial screening. Beneficiaries are triaged, if a crowd shows up.
Assessment Coordinator (AC)—Welcomes the beneficiary and starts to form the therapeutic alliance. Performs the initial screening, comes up with an initial provisional level of care (ASAM), sets the beneficiary with their initial appointments for their next steps, including their treatment options

(individual/group times days, drug testing color, case management services), has the client drug test and places them on color code drug testing. **Licensed Psychiatric Technician (LPT)—Welcomes the beneficiary, assesses for any medical needs, assesses for possible withdrawal management and/or Medication Assisted Treatment (MAT). May conduct any physical health care assessments, if needed. Provides naloxone education for all individuals with opiate use disorder or at high-risk for overdose.** **Assessment Case Manager—Welcomes the beneficiary and assesses for any initial and immediate needs such as food, housing, transportation, health needs/insurance, and need for peer-to-peer support. Sets the next steps for any case management services.** **Peer Support Volunteers—When available, the hospital will call the Peer Support Volunteers to reach out to their patients with substance use issues. The Peers try and form an empathetic, warm bond while introducing the patient to available county resources and sometimes they provide transportation to treatment clinics. When the patient is available, the Peer Support Volunteer will show up at our walk-in clinic and welcome the beneficiaries and offer their card with available male/female phone numbers to offer extra peer support which is available on a broad array of times.**

Case Management- Describe if it's centralized or integrated into programs or both:	
Monthly Estimated Billable hours of Case Management: $30,165	**FY 17-18 = 8784**

How are you structuring Recovery Services?

Recovery Services – Support services for clients in remission from SUD having completed treatment services, but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing peer support.			
Pick 1 or more as applicable and explain below: **1) Included with Outpatient sites as step-down** **2) Included with Residential levels of care as step down** **3) Included with NTPs as stepdown for clients in remission**			
Total Legal Entities:	**5**	Choice(s): 1	

Explanation: **Recovery Support Services are included with Outpatient sites as a step-down continuum of care. This is available to all of our beneficiaries at each one of our clinics. We have started to add the Recovery Support Phase at the tail end of treatment programs within our distinct**

levels of care and see this as a part of our normal phase down approach from treatment (decreasing level of care).

We have recently hired one temporary Student Intern-Recovery Support Specialist and have several volunteer peer-to-peer support individuals who all form a network to help link our beneficiaries from treatment services to community-based resources.

The Peer-to-Peer volunteers are a part of a newly formed local non-profit called SLO Co. Recovery Support Network and link up with the clients to help provide resources, events, and education for our community.

What is your estimated monthly estimated billable hours of recovery support services?

Estimated monthly billing for Recovery Support Services at this time: $5,861
Temporary Student Intern-Recovery Support Specialist can average 6-20 hours per week and is presently taking the classes included in the DMC-ODS Peer Support training plan. She will soon be granted computer access and start progress noting her own activities. The volunteer peer-to-peers average 9-15 hours per month.

Count of clients in Recovery Support Services for FY 17-18 = 72 (unduplicated count)
AT Adult RSS 1.0 = 10
AT Adult RSS MAT = 3
GB Adult RSS 1.0 = 11
GB Adult RSS MAT = 5
SLO Adult RSS ADC 1.0 = 20
SLO Adult RSS 1.0 = 10
SLO Adult RSS MAT = 13

Withdrawal Management Outpatient – withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).			
Number of Sites:	5	Estimated Billable hours per month:	$105

How are you structuring it? - ***Pick 1 or more as applicable and explain below***

1) **NTP?**
2) **Hospital**
3) **Outpatient**
4) **Primary Care Sites**

Choice(s): 3	

Explanation:
Access into our Withdrawal Management Outpatient program occurs during our walk-in process as established by the beneficiaries' ASAM assessment. Once medical necessity is established, the individual works with the LPT to establish an appropriate medication protocol under direction of the Nurse Practitioner. Telehealth has been established in each of the clinics for ease of access and continued medication management.

In FY 17-18:
14 Unduplicated count of clients who received services in Withdrawal Management Detox
43 Unduplicated count of clients who received services in Withdrawal Case Management

32 Services were provided to clients enrolled in **Withdrawal Management Detox**
Assessments = 2
Case Management = 7
Detox-Alcohol days = 18
Individual sessions = 1
WM MAT monitoring/ordering/administering = 4

289 Services were provided to clients enrolled in **Withdrawal Case Management**
Assessment = 1
Case Management = 153
ETG Drug Testing = 31
Pregnancy Tests = 2
UA Dip Tests = 21
UA Lab Tests = 54
Individual sessions = 7
WM MAT monitoring/ordering/administering = 20

How are you doing this?

Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports for the withdrawal.			
Number of Sites:	1	Estimated Billable Days:	unknown
Total Legal Entities:	**1 – Out of County contract provider**		

Pick 1 or more as applicable and explain below: 1) Hospitals 2) Freestanding 3) Within residential treatment center	
Choice(s) 3	

Explanation:
This level of care is established during our walk-in process by using the ASAM assessment instrument and/or increased level of care while beneficiary is in existing outpatient treatment levels of care.
This level of care has been contracted out to Tarzana Treatment Center (we are currently working on establishing more contracts) which is an out-of-county facility.
We also send beneficiaries to non-contracted, non-MediCal provider Withdrawal Management Residentials and are working on a better tracking system so all of these can be documented and reported.

Count of clients in any Residential subunit in FY 17-18 = 17
Bryan's House Peri = 5
Tarzana Peri 3.1 = 3
Tarzana Peri 3.3 = 2
Tarzana WM Tarzana 3.2 = 4
Tarzana Adult 3.3 = 2
Tarzana Adult 3.5 – 1

How are they organized?

NTP Programs- Narcotic Treatment Programs for opioid addiction and stabilization including counseling, methadone, and coordination of care.				
Total Slots:	225 in Co. slots 98 out of Co.		Number of Sites:	2+
Total Legal Entities:	**(1) Aegis Treatment Centers**			
Out of County NTP	**Slots:**	**98**	**Sites:**	**1 (Santa Barbara County)**
In County NTP	**Slots:**	**225**	**Sites:**	**1**

Comments:

Aegis has one clinic in San Luis Obispo County (Atascadero) and one clinic in closely neighboring Santa Barbara County (Santa Maria) that also provides care to beneficiaries of San Luis Obispo County.

Aegis Treatment Centers has not started using the ASAM assessment instrument so a level of care is not established unless the beneficiary comes through the County of San Luis Obispo Behavioral Health Department and we coordinate care.

MAT Outpatient (providing other drugs besides methadone)- Outpatient services providing MAT medical management including a range of medications other than methadone, usually accompanied by counseling for optimal outcomes.			
Total Legal Entities:	1	Number of Sites:	5

Comments:
Access into our MAT Outpatient program occurs during our walk-in process as established by the beneficiaries' ASAM assessment. Once medical necessity has been identified, the individual works with our LPT to establish the appropriate medication protocol. Telehealth has been established in each of the clinics for ease of access and continued medication management. This level of care is available in all five clinics. MAT Outpatient program is established within our SUD treatment clinics, so that clients are required to attend treatment services concurrent with MAT Outpatient and to adhere to the outpatient treatment protocols, including individualized level of care and treatment plan. Average monthly billing for MAT Outpatient: $22,089

Level 1: Outpatient – Less than 9 hours of outpatient services per week (6 hrs/week for adolescents) providing evidence based treatment.			
Average estimated billable hours per month:		***$ 242,671***	
Total Legal Entities:	1	***Total Sites for all Legal Entities:***	***5***

Comments:
Access into Level 1.0 Outpatient Treatment occurs during our walk-in process as established by the beneficiaries' ASAM assessment. Level 1.0 treatment can be 1-4 times per week on an individualized basis, depending on the beneficiary's severity. Once medical necessity has been established, the Assessment Coordinator will work with the beneficiary to establish an individualized treatment plan. I have enclosed a schedule of the Atascadero clinic for your example (See Attachment B).

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.			
Estimated Billable hours per month:	***$ 103,618***		
Total Legal Entities:	1	***Total Sites for all Legal Entities:***	**5**

Comments:
Access into Level 2.1 Intensive Outpatient Treatment (IOT) occurs during our walk-in process as established by the beneficiaries' ASAM assessment. Level 2.1 treatment can be 3-4 times per week (3 hours per day group) on an individualized basis, depending on the beneficiary's severity. Once medical necessity has been established, the Assessment Coordinator will work with the beneficiary to establish an individualized treatment program. I have enclosed a schedule of the Atascadero clinic for your example (See Attachment B).

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

Comments:

N/A

Level 3.1: Residential – Planned, and structured SUD treatment / recovery that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.			
Number of Program Sites:	2+	***Number of Legal Entities:***	***2***
Total Beds:	***5 women and children***		

Level 3.3: Clinically Managed, Population Specific, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.			
Number of Program Sites:	1	***Number of Legal Entities:***	***1***
Total Bed Capacity:	**As needed**		

(Can be flexed and combined in some settings with 3.5)

Comments:
San Luis Obispo County contracts for this level of care to Tarzana Treatment Centers and are currently working on setting up more contracts for services.

Level 3.5: Clinically Managed, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.			
Number of Program Sites:	1	***Number of Legal Entities:***	***1***
Total Bed Capacity:	***As needed***		

(Can be flexed and combined with 3.5)

Comments:
San Luis Obispo County contracts for this level of care to Tarzana Treatment Centers and are currently working on setting up more contracts for services.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??)			
Total Program Sites:	4	***Number of Legal Entities***	**2**
Total Bed Capacity:	***unknown***		

Comments:
We utilize our local hospitals, Arroyo Grande Community Hospital and French Hospital (both are Dignity Health), Sierra Vista Hospital and Twin Cities Hospital (both are Tenet) for continuum of care. If, during the walk-in process it is deemed necessary, our Assessment Team will access Emergency Medical Services to ensure that the beneficiary gets to immediate medical services.
We utilize a full-time clinician (Assessment Coordinator – LPHA) to work with the hospitals in San Luis Obispo and Arroyo Grande to help with transitioning any identified hospital patients to access services and to appropriate levels of care.
Peer-to-Peer volunteers are utilized at Twin Cities Hospital in Templeton (North County) to help with transitioning any identified hospital patients to access services and appropriate levels of care.

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting. (billing Health Plan/FFS can you access services?)

Total Program Sites:	4	***Number of Legal Entities-***	**2**
Total Bed Capacity:	***unknown***		

Comments:

We are working with our local hospitals to set up Memorandum of Understanding to establish a referral and transition system to Level 4: Medically Managed Intensive Inpatient Services as needed.

Other comments on Continuum of Care:

The County of San Luis Obispo has implemented a level of care system that has started to fill in all of the previous gaps we have experienced in the past and creates a well-balanced continuum of care. From the clinics to the hospitals, and from the hospitals to the clinics. Our relationships to these valuable resources have drastically improved and working together for the benefit of our beneficiaries seems to be everyone's common goal. Establishing an Assessment Team at all five county-operated clinics and implementing the ASAM assessment tool to determine established levels of care has proved essential for ease of operations and improved client care. We have established protocols for transferring between levels of care as well as between clinics and/or out-of-county resources. The Recovery Support Phase has been an added bonus with the DMC-ODS as we have utilized Alumnae groups for years to help with this area of transition and this will help expand existing resources. We still have some improvements to make and contracts to acquire with some additional levels of care and outside agencies, although these have been easily identified and are attainable.

Attachment H—Acronym List Drug Medi-Cal EQRO Reviews

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

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

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