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DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

SAN BERNARDINO DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
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SAN BERNARDINO DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2018-19 — 4,327
San Bernardino Threshold Language(s) — Spanish
San Bernardino Size — Large
San Bernardino Region — Southern
San Bernardino Location — San Bernardino
San Bernardino Seat — San Bernardino
San Bernardino Onsite Review Process Barriers — None

Introduction

San Bernardino County is comprised of 20,053 square miles, the largest county in the contiguous United States with 24 incorporated cities. Its geography presents service challenges with diversity that includes urban, suburban and very rural communities.

San Bernardino officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in March 2018 for Medi-Cal recipients as part of California's 1115 DMC Waiver. In this report, "San Bernardino" shall be used to identify the San Bernardino DMC-ODS program unless otherwise indicated.

San Bernardino County includes 93 percent of land that is desert and 82 percent that is vacant. Thirteen percent of the land is used for military purposes and five percent is dedicated to housing, industry, utilities, agriculture, transportation and parks. As of 2018 San Bernardino population was 2,857,960 with 35 percent on Medi-Cal and the majority ethnic populations being Caucasian (44 percent) and Latino/Hispanic (39 percent). The county is divided into five regions including Central, East and West Valley, High Desert/Mountain and Morongo Basin, with service continuums in each of the areas. The major employers are from education, health care and retail industries. The San Bernardino cost of living is low, but homelessness is still a concern as in other counties.

During this FY 2019-20 San Bernardino review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to DMC-ODS access, timeliness, quality, and outcomes. This is the first-year of DMC-ODS services implementation in San Bernardino. More details from the EQRO-mandated review are provided in the full report. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2018-19.

Access

San Bernardino began the Waiver stakeholder planning process in April of 2015 and included community meetings, county advisory groups and focus groups prior to DMC-ODS Implementation. Stakeholders included the San Bernardino County Board of Supervisors, contract providers, physical health care providers, managed health plans, health clinics, client and advocacy groups, County Executives, Public Health, Human Services (called Transitional Assistance in San Bernardino), Probation and other law enforcement partners. These partner agencies continue to work with the Department of Behavioral Health Substance Use Disorders Recovery Services (DBH SUDRS) to provide feedback and collaboration as part of the ongoing Waiver process.

Prior to the 1115 Waiver San Bernardino had an extensive continuum of care including prevention, outpatient/intensive outpatient, residential treatment, withdrawal management, recovery centers, and medication assisted treatment (MAT) including methadone and alternative addiction medicines. The San Bernardino Screening Assessment and Referral System (SARC), established in 2014, was also in place prior to the Waiver and provided both phone and drop-in screenings.

During FY 2018-19 the Access Call center received 7,778 calls and completed 5,254 screenings. In February of 2019 SARC became unable to effectively manage the increasing volume of calls for screenings and for authorizations of residential services in a timely manner. San Bernardino has recognized this issue and hired seven new staff to assist with screening and case management. They are also making changes to the SARC process flow and shortening the screening form. These changes in call volume and demand have occurred in many counties in their first year of operations under the DMC-ODS.

San Bernardino was successful in transitioning the majority of their SUD services continuum into the DMC-ODS system in this first year with an even mix of outpatient, residential and narcotic treatment program (NTP) services. The NTPs offer all required MAT including methadone, buprenorphine, naloxone (Narcan), and disulfiram. San Bernardino has defined recovery services and how they want programs to deliver them, and contract providers are ready to begin this service as soon as the Board of Supervisors approves the plan on October 22, 2019.

San Bernardino hired an Addiction-certified Physician to support the expansion of non-methadone MAT including injectable naltrexone (Vivitrol). They will be continuing their Clinical PIP for a second year with an expanded focus on expansion of all MAT services through all levels of care in their SUD continuum. San Bernardino has started an Emergency Department (ED) Bridge Partnership with Arrowhead Regional Medical Center (ARMC) for ED access to buprenorphine and linkage to continued treatment. A small number of clients have been served. They also have a two-way mutual agreement for referral processes with Global Medical Detox, a hospital that provides Voluntary Inpatient Detox (VID, located in Menifee, Riverside County that accepts San Bernardino County Medi-Cal. This program qualifies for ASAM level 3.7 withdrawal management

(WM). The program also provides ambulatory transportation to the hospital and to the next level of care upon discharge.

San Bernardino DBH-SUDRS currently contracts with multiple SUD providers who operate in various locations, offering services to beneficiaries in the Central, West, and East Valley, High Desert/Mountain Communities and Morongo Basin. There are currently thirty-three SUD treatment locations, providing the following services:

- Outpatient: Adult 17 locations/Adolescent nine locations
- Intensive Outpatient Treatment: Adult 13 locations/Adolescent nine locations/Perinatal three locations
- Residential Treatment (3.1, 3.3, 3.5): Adult seven locations/Adults with children three locations
- Residential Withdrawal Management: Adult four locations/Adolescent one location
- NTP: five locations

In addition, San Bernardino has seven Community-Based Recovery Service Centers that provide a supportive substance-free environment where persons in recovery and those seeking recovery can work to secure resources that will help them sustain and strengthen their recovery efforts. These centers host some of the identified treatment programs but are available to clients on a drop-in basis.

San Bernardino has established contracts with 3 recovery residence providers which provides 33 available beds. These recovery residences are used to assist clients to step down from residential treatment into a lower level of care. In addition, they have an array of clean and sober housing provided by many providers in their community. They utilize long-term shelter beds to house persons while they remain in treatment with the Department of Behavioral Health (DBH), providing dedicated funding to manage over 200 beds that will increase to 265 beds in the next year.

San Bernardino has excellent collaborative efforts with criminal justice partners. These include a drug court program, SUD counselors embedded in the Probation Day Reporting Centers, and SUD counselors working in the Juvenile Detention and Re-entry program for adults leaving jail with treatment and support based on needs and ASAM assessment data. The drug court program, at one provider location, is hosting the first year Clinical PIP to determine how to expand the use of Vivitrol with the criminal justice population.

Substance Use Disorder (SUD) clinics have been established and DMC-certified as part of the county-operated mental health clinics in the four major districts. The board-certified addictionologist has trained psychiatrists working in these clinics to provide MAT so that mental health clients with addiction issues will have access to both medication and non-MAT addiction treatment. Psychiatrists are also assisting with MAT for clients with SUD-only services.

San Bernardino participates in the Inland Opioid Coalition that meets quarterly and includes participation from the DBH Addiction Physician. This is an active coalition with participation from executive leadership and MAT sub-committees that meet monthly. They have goals for safer prescribing, emergency response tool kits, and increasing the X-waivered providers so that MAT and Naloxone distribution can increase throughout networks of the Health Plans.

Timeliness

San Bernardino is in process of implementing an electronic health record (EHR) utilizing Netsmart Avatar, but at the time of the review San Bernardino was measuring timeliness data without benefit of this electronic tool. The EHR is scheduled to be implemented in March of 2020.

Timeliness was measured at the SARC with an access data base showing that there are delays for persons getting into residential treatment, and confirmed by the staff and client focus groups. A plan to resolve this is being implemented.

San Bernardino can measure timely access to county-operated clinics by phone and walk-in but cannot yet measure timely access for contract providers. They are collecting reporting tools being used by the contract providers and will be developing a reporting mechanism to be started in the second year. San Bernardino can track timeliness to first face-to-face for any provider if the client starts at SARC. They report that only 30 percent of adults and 13 percent of children currently meet their standard of ten days from time of first contact to first face-to-face session. San Bernardino produces a detailed annual report on the length of time between first contact at SARC and first treatment session that details the number of clients by number of days it takes to first treatment session, with the mean at 39.5 days.

San Bernardino does have a definition for urgent conditions but is not yet able to track timeliness for these services. This is identified in the electronic health record and training on the clinical process is being developed.

San Bernardino tracks the number of persons who exit WM and residential treatment and reports that 25 percent of this population transitions to any one of several other levels of care within seven days. The EQRO claims data reports on only those who leave residential treatment, excluding WM, and find that only five percent move to a lower level of care post-residential within seven days. As in other counties, the treatment culture change for service transition to lower levels of care is a priority and San Bernardino and their contract providers have made improvements to this process a primary focus for the second year of their DMC-ODS implementation.

San Bernardino does track unduplicated client counts annually for each fiscal year including indicators of gender, age, ethnic groups, preferred language and residence region.

Quality

San Bernardino has a continuum of care that includes all required levels of care. San Bernardino has a specific DMC-ODS Quality Improvement Performance Plan (QIPP) and evaluation that will be integrated with the mental health quality improvement plan next year. The Quality Improvement Program Committee (QIPC) oversees the implementation of the QIPP through the department infrastructure which includes workgroups, beneficiaries, peer and family advocates, DBH Administration/Management, and DBH staff and contract providers.

DBH SUDRS recently coordinated with mental health to train a cohort of with mental health and/or substance use treatment experience to review consumer outcomes. They will be trained and supported to attend QIPP committee meetings as well as to participate in events such as Recovery Happens. DBH believes this will increase the client voice in the QIPP committee process.

San Bernardino implemented a relapse response policy assuring clients are assisted when they relapse, helping clients to stay in treatment at the same or a higher level, and when discharge is necessary to assist clients in finding an alternative resource for support. The consistency with which the relapse policy is implemented was validated by providers and clients.

San Bernardino and contract providers have been successful at hiring staff at all levels of the organization. They promote a “Grow your Own” approach that provides promotional opportunities for internal staff with mentoring and training so they can become successful at the next level of the organization. Contract providers were able to build into their rate-setting negotiations a necessary set of wage increases to reduce staff turnovers that are otherwise experienced in many parts of California. DBH deploys additional strategies for staff recruitment and retention that include supporting physician fellowships with local universities and an addiction fellowship starting soon, that are proving successful at transitioning some students to permanent employees at DBH.

San Bernardino began their ASAM training several years prior to their Waiver implementation. Dr. Mee-Lee began their training with a large kickoff session and they followed up with three ASAM training modules that can be taken online. There were 193 assigned subscriptions for these modules in FY 2017/18 and on average 77 percent of those staff (including contract providers) completed all modules.

An important quality measure is the degree to which a DMC-ODS uses ASAM Criteria for guiding its referral placements at the onset and throughout treatment. In San Bernardino the congruence is quite high between the suggested level of care referral based on ASAM criteria findings and the actual referral made. San Bernardino showed results of a 97.3 percent congruence rate at the initial screening, 98.3 percent at the initial assessment and 96.5 at the follow up assessment. The highest reasons for any difference were clinical judgment and patient preference.

The Cultural Competency Plan update has strategies to reach DMC-ODS underserved populations including persons who identify as lesbian, gay, bisexual, transgender and queer (LGBTQ), youth and Latino/Hispanic. These strategies include outreach activities, training providers in cultural competence and engaging the communities in creative ways. CalEQRO suggested that San Bernardino increase their involvement with faith-based communities to heighten awareness in the community of SUD services and to engage those in the Latino/Hispanic community who can be reached through their church connection.

San Bernardino has developed excellent working relationships with their two health plans--Molina and Inland Empire--who coordinate with each other and through the Memorandum of Understanding (MOU) with the county. Joint projects include writing protocols for youth MAT, coordination of medical issues with the plans while clients are in residential treatment, and two projects that have co-location of behavioral health with primary care.

Outcomes

San Bernardino participated in the Treatment Perception Survey in October of 2018 and is planning to participate again this year. After receiving their reports from UCLA, they evaluated their overall results and compared themselves to the counties who had begun their Waiver services in 2017. The comparison showed them to be the same or higher in the five domains. They received 4.5 scores in quality, care coordination and general satisfaction, 4.3 in access and 4.4 in outcome.

San Bernardino presented these findings to contract providers, QIPP and the Quality Management Action Committee (QMAC). They were balanced in their report of these high scores, reminding contract providers that evidence of positive client satisfaction is not, in itself, sufficient to establish the effectiveness of treatment. They also identified other behavioral indicators they plan to track that would identify dissatisfaction with services including high drop-out rates, high no show rates and missed drug tests.

San Bernardino CalOMS data shows the county serves a higher percentage of clients who are not in the criminal justice system than is the combined average for all other DMC-ODS counties statewide (71 percent compared to 60 percent). San Bernardino providers rated their clients' progress at the time of discharge relatively lower than the statewide average, with only 38 percent rated as improved compared with 42 percent statewide. This is an important difference which bears exploring and signals an opportunity for focusing on improvements.

Client/Family Impressions and Feedback

Three stakeholder groups were held in San Bernardino County that included clients from a women's perinatal outpatient program, an adult MAT program and a youth outpatient program. There were a total of 32 participants across the three groups. The scores were primarily in the four range with some scores in the three range of a scale of

1 – 5. There were a high number of undecided scores that came primarily from the youth.

The perinatal outpatient participants described long waits in regard to access to sober living, and were required to call in daily while awaiting bed availability with reportedly no offer of interim services. Some women described a previous experience of being discharged from residential programs due to relapsing. Some women who had a relapse while in an outpatient program remarked that they were then placed on a behavioral contract under which they were allowed to remain in the program.

The perinatal outpatient program participants found the recovery center to be very helpful and described it as doing all it can. They did want more resources such as help with jobs, housing and transportation as well as assistance with school options to determine that their choices were going to help them be successful. They wanted more one to one counseling. They suggested that if more of the services they needed, such as domestic violence counseling and parenting classes, could be under one roof it would be more efficient for them. Recommendations included longer office hours, more one to one counseling and more interaction and navigation assistance for transition from the program.

The adult MAT outpatient participants reported that the stigma for MAT remains an issue with family and friends. They did find support for MAT was encompassed throughout the entire program from induction to completion; in addition, staff would work with those who wanted to get off MAT once they were stable. Several participants discussed previous experiences of waiting lists and required daily calls to get into residential treatment with no services offered in the interim. They did report that services were easily found and as a result of those services they felt more equipped to do things they want.

The adult MAT outpatient participants found the staff helpful and said that counselors seemed to be doing all they could to help the participant. They liked their counselors and reported the program “strives to help us get better”. Everyone on staff was seen as supportive. Participants suggested for improvements that there be more groups and a process to more easily get take-home medications for workdays when coming to the treatment program would not be feasible. Recommendations included expanded hours on weekends, more counselors, and receiving positive feedback when testing clean.

The youth outpatient participants reported the services they received as helpful and found that they assisted with problem solving. Some youth reported that they loved their counselors. They identified that additional assistance to quit smoking and stay sober was needed; however, some wanted to have less drug testing. The youth participants’ only recommendation was to go on more trips and have fun.

Recommendations

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

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has 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 2019-20 EQR findings of San Bernardino's CY 2018 implementation of their DMC-ODS by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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

[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.

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.caleqro.com/pip-library. PIPs usually focus on access to care, timeliness, client satisfaction/experience of care, and expansion of evidence-based practices and programs known to benefit certain conditions.

DMC-ODS Information System Capabilities[3]

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

Validation of State and County Client Satisfaction Surveys

CalEQRO examined the 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 satisfaction surveys. DHCS Information Notice 17-026 describes the TPS process in detail and can be found on the DHCS website for DMC-ODS. The results each year include analysis by UCLA for the key questions organized by domain. The survey is administered at least annually after a DMC-ODS has begun services and can be administered more frequently at the discretion of the county DMC-ODS. Domains include questions linked to ease of access, timeliness of services, cultural competence of services, therapeutic alliance with treatment staff, satisfaction with services, and outcome of services. Surveys are confidential and linked

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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.

to the specific SUD program that administered the survey so that quality activities can follow the survey results for services at that site. CalEQRO reviews the UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

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

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.

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

Discussed in the following sections 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

DBH has worked hard to fill vacancies, add specialized providers and increase staffing as appropriate and necessary, which has led to significant personnel changes to the organization, including, but not limited to the following:

- Hired the Chief of Quality Management, Tamara Weaver
- Hired the Chief Financial Officer, Tan Suphavarodon
- Increased staffing for Information Technology
- Hired an Addiction Medicine Physician, Jonathan Avalos, MD
- Hired the Senior Program Manager for Substance Use Disorder and Recovery Services, Alyce Belford, PhD
- Hired the Cultural Competency Officer, Maribel Gutierrez

Past Year's Initiatives and Accomplishments

- Effective March 1, 2018, implementation of the Drug Medi-Cal (DMC) ODS Waiver began. Billing went live August 2018.
- Effective March 19, 2019, San Bernardino County moved from contracting with withdrawal management and residential treatment providers by annual number of beds for each contract agency to an aggregate amount of funding annually that is shared by providers and is not limited by annual number of beds. All residential and withdrawal management providers can access this shared aggregate amount.
- The opening, operation and billing began for delivery of services for the remaining three Community Residential Treatment (CRT) Centers and two Community Stabilization Units (CSU) that were established to address the immediate crisis needs of individuals residing in the County of San Bernardino.
- As a result of the passage of Assembly Bill (AB) 1810, DBH established a diversion program, Diversion Opportunities for Outpatient Recovery Services (DOORS), for individuals with serious mental illness who face felony charges and are determined to be incompetent to stand trial (IST). Many of these individuals have co-occurring mental health and substance use disorders.
- Expansion of Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program in the City of Barstow began, with the mission to address the growing population of probationers needing behavioral health services.
- DBH SUDRS secured $865K in funding through the Department of Health Care Services (DHCS) from Senate Bill (SB) 840 – Homeless Mentally Ill Outreach and Treatment Program to provide one-time funding for activities involving

individuals with serious mental illness, and who are homeless or at risk of becoming homeless.

- Effective January 1, 2019, as a result of AB 1214, the Juvenile Justice program implemented a competency restoration program for adolescents when the court has a doubt as to the competence of the minor.
- DBH established a Child Psychiatrist Fellowship agreement with Loma Linda University.
- San Bernardino administered the Treatment Perception Survey (TPS) and used data elements from the CalOMS data set as an outcome measure. San Bernardino also implemented ASAM Level of Care Referral Data for screening and assessment of clients. For more information about CalOMS, TPS, and ASAM Level of Care, go to:

  CalOMS Treatment Data Collection Guide:

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

  TPS:

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

  ASAM Level of Care Data Collection System:

  http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

San Bernardino Goals for the Coming Year

- Medication Assisted Treatment (MAT) Initiative: Expand Narcan program; implement withdrawal management within outpatient clinics for the purpose of the ED Bridge program; and implement an NTP medication unit in Ridgecrest to meet network adequacy and service access for the residents of Trona, CA.
- Care Coordination Initiative: Expand care coordination to include outpatient and intensive outpatient programs; streamline care coordination processes through expansion of the placement coordinator role; develop a resource network for care coordinators; and identify quality improvement opportunities with providers.
- EPSDT/Adolescent Services Initiative: Improve screening and referral processes to enhance access to services; identify training needs and collaboration opportunities with children’s behavioral health programs.
- Training Initiative: Continue providing trainings around addiction medicine, MAT, including Narcan and Vivitrol trainings; continue ASAM e-module trainings; and continue trainings in evidence-based practices to ensure fidelity to services delivery.

- Integration Initiative: Integrate selected services with the Managed Care Plan--Inland Empire Health Plan (IEHP)--to create a continuum of integrated care across physical, mental and behavioral health services.
- Implement an Electronic Health Record for substance use disorders, recovery services and mental health services.
- Fully implement recovery services through development of policies and procedures; hiring and training peer support specialists; and, integrating recovery services into the continuum of care.

PERFORMANCE MEASURES

The purpose of PMs is to foster access to treatment and quality of care by measuring indicators with solid scientific links to health and wellness. CalEQRO conducted an extensive search of potential measures focused on SUD treatment, and then proceeded to vet them through a clinical committee of over 60 experts including medical directors and clinicians from local behavioral health programs. Through this thorough process, CalEQRO identified 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.

For counties beyond their first year of implementation, four additional performance measures have been added. They are:

- Use of ASAM Criteria in screening and referral of clients (also required by DHCS for counties in their first year of implementation)
- Initiation and engagement in DMC-ODS services
- Retention in DMC-ODS treatment services
- Readmission into residential withdrawal management within 30 days

HIPAA Guidelines for Suppression Disclosure:

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

Year 1 of Waiver Services

This is the first year that San Bernardino has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (CY 2018), and from UCLA for TPS, ASAM, and CalOMS data from CY 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 may be a claims lag for services in the data available at the time of the review.

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

CY 2018 Table 1 shows San Bernardino's number of clients served and penetration rates overall by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties.

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

Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

For San Bernardino, the adult age group 18-64 makes up the majority of DMC-ODS clients served (91 percent). Youth ages 12-17 are currently underserved with only a 0.09 percent penetration rate compared to 0.16 statewide. Adults ages 65 and over are proportionally underserved, but on par with the penetration rates for like-sized counties and statewide.

Table 1 – Penetration Rates by Age, CY 2018

Penetration Rates by Age CY 2018					
San Bernardino				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	112,402	99	0.09%	0.14%	0.16%
Ages 18-64	465,623	3,929	0.84%	0.78%	0.77%
Ages 65+	59,853	299	0.50%	0.55%	0.52%
TOTAL	**637,877**	**4,327**	**0.68%**	**0.65%**	**0.64%**

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).

Table 2 below shows San Bernardino's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. San Bernardino's overall average approved claims are slightly higher than claims statewide ($4,370 compared to $3,863). Average approved claims for youth are much lower than statewide claims ($480 compared to $1,430), while claims for older adults are more than twice as high ($7,420 compared to $3,168).

Table 2 – Average Approved Claims by Age, CY 2018

Average Approved Claims by Age CY 2018			
San Bernardino			Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	$47,488	$480	$1,430
Ages 18-64	$16,641,454	$4,236	$4,054
Ages 65+	$2,218,511	$7,420	$3,168
TOTAL	**$18,907,454**	**$4,370**	**$3,863**

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total beneficiaries served as clients. For San Bernardino, clients who are White are accessing services more readily than Hispanic/Latino, Asian/Pacific Islander, and Native American clients. African-American clients and clients who fall into the “Other” race/ethnicity category are almost proportionally receiving services.

Figure 1 - Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 2018

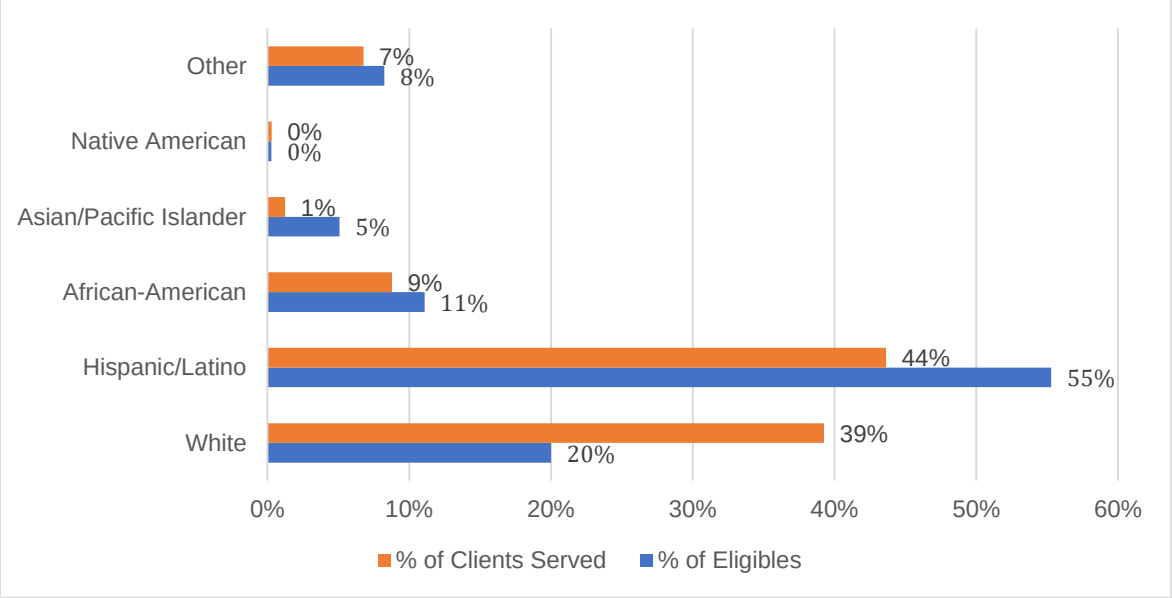


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. As discussed above, White clients have the highest penetration rate, slightly higher than the statewide rate. Latino/Hispanic clients have a penetration rate of 0.54 percent, slightly higher than the statewide rate of 0.46 percent.

Table 3 - Penetration Rates by Race/Ethnicity, CY 2018

Penetration Rates by Race/Ethnicity CY 2018					
San Bernardino				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	127,660	1,699	1.33%	1.36%	1.20%
Latino/Hispanic	352,641	1,888	0.54%	0.44%	0.46%
African-American	70,725	380	0.54%	0.95%	0.95%
Asian/Pacific Islander	32,482	54	0.17%	0.10%	0.11%
Native American	1,740	13	0.75%	1.44%	1.01%
Other	52,632	293	0.56%	0.65%	0.69%
TOTAL	**637,877**	**4,327**	**0.68%**	**0.65%**	**0.64%**

Table 4 below shows San Bernardino's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. The eligibility categories with the most clients served are ACA, Family Adult, and Disabled.

Table 4 – Clients Served and Penetration Rates by Eligibility Category, CY 2018

Clients Served and Penetration Rates by Eligibility Category CY 2018				
San Bernardino				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	65,573	564	0.86%	1.19%
Foster Care	2,983	38	1.27%	1.38%
Other Child	74,359	57	0.08%	0.17%
Family Adult	144,929	1,064	0.73%	0.63%
Other Adult	74,032	65	0.09%	0.07%
MCHIP	39,228	10	0.03%	0.11%
ACA	236,117	2,689	1.14%	1.01%

Table 5 below shows San Bernardino's approved claims per penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. Average approved claims for clients in the Disabled and Other Adult categories are higher than statewide. Claims for the three youth categories—Foster Care, Other Child, and MCHIP--are lower than statewide average claims.

Table 5 – Average Approved Claims by Eligibility Category, CY 2018

Average Approved Claims by Eligibility Category CY 2018				
San Bernardino				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	65,573	564	$5,707	$3,112
Foster Care	2,983	38	$362	$1,083
Other Child	74,359	57	$562	$1,337
Family Adult	144,929	1,064	$3,817	$3,281
Other Adult	74,032	65	$7,808	$2,928
MCHIP	39,228	10	$185	$1,710
ACA	236,117	2,689	$4,117	$4,274

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 need treatment for SUD. Foster Care, Other Child and Maternal and Child Health Integrated Program (MCHIP) include children of all ages contributing to a low penetration rate.

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in CY 2018. The majority of clients served in CY 2018 were in outpatient programs (36.7 percent). The next largest category was narcotic treatment programs (33.3 percent), followed by residential treatment (17 percent). San Bernardino has a robust continuum of care with clients reflected in most levels of care.

Table 6 - Percentage of Clients Served and Average Approved Claims by Service Categories, CY 2018

% of Clients Serviced and Average Approved Claims by Service Categories, CY 2018			
Service Categories	**# of Clients Served**	**% Served**	**Average Approved Claims**
Narcotic Tx. Program	1,624	33.3%	$8,227
Residential Treatment	831	17.0%	$5,222
Res. Withdrawal Mgmt.	316	6.5%	$1,700
Ambulatory Withdrawal Mgmt.	0	0.0%	$0
Non-Methadone MAT	64	1.3%	$1,581
Recovery Support Services	1	0.0%	$34
Partial Hospitalization	0	0.0%	$0
Intensive Outpatient Tx.	253	5.2%	$388
Outpatient Drug Free	1,789	36.7%	$263
TOTAL	**4,878**	**100.0%**	**$4,370**

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

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

Persons seeking methadone maintenance medication must first show a history of at least one year of opiate addiction and at least two unsuccessful attempts to quit using opioids through non-MAT approaches. They are likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they may soon resume opiate use and an addiction lifestyle that can be life-threatening. For these reasons, NTPs regard the request to begin treatment with methadone as time sensitive.

Median number of days indicated below for San Bernardino clients suggest they are able to access care in a timely manner, on average within one (1) day of diagnosis/assessment.

Table 7 –Days to First Dose of Methadone by Age, CY 2018

Days to First Dose of Methadone by Age CY 2018						
San Bernardino				Statewide		
Age Groups	Clients	%	Median Days	Clients	%	Median Days
Age Group 12-17	0	0.0%	n/a	5	0.1%	<1
Age Group 18-64	1,326	84%	<1	21,338	79.4%	<1
Age Group 65+	244	16%	<1	5,493	20.4%	<1
Total	**1,570**	**100%**	**<1**	**26,886**	**100%**	**<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 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 in addition 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 clinical consultation once they begin prescribing. Consequently, physician uptake throughout most counties throughout the state tends to be slow.

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

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

While the total number of clients receiving non-methadone MAT is rather low, San Bernardino is doing well at retaining those clients in services. Approximately 94 percent

received three or more services, which is much higher than the statewide percentage of 41 percent.

Table 8 – DMC-ODS Non-Methadone MAT Services by Age, CY 2018

DMC-ODS Non-Methadone MAT Services by Age, CY 2018								
	San Bernardino				Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	0	0.00%	0	0.00%	2	0.08%	1	0.04%
Ages 18-64	60	1.53%	56	1.43%	1,734	3.16%	723	1.32%
Ages 65+	4	1.34%	4	1.34%	121	1.86%	43	0.66%
TOTAL	**64**	**1.48%**	**60**	**1.39%**	**1,871**	**2.88%**	**767**	**1.18%**

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

Transitions in Care Post-Residential Treatment – CY 2018

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

Table 9 show two aspects of this expectation — (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment. 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.

Of the 862 clients discharged from residential treatment, only 135 (15.6 percent) had a transition to a lower level of care within any days. While this percentage is on par with the statewide percentage, this is an area for attention for San Bernardino to make sure clients discharging from residential are continuing to receive services to support their recovery.

Table 9 – Timely Transitions in Care Following Residential Treatment San Bernardino, CY 2018

Timely Transitions in Care Following Residential Treatment CY 2018				
	San Bernardino (n= 862)		Statewide (n= 20,141)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	42	5%	1140	5.7%
Within 14 Days	60	7%	1,579	7.8%
Within 30 Days	77	9%	1,987	9.9%
Any days (TOTAL)	**135**	**15.6%**	**2,895**	**14.4%**

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

Access Line Quality and Timeliness

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

Table 10 shows Access Line critical indicators from July 1, 2018 to June 30, 2019. San Bernardino does not currently have software to track key indicators, such as percentage of dropped calls and time to answer calls. This software is important to obtain to be able to monitor and track important metrics related to the operation of a centralized access line.

Table 10 – Access Line Critical Indicators, FY 2018-19

San Bernardino Access Line Critical Indicators July 1, 2018 through June 30, 2019	
Average Volume	603 calls per month
% Dropped Calls	Software does not track
Time to answer calls	Software does not track
Monthly authorizations for residential treatment	215
% of calls referred to a treatment program for care, including residential authorizations	90% of callers are linked to treatment through the Access Line
Non-English capacity	DBH utilizes bilingual staff and interpretation services; formal language policies and procedures, and vendors are in place.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services in San Bernardino. 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 $11,172 approved claims per year. The table lists the average approved claims costs for the year for San Bernardino 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. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

San Bernardino had 616 clients (14 percent of all client served) whose costs met the criteria for high cost beneficiaries. The costs for this group accounted for over half of total claims (52 percent) in San Bernardino. The average costs per client in this group were substantially lower than the average cost for high cost beneficiaries statewide.

Table 11a – High Cost Beneficiaries by Age, San Bernardino, CY 2018

San Bernardino High Cost Beneficiaries by Age, CY 2018						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	99	0	n/a	n/a	n/a	n/a
Ages 18-64	3,929	543	14%	$15,902	$8,634,877	52%
Ages 65+	299	73	24%	$15,205	$1,109,937	50%
TOTAL	**4,327**	**616**	**14%**	**$15,820**	**$9,744,814**	**52%**

Table 11b – High Cost Beneficiaries by Age, Statewide, CY 2018

Statewide High Cost Beneficiaries CY 2018					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	2,498	25	1.0%	$17,005	$425,116
Ages 18-64	54,833	3,939	7.2%	$29,974	$86,556,047
Ages 65+	6,511	173	2.7%	$20,893	$3,614,507
TOTAL	**64,870**	**4,137**	**6.4%**	**$21,899**	**$90,595,670**

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.

Of 315 clients who received withdrawal management services, only 0.32 percent had three or more episodes with no other services, which was much lower than the statewide average of 1.95%.

Table 12 – Residential Withdrawal Management with No Other Treatment, CY 2018

Residential Withdrawal Management with No Other Treatment CY 2018				
	San Bernardino		**Statewide**	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	315	0.32%	3,794	1.95%

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

Use of ASAM Criteria for Level of Care Referrals

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

San Bernardino has high congruence between the initial assessment and the referred level of care (97.3 percent). When the assessed level of care is different than the referred level, the reason is most often due to the level of care not being available (0.9 percent).

Table 13 - Congruence of Level of Care Referrals with ASAM Findings, CY 2018

Congruence of Level of Care Referrals with ASAM Findings, CY 2018						
San Bernardino ASAM LOC Referrals	**Initial Screening**		**Initial Assessment**		**Follow-up Assessment**	
March 2018 to August 2019	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference	219	97.3%	525	98.3%	28	96.5
Not Applicable - No Difference	1	0.4%	4	0.7%	0	0.0%
Patient Preference	1	0.4%	0	0.0%	0	0.0%
Level of Care Not Available	2	0.9%	4	0.7%	1	3.4
Clinical Judgement	1	0.4%	0	0.0%	0	0.0%
Geographic Accessibility	0	0.0%	0	0.0%	0	0.0%
Family Responsibility	0	0.0%	0	0.0%	0	0.0%
Legal Issues	1	0.4%	0	0.0%	0	0.0%
Lack of Insurance/Payment Source	0	0.2%	1	0.2%	0	0.0%
Other	0	0.0%	0	0.0%	0	0.0%
Actual Referral Missing	225	100.0	534	100.0%	29	100.0%
TOTAL	219	97.3%	525	98.3%	28	96.5

Diagnostic Categories

Table 14 compares the breakdown by diagnostic category of the San Bernardino and statewide number of beneficiaries served and total approved claims amount, respectively, for CY 2018. Opioids (45.5 percent), stimulants (29.9 percent), and alcohol (13.7 percent), were the most prominent types of SUDs addressed by San Bernardino's DMC-ODS treatment providers. Average cost to treat opioid disorder in San Bernardino was higher than the statewide average ($7,329 compared to $3,372).

Table 14 – Percentage Served and Average Cost by Diagnosis Code, CY 2018

Percentage Served and Average Cost by Diagnosis Code, CY 2018				
Diagnosis Codes	San Bernardino		Statewide	
	% Served	Average Cost	% Served	Average Cost
Total	**100%**	**$4,369**	**100%**	**$4,010**
Alcohol Use Disorder	13.7%	$2,570	16.0%	$5,870
Cannabis Use	8.9%	$891	8.0%	$1,116
Cocaine Abuse or Dependence	1.2%	$2,493	2.4%	$5,342
Hallucinogen Dependence	0.2%	$2,914	0.3%	$4,353
Inhalant Abuse	0.0%	$0	0.0%	$4,785
Opioid	45.5%	$7,329	45.4%	$3,372
Other Stimulant Abuse	29.9%	$1,824	25.1%	$4,865
Other Psychoactive Substance	0.2%	$1,737	0.8%	$4,035
Sedative, Hypnotic Abuse	0.4%	$4,014	0.6%	$6,565
Other	0.2%	$4,427	1.4%	$3,730

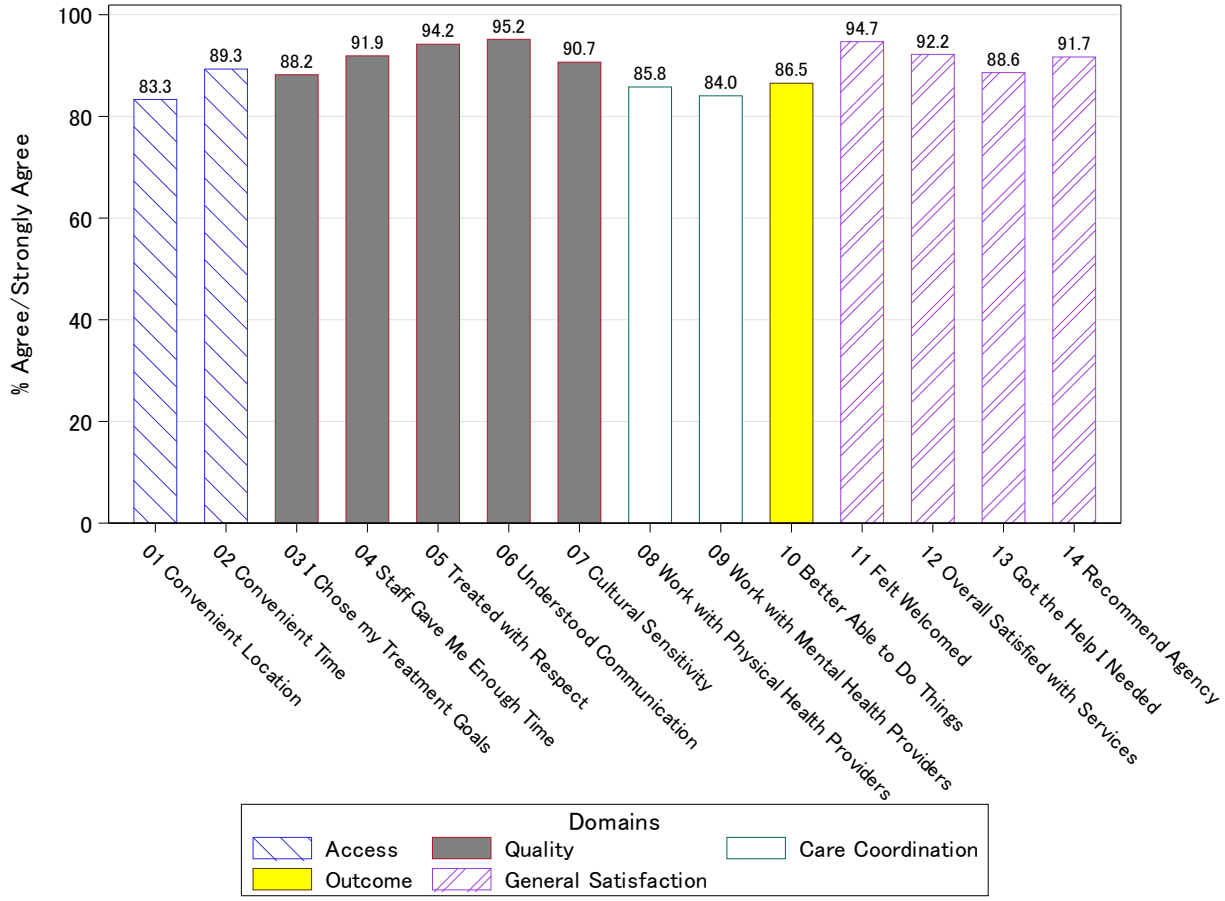
Asterisks, n/a and - indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Client Perceptions of Their Treatment Experience

CalEQRO regards the client perspective as an essential component of the EQR. In addition to obtaining qualitative information on that perspective from focus groups during the onsite review, CalEQRO uses quantitative information from the TPS administered to clients in treatment. DMC-ODS counties 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.

Clients who responded to the TPS were generally positive about their treatment experience in San Bernardino across all domains. The domains that were less high than others were: Convenient Location, Work with Physical Health Providers, and Work with Mental Health Providers. These three domains are the ones relatively lower in most other DMC-ODS counties as well.

Figure 2 - Percentage of Participants with Positive Perceptions of Care, San Bernardino, TPS Results from UCLA



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

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

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

San Bernardino has fewer clients who are homeless compared to statewide, but more clients whose status is dependent living.

Table 15: CalOMS Living Status at Admission, San Bernardino and Statewide, CY 2018

CalOMS Living Status at Admission CY 2018				
Admission Living Status	San Bernardino		Statewide	
	#	%	#	%
Homeless	1,125	21.0%	24,020	26.2%
Dependent Living	1,879	35.1%	26,296	28.6%
Independent Living	2,359	43.9%	41,472	45.2%
TOTAL	5,355	100.0%	91,788	100.0%

San Bernardino also has a higher percentage of clients with no criminal justice involvement compared to statewide (71 percent versus 59.8 percent).

Table 16 – CalOMS Legal Status at Admission, San Bernardino and Statewide, CY 2018

CalOMS Legal Status at Admission CY 2018				
Admission Legal Status	San Bernardino		Statewide	
	#	%	#	%
No Criminal Justice Involvement	3,804	71.0%	54,930	59.8%
Under Parole Supervision by CDCR	204	3.8%	2,288	2.5%
On Parole from any other jurisdiction	46	0.9%	890	1.0%
Post release supervision - AB 109	1,249	23.3%	28,801	31.4%
Court Diversion CA Penal Code 1000	18	0.3%	1,259	1.4%
Incarcerated	2	0.04%	389	0.4%
Awaiting Trial	32	0.6%	3,221	3.5%
TOTAL	5,355	100.0%	91,788	100.0%

Lastly, slightly more clients in San Bernardino were unemployed than the statewide average for DMC-ODS counties. However, among the unemployed San Bernardino had a much higher percent than statewide who were no longer looking for work (69 percent compared to 51 percent). Most of the clients in this category tend to be disabled.

Table 17 – CalOMS Employment Status at Admission, San Bernardino and Statewide, CY 2018

CalOMS Employment Status at Admission, CY 2018				
Current Employment Status	San Bernardino		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	599	11.2%	12,134	13.2%
Employed Part Time - Less than 35 hours	294	5.5%	7,259	7.9%
Unemployed - Looking for work	758	14.1%	25,522	27.8%
Unemployed - not in the labor force and not seeking	3,704	69.1%	46,873	51.1%
TOTAL	5,355	100.0%	91,788	100.0%

The information displayed in Tables 18-19 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 18 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment.

The majority of San Bernardino's discharges are Standard Adult Discharges (59.6 percent), and their administrative discharge rate is similar to the statewide rate.

Table 18 – CalOMS Types of Discharges, San Bernardino and Statewide, CY 2018

CalOMS Types of Discharges, CY 2018				
Discharge Types	San Bernardino		Statewide	
	#	%	#	%
Standard Adult Discharges	3,549	59.6%	43,654	49.6%
Administrative Adult Discharges	2,242	37.6%	33,344	37.9%
Detox Discharges	89	1.5%	8,470	9.6%
Youth Discharges	74	1.2%	2,609	3.0%
TOTAL	5,954	100.0%	88,077	100.0%

Table 19 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients with SUDs. The first four rating options are positive. "Completed Treatment" means the client met all their treatment goals and/or the client learned what the program intended

for clients to learn at that level of care. “Left Treatment with Satisfactory Progress” means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options indicate lack of satisfactory progress for different types of reasons.

Only 38 percent of clients had a positive discharge outcome, much lower than the statewide percentage (52 percent).

Table 19 – CalOMS Discharge Status Ratings, San Bernardino and Statewide, CY 2018

CalOMS Discharge Status Ratings, CY 2018				
Discharge Status	**San Bernardino**		**Statewide**	
	#	**%**	**#**	**%**
Completed Treatment - Referred	1,557	16.5%	20,054	22.9%
Completed Treatment - Not Referred	174	7.4%	6,015	6.9%
Left Before Completion with Satisfactory Progress - Standard Questions	462	9.4%	12,155	13.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	601	4.8%	7,227	8.3%
Subtotal	*2,794*	*38%*	*45,451*	*52%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	1,519	26.8%	16,187	18.5%
Left Before Completion with Unsatisfactory Progress - Administrative	1,571	33.6%	24,666	28.2%
Death	6	0.6%	96	0.1%
Incarceration	64	0.9%	1,195	1.4%
Subtotal	*3,160*	*62%*	*42,144*	*48%*
TOTAL	**5,954**	**100.0%**	**87,595**	**100.0%**

Performance Measures Findings—Impact and Implications

Access to Care PM Issues

- The SARC receives an average of 603 calls per month and authorizes 214 residential treatment episodes.
- In their first year of implementation, San Bernardino has a robust continuum of care with clients receiving NTP, residential, withdrawal management, non-methadone MAT, intensive outpatient, and outpatient services.

- Clients who are White access services more readily than clients who are Hispanic/Latino; however, the penetration rate for Hispanic/Latino clients in San Bernardino is 0.54 percent, slightly higher than the statewide rate of 0.46 percent.

Timeliness of Services PM Issues

- Without a functional electronic health record, certain timeliness metrics are difficult to track, especially when 98.3 percent of services are delivered by contract providers.
- San Bernardino is not consistently meeting the standard for time from first request for service to first face-to-face appointment. The mean number of days is 39 and the standard is met only 30 percent overall and 13 percent for youth.

Quality of Care PM Issues

- The SARC Level of Care Assessment modeled after the ASAM criteria is not brief. The screening will be shortened as part of the redesign and program improvement process in Waiver year two to streamline the intake and referral process.

Client Outcomes PM Issues

- San Bernardino has administered the TPS to clients once since going live. The County reviewed their results against baseline data from UCLA and plan to review trends once they have two waves of data to compare.

INFORMATION SYSTEMS REVIEW

Understanding the capability of a county DMC-ODS information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the responses to standard questions posed in the California-specific ISCA, additional documents provided by the DMC-ODS, 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	1.7%
Contract providers	98.3%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 3.7 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**
58	9	6	8

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**
20	3	3	3

The following should be noted regarding the above information:

- The staffing summaries for both Information Systems and Data/Analytics staff are for the Department of Behavioral Health, and not only for DMC-ODS.

Current Operations

San Bernardino is currently using InSyst for billing while they wait for implementation of Avatar. The IS team is working in collaboration with Quality Management to look at the business processes and workflow that had been set up with InSyst toward the goal of setting up myAvatar with correct functionality and optimal workflows from the outset.

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**
Insyst	Claiming System	Echo	28 yrs	MHP
Level of Care	ODS Waiver	ISD	3/2019	ISD

Priorities for the Coming Year

- Billing System: To convert Insyst and multiple add-on applications into one billing system with myAvatar.
- Electronic Health Record: To fully implement the electronic health record by end of 2020 (Phase 1 billing system and Phase 2 clinical workstation).
- Implementing hardware and application upgrades for Insyst: San Bernardino continues to support operations with its legacy systems as they prepare for replacement with Netsmart's myAvatar EHR. This project is necessary now and for the next year because InSyst will continue to operate for 12 to 18 months after the Netsmart CalPM module goes into use to process claims, some of which were initially entered and processed in InSyst. InSyst can no longer continue to operate on its existing platform; the upgrades are necessary to support continued operation.
- Level of Care Application: San Bernardino created a web-based application to incorporate ASAM principles into the Level of Care screening and referral tool used at the call center and access points.
- NACT: San Bernardino has been working on web-based solutions to capture data and mapping required for Network Adequacy.
- Provider Directory: San Bernardino is working on a searchable provider directory that is dynamic and allows a beneficiary to search specific preferences, such as gender and geographic location.

Major Changes since Prior Year

- Increased number of Information Technology staff.
- Fully implemented ODS Waiver, including ASAM LOC application.
- Increased project management staff for BHMIS project.
- Added new staff to support the News Reel for the DBH Clinics: This is a broadcast in the DBH Clinics that pushes out information to clients, such as upcoming events.

- Initiated IP communicator phone (CIP) for Call Center: Using Cisco's system to make sure that call center phones are configured to allow management and supervision of key access call center indicators.

Plans for Information Systems Change

- Working with Netsmart to implement myAvatar by the end of 2020.

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	myAvatar Practice Management (CalPM) & OrderConnect/Netsmart Technologies			x	
Assessments	myAvatar Clinical Workstation (CWS)/Netsmart Technologies			x	
Care Coordination	CareConnect/Netsmart Technologies			x	
Document imaging/storage	Perceptive Document Imaging/Netsmart Technologies			x	
Electronic signature—client	myAvatar/eSignature Module/Netsmart Technologies			x	
Laboratory results (eLab)	Order Connect & CareConnect/Netsmart Technologies			x	
Level of Care/Level of Service	myAvatar Clinical Workstation (CWS)/Netsmart Technologies			x	
Outcomes	Knowledge Performance Indicators (KPI)/Netsmart Technologies			x	
Prescriptions (eRx)	OrderConnect & CareConnect/Netsmart Technologies			x	
Progress notes	myAvatar Clinical Workstation			x	

Table 5: EHR Functionality					
		Rating			
Function	System/ Application	Present	Partially Present	Not Present	Not Rated
	(CWS)/Netsmart Technologies				
Referral Management	myAvatar Practice Management (CalPM)/Netsmart Technologies			x	
Treatment plans	myAvatar Clinical Workstation (CWS)/Netsmart Technologies			x	
Summary Totals for EHR Functionality:					

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

- Once myAvatar is functional, contract providers will have the option to do either direct data entry or EDI uploads.

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

ASAM LOC Referral Data, CalOMS, and 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.			37.6
TPS being administered in all Medi-Cal Programs.	x		

Highlights of use of outcome tools above or challenges:

- CalOMS currently tracked in InSyst.
- Level of Care, based on ASAM principles, is tracked by access sites, including the SARC, through a web-based platform.
- The Treatment Perception Survey was administered last October 2018 and will be again this October 2019.

Drug Medi-Cal Claims Processing

- Claims are submitted on a monthly basis.
- San Bernardino has capability to perform end-to-end claims reconciliation using MediCal Claims Tracking System (MCTS).

Special Issues Related to Contract Agencies

- San Bernardino has involved contract providers in the planning and development of myAvatar.

Overview and Key Findings

Access to Care

- All access points are using the web-based Level of Care tool to incorporate ASAM principles into screening and referral.

Timeliness of Services

- Without an operational EHR, some timeliness measures are difficult to track, including data collected from contract agencies.

Quality of Care

- Contract providers have been included in the planning process for myAvatar implementation.

Client Outcomes

- TPS, CalOMS, and ASAM have been successfully launched as part of DMC-ODS waiver. These tools can all be used in various ways to track client outcomes.

NETWORK ADEQUACY

CMS has required all states with managed care plans to implement new rules for network adequacy as part of the Final Rule. In addition, the California State Legislature passed AB 205 which was signed into law by Governor Brown to specify how the Network Adequacy requirements must be implemented by California managed care plans, including the DMC-ODS plans. The legislation and related DHCS policies assign responsibility to the EQRO for review and validation of the data collected by DHCS related to Network Adequacy standards with particular attention to Alternative Access Standards.

DHCS produced a detailed plan for each type of managed care plan related to network adequacy requirements. CalEQRO followed these requirements in reviewing each of the counties which submitted detailed information on their provider networks in April of 2019, and will continue to do so each April thereafter to document their compliance with the time and distance standards for DMC-ODS and particularly to Alternative Access Standards when applicable.

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Bernardino, the time and distance requirements are 30 minutes or 15 miles. The two types of care that are measured for compliance with these requirements are outpatient treatment services and narcotic treatment programs. These services are separately measured for time and distance in relation to two age groups—youth and adults.

CalEQRO reviews the provider files, maps of clients in services, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the county DMC-ODS plan must submit a request for an alternate access standard for that area with details of how many individuals are impacted, and access to any alternative providers who might become Medi-Cal certified for DMC-ODS. They must also submit a plan of correction or improvement to assist clients to access care by: 1) making available mobile services, transportation supports, and/or telehealth services, 2) making possible the taking of home doses of MAT where appropriate, and 3) establishing new sites with new providers to resolve the time and distance standards.

CalEQRO will note in its report if a county can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance reports, facilitate client focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Network Adequacy Certification Tool (NACT) Data Submitted in April 2019

NACT Data Submitted in April 2019

CalEQRO reviewed separately and with San Bernardino County staff all documents and maps submitted to DHCS. CalEQRO also reviewed the special form created by CalEQRO for alternative access standard zip codes and efforts to resolve these access issues. There were two zip codes with approved alternative access standards (AAS) in San Bernardino and one zip code with a plan approved but not yet implemented. They were in three very remote areas of the county with sparse populations and all the AAS were for NTP services. All youth and adult outpatient services met time and distance standards as required by DHCS. The county identified two of these areas that were in the most eastern side of the county next to the state of Nevada. These areas have adult and youth services within timeliness standards but no NTP. To date there have not been requests for NTP; however, there is now an approved plan should that request occur.

The first area is Cima, where Mental Health Systems (MHS) provides adult and youth Outpatient, Intensive Outpatient and Recovery Services with Recovery Centers. If MAT is required, they work with a contracted provider out of Palm Springs who provide their NTP services and the county has added all Riverside MAT providers to their contracts in anticipation of this happening. To date San Bernardino does not have any Medi-Cal beneficiaries in this zip code. There was one listed as living there but upon further review, it was determined the beneficiary actually resides in Redlands.

The second area is Needles and MHS also provides adult and youth Outpatient, Intensive Outpatient, Recovery Services and Recovery Centers. The approved plan for MAT would provide that service through the DBH clinic with the physician there providing the appropriate non-methadone MAT. If Methadone is needed, the approved alternative access is provided by the nearest NTP, in Bullhead City. San Bernardino has worked with them to provide Methadone in the past when requested by a client.

The third area is Trona, a very small remote area in the most North West part of the county, which borders on both Kern and Inyo in a geographically remote area for all three counties. To meet the required standards in Trona, San Bernardino is working with a provider in Ridgecrest which is within 24 miles of the geographic area of need. That provider is setting up an NTP service. The provider will contract with a medication unit that will serve the surrounding northern rural areas of San Bernardino including Trona. The location is within the Timely Access Standards (26 minutes) from Trona. The NTP provider is working with DHCS to be certified to provide tele-counseling services to eliminate unnecessary travel.

San Bernardino’s NACT was accepted and approved with no plan of correction.

Also discussed were access issues for physically disabled clients. San Bernardino, as part of their quality improvement plan, created a subcommittee on disabilities hosted by Inland Empire Health Plan that focuses on capacity building for partner agencies. They fly in disability experts to assist with training and do resource sharing. San Bernardino reported that they also use a variety of resources if a client needs a resource not available at a particular provider or site. These include Center on Deafness Inland Empire (CODIE) and Rolling Start. Both agencies also provide advocates. San Bernardino partners with Inland Regional Center as a resource for clients with Developmental Disabilities. CODIE provides regular training to DBH staff on deaf sensitivity and awareness.

In addition, transportation needs of members were also being monitored to support access to care with extensive use of transportation through the Health Plan for NTP, MAT, outpatient and intensive outpatient treatment. Clients are routinely informed of this service and many take advantage of it to get regular transportation to NTP and outpatient services, especially if they are in rural areas. The treatment agency is provided vouchers for transportation from the Health Plan and can provide them to clients upon request

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 Bernardino PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. Following are descriptions of the two PIPs submitted by San Bernardino and then reviewed by CalEQRO as required by the PIP Protocols: Validation of PIPs. [4]

Clinical PIP— Vivitrol Utilization & Outcomes

Date PIP Began: 08/01/2018 **Status of PIP:** Active and ongoing

Brief Description of the problems the PIP is designed to address:
The PIP examines the administration of Medication Assisted Treatment - Vivitrol as a harm reduction, supplemental treatment approach in an effort to decrease the following: Quantity of opioid use; frequency of opioid use; cravings, withdrawal symptoms and effects of use; and the MDST Dimension 5 severity score that measures relapse.

PIP Question:
San Bernardino presented its study question for the clinical PIP as follows:
Will administering Vivitrol result in improved Multi-Dimensional Screening Tool (MDST) outcomes including:

A. Decrease in frequency of opioid use
B. Decrease in quantity used
C. Decrease in frequency of cravings, withdrawal symptoms and effects of use

[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.

D. Decrease in ASAM dimension #5 severity score?

Indicators:
San Bernardino listed the following PIP indicators:

1. Decrease in frequency of opioid use based upon pre-post assessment change scores from the MDST
2. Decrease in opioid quantity used based upon pre-post assessment change scores from the MDST
3. Decrease in opioid frequency of cravings, withdrawal symptoms and effects of use based upon pre-post assessment change scores from the MDST
4. Decrease in relapses based upon pre-post assessment change scores from the MDST

Interventions:
San Bernardino cited the following interventions:

1. Both the control and treatment group are clients in the San Bernardino Center for Change Program, which is a criminal justice outpatient program that collaborates with the San Bernardino County Treatment Court system and DBH SUDRS. All clients received basic program outpatient services that included: individual counseling, group counseling, drug and alcohol screenings, case management services, referral for mental health services when indicated, and referral for MAT services when indicated.
2. The treatment group also received Vivitrol injections, although the periodicity was inconsistent across the client participants.

Results/Impact upon Clients:
San Bernardino cited the following client outcomes:

1. Results were equivocal, with improvement in some areas and not in others.
2. There were challenges in the experiment, making it difficult to draw any generalizable conclusions. The challenges were: the number of subjects (five in each of the two groups) were too few, the time periods between MAT injections were inconsistent, and the time periods between administrations of the MDST were also inconsistent.

Technical Assistance Provided: After the PIP was presented, San Bernardino requested input from CalEQRO on whether the PIP should be ended or expanded. CalEQRO recommended the PIP be expanded beyond Vivitrol to include all non-methadone MAT options that are available in multiple locations.

PIP Score: 76.0 percent

Non-Clinical PIP— Vivitrol Education and Outreach

Date PIP Began: 5/1/18

Status of PIP: PIP determined not to be viable, see details (not rated)

Brief Description of the problems the PIP is designed to address: This PIP intervention was designed to provide education related to MAT options, specifically Vivitrol, as a legitimate and effective supplemental treatment option for individuals with opioid use disorder. This outreach and education project targets both consumers and providers.

PIP Question:
San Bernardino presented its study question for the non-clinical PIP as follows:

Will providing education around MAT, specifically Vivitrol, as a legitimate and effective supplemental treatment option lead to:

A. For providers: Increased knowledge around access, willingness to refer, decreased stigma, and increased referrals for Vivitrol?
B. For consumers with opioid use disorder: increased knowledge around access, decreased stigma, and increased utilization of Vivitrol?

Indicators:
San Bernardino listed the following PIP indicators:

1. Increase in knowledge regarding how to access Vivitrol based on an item in a provider survey
2. Increase in willingness to refer based upon an item in a provider survey
3. Decrease in stigma attitudes towards MAT based upon an item in a provider survey
4. Increase in rate of actual Vivitrol referrals
5. Increase in knowledge regarding how to access Vivitrol based on an item in a client survey
6. Decrease in stigma attitudes towards MAT base on an item in a client survey
7. Increase in clients with Vivitrol injections

Interventions:
San Bernardino cited the following interventions:

1. Informative MAT/Vivitrol trainings were provided to staff and consumers by the DMC-ODS's Addiction Medicine Physician, Dr. Jonathan Avalos. These trainings provided education on Vivitrol MAT as a supplemental treatment option and delivered the presentation specifically to target and address barriers to accessing this type of treatment including lack of knowledge around access for both providers and consumers, provider lack of willingness to refer, and stigma toward MAT as replacing one drug for another.

Results/Impact upon Clients:
San Bernardino cited the following client outcomes:

1. All indicators showed change in the desired direction except for indicator #3.
2. Indicators 1, 4, 6 and 7 showed a degree of change that met the desired goals.
3. Indicators 1 and 6 showed a degree of change that was statistically significant.

Technical Assistance Provided: This PIP was determined not viable as there were no consumer outcomes and it was considered too similar to the clinical PIP. There was a discussion on possible study projects that would be acceptable as non-clinical PIPs. San Bernardino will follow up with EQRO in the next month to finalize the focus of the new non-clinical PIP.

PIP Score: Not rated

PIP Table 1, on the following page, provides the overall rating for the Clinical PIP (the other was not rated), based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

PIP Table 1: PIP Validation Review

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

PIP Table 2 provides a summary of the PIP validation review.

PIP Table 2: PIP Validation Review Summary

Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	16	n/a
Number Partially Met	6	n/a
Number Unable to Determine or Not Met	3	n/a
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	n/a
Overall PIP Rating Clinical: ((16*2)+(6))/(25*2) Non-clinical: Not rated	**76.0%**	n/a

PIP Findings—Impact and Implications

Overview

San Bernardino is interested in adding Vivitrol to the mix of MAT options available for beneficiaries, especially those in the criminal justice system. The PIP studied how to expand the use of Vivitrol to those persons in one criminal justice program. The small study size impacted conclusion validity but initial findings were positive.

Access to Care Issues related to PIPs

Education to providers and clients seemed to increase access to Vivitrol.

Timeliness of Services Related to PIPs

Education to providers and clients increased timeliness to Vivitrol.

Quality of Care Related to PIPs

This PIP was limited to Vivitrol but expanding it to all non-methadone MAT and including the educational components will study how to effectively increase access to non-methadone MAT in San Bernardino.

Client Outcomes Related to PIPs

Clients on Vivitrol compared to a like size group showed no change in frequency of use or relapse but did show reduced quantity of use and decreased cravings.

CLIENT FOCUS GROUPS

CalEQRO conducted three 90-minute client and family member focus groups during the San Bernardino 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/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 and family member involvement.

Focus Group One: Perinatal Women Outpatients

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

Twelve women in a perinatal outpatient program, including ten who were new in the past ten months, participated in the focus group. All of the women were adults with ages 25-59, and with English as their preferred language. Their ethnicities included four women who identified as Caucasian and eight who identified as Hispanic/Latino.

Number of participants: 12

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions associated with numbers from five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected 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.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	3.91	2-5
2. I got my assessment appointment at a time and date I wanted.	3.58	1-5
3. It did not take long to begin treatment soon after my first appointment.	4.58	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.08	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.00	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.08	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.25	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.58	4-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	5.00	4-5

The following comments were made by some of the 10 participants who entered services within the past year and who described their experiences as follows:

- All felt their counselors were responsive, resourceful and caring.
- No services were provided while awaiting admission.
- Clients reported they wanted the program to provide more one-to-one counseling and case management.

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

- Some participants felt that more structure and mandatory attendance standards would benefit the beneficiaries in adoption of a recovery lifestyle.
- Housing is a problem to many participants.

Recommendations for improving care included the following:

- Reduce the long waiting lists for treatment.
- Help navigate the system coordinating legal, health and mental health issues.
- Locate all related organizations and related services at one stop for easier access.
- The SARC should address both substance use and mental health issues.

Interpreter used for focus group 1: No

Focus Group Two: Adult MAT

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

Six adult beneficiaries treated at a MAT outpatient program participated. Three had begun treatment in the last 12 months. They included adult and older adults who identified as Caucasian, Latino/Hispanic, Native American and other (some identifying in more than one category). There were three males and three females.

Number of participants: 6

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale using feeling facial expressions associated with numbers from five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected 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.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.50	4-5
2. I got my assessment appointment at a time and date I wanted.	4.17	3-5
3. It did not take long to begin treatment soon after my first appointment.	4.17	3-5
4. I feel comfortable calling my program for help with an urgent problem.	4.17	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.66	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.33	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.33	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.50	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.00	3-5

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

- “They seem to be very helpful and there is not very much that I would change.”
- “This program strives to help you get better. Everyone is very supportive.”

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

- Stigma of MAT remains an issue with family and friends. The program will work with you if you want to get off all MAT, once you are stable.
- Drug testing prior to residential admission is a challenge. There are waiting lists that require daily beneficiary calls to check bed availability. There were no services offered during the wait for admission.

Recommendations for improving care included the following:

- Make it “Easier to get ‘take homes’ for job.”
- Have more program groups.
- “Weekend access with longer hours than 5:00 am to 9:00 am on Saturday.”
- Have more available counselors to improve the program.
- “A better look into the addict’s daily life.”

Interpreter used for focus group two: No

Focus Group Three: Youth Outpatient

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.

Fourteen youth beneficiaries, all under age 17 and new in the last 12 months, participated. All beneficiaries preferred English and nine identified as Hispanic/Latino. Participants identified as African American/Black, Native American, Caucasian and Other. There were 11 males and three females.

Number of participants: 14

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale using feeling facial expressions associated with numbers from five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected 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.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	3.15	2-5
2. I got my assessment appointment at a time and date I wanted.	3.15	2-5
3. It did not take long to begin treatment soon after my first appointment.	3.61	2-5
4. I feel comfortable calling my program for help with an urgent problem.	3.30	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	2.46	1-3
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.23	1-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	3.69	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	3.53	2-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	3.38	1-5

The following comments were made by some of the 14 participants who entered services within the past year and who described their experiences as follows:

- "I love my counselors."

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

- "Additional help to quit smoking and stay sober."
- "Less drug testing."

Recommendations for improving care included the following:

- "More trips to go out and have fun."

Interpreter used for focus group three: No

Client Focus Group Findings and Experience of Care

Overview

Three stakeholder groups were held in San Bernardino County that included a women's perinatal outpatient program, an adult MAT program and a youth outpatient program with a total of 32 participants across the three groups. The scores were primarily in the four range with some scores in the three range of a scale of 1 – 5. There were a high number of undecided scores that came primarily from the youth.

Access Feedback from Client Focus Groups

- Services were easy to find.
- Long wait lists were identified by clients as barriers to treatment.
- Coordination with other required or desired services was sometimes challenging.

Timeliness of Services Feedback from Client Focus Groups

- Assessment times for MAT services were at days and times wanted by clients.
- Treatment began quickly after the assessment.

Quality of Care Issues from Client Focus Groups

- Recovery Center was described as very helpful with many resources.
- Adult MAT services were described as comprehensive and staff were willing to work with clients who wanted to get off MAT once they were stable.
- Counselors were described as responsive, resourceful, supportive and caring.
- The stigma of MAT was an issue for clients when dealing with family and friends.
- Assistance was needed in navigating the system and coordinating with legal, health and mental health services.
- Increased weekend access to MAT services was suggested with more days and longer hours.
- Youth MAT discussion scored low per the written survey completed by clients suggesting this was not discussed.
- Increased groups and one-to-one time with counselors were requested.
- Smoking cessation assistance was needed.

Client Outcomes Feedback from Client Focus Groups

- A need was expressed for assistance with transition out of the program including resources for job skills.
- The need for additional housing resources was identified.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1

Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	PM
Hired Specialist to outreach and engage the Hispanic Community starting with Promotores and participating in the Bi-National Health Fair. There was on-going engagement with the Diocese for education and feedback regarding the Hispanic/Latino Community. In addition, there was a strategy and training of providers to better serve the LGBTQ community. San Bernardino did not systematically evaluate the implementation and outcomes of its strategies to address the cultural, ethnic, racial, and linguistic needs of its eligibles.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	PM
With no EHR there is limited capacity to monitor real time system demands. The focus groups with clients, line staff, access staff and providers expressed concern there is not enough residential and withdrawal management capacity while providers report there is capacity not being used. San Bernardino is working on the development of a searchable data base, to replace the current PDF provider directory, in an effort to produce a more consumer-friendly service directory. There is a creative plan to provide MAT services with Tele-Health counseling and a medication unit, in order to serve a remote area, awaiting approval from DHCS.		

Table 1: Access to Care Components		
	Component	**Quality Rating**
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
San Bernardino works well with other partners in the community and provided evidence of long-term working relationships with many partners including managed health plans, faith-based communities, hospitals, emergency departments and many others.		

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 Appointment	NM
San Bernardino is currently addressing the challenges they have found with SARC, developing solutions to improve their system and processes. They responded by hiring a new manager to review the current system, evaluate the processes and make necessary changes; however, this was a recent intervention, so results are not yet available. San Bernardino developed a PIP to increase specific MAT strategies in their Drug Court Program		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	NM
San Bernardino has recently requested timeliness reports developed by the NTPs in order to standardize a county wide report and track provider timeliness to NTP. This is expected to be in place during the second year of San Bernardino's Waiver implementation.		
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment:	NM
San Bernardino has developed a PIP to track usage of Vivitrol in Drug Court. The NTP providers are providing non-methadone MAT as evidenced by the claims data. However, as identified above, the timeliness tracking is not yet in place and is planned for year two of San Bernardino's Waiver implementation.		
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	NM

Table 2: Timeliness of Services Components		
Component		**Quality Rating**
San Bernardino does have a definition for urgent conditions but timeliness to this service is not yet tracked. There will be some tracking put in place, prior to EHR implementation in year two of San Bernardino's Waiver implementation. The EHR is being designed with a "flag" for urgent conditions to track for timeliness--from time of screening to first service--with implementation scheduled next year.		
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential	PM
San Bernardino does track appointments to the next level of care post discharge whether it is to a lower or higher level of care. San Bernardino has looked at this data but has not yet scheduled a routine review and analysis. San Bernardino claims data shows that 5% of clients were admitted to a lower level of care within 7 days. This is an area San Bernardino will focus on in year two of their Waiver implementation in order to increase that percentage.		
2F	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	M
San Bernardino tracks re-admission to withdrawal management within 30 days and is successful at having a very low readmission rate of 1%.		
2G	Tracks and Trends No Shows	NM
San Bernardino does not yet track no shows but plans to do so in year two of their Waiver implementation.		

Quality of Care

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

KC Table 3

Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The Quality Improvement Committee is robust and has multiple committees. They are in process of training consumers with SUD and SMI experience to join multiple subcommittees with training and support. In addition, San Bernardino coordinates with the Behavioral Health Commission to solicit feedback from clients and family		

Table 3: Quality of Care Components		
Component		**Quality Rating**
members. The Commission members are required to host regular district level meetings that are well attended by family members and clients. These meetings provide educational presentations, new program information and response to questions about services. Specific questions about an individual's services are also responded to after the meeting with one-to-one conversations. An annual plan was developed and then evaluated. Beginning in 2020 this plan will be integrated with the mental health plan. The quality management process is coordinated with a Quality Improvement Program Committee (QIPC) that includes line staff and providers. There is also a leadership group, the Quality Management Action Committee (QMAC), which determines what system changes are necessary as a result of data and feedback from QIPC.		
3B	Data is used to inform management and guide decisions	M
The ASAM training was required for all staff with follow up tracking that validated 193 county and provider staff were assigned training subscriptions for web-based modules and on average 77 percent completed all three modules. The contracts require contract providers to provide evidenced based treatment. They also require contractor staff to attend mandatory cultural competency trainings. San Bernardino evaluates their annual plan and reports the results to the provider group, QIPC and BH Commission with recommendations and follow-up information.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	PM
Contract providers identified the increase of monthly meetings that were established in the last four months as positive but feel communication needs to be more collaborative. Clients reported that they had no communication with San Bernardino. Some staff identified increased changes but believe that those making the changes do not always understand their work flow. It was reported that family members more regularly give feedback at the Behavioral Health Commission and/or the regular district Community Policy Advisory Committees and receive feedback on behavioral health services. Regular communication appears to be provided to line staff, supervisors and community partners based on feedback in the focus groups.		
3D	Evidence of an ASAM continuum of care	M
San Bernardino has established a robust continuum of care with the required spectrum of services that includes prevention programs, school-based programs, SBIRT development, recovery residences and alternative housing options. In addition, they have expanded MAT services beyond required medications and trained psychiatrists in MAT treatment to better serve those with co-occurring disorders. They have a unique model of recovery centers that allow drop in support services for persons struggling with addiction. San Bernardino has developed strategies to assure they have adequate staffing to meet program and client needs. They have also made investments to assure these staff are adequately trained.		

Table 3: Quality of Care Components		
Component		**Quality Rating**
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
San Bernardino has a goal of saturation of Narcan in the community in response to the opioid epidemic impacting this county. Their newly hired addiction-certified physician is now certified to train other physicians to become X-waivered and has started by training all psychiatrists to provide this MAT. In the next year promoting MAT stigma reduction is planned to better serve all those in need of MAT. San Bernardino is active in the Inland Empire Opioid Coalition with committees that track client prescription use, review opioid related deaths, monitor prescribing practices of local providers and coordinate a Take Back Prescription program. In addition, San Bernardino has a Bridge program in which EDs start patients on Buprenorphine and then transition beneficiaries to continue services at designated county outpatient clinics.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
There is evidence of county and provider staff participating in ASAM training, a high percentage completing the training and San Bernardino providing ongoing supervision and continuous feedback. The continuum of care is extensive in San Bernardino. The ASAM criteria and six dimensions are in the assessment document and will be in the EHR. San Bernardino has a relapse policy and focus groups validated that persons can remain in treatment or be provided alternatives when they relapse. San Bernardino continues to work on transitions from initial LOC to subsequent treatment but will have increased tracking capability when there is an EHR in place.		
3G	Measures clinical and/or functional outcomes of clients served	M
San Bernardino tracks sub populations (e.g., youth, ethnicity) by service for outcomes. They also track CalOMS data and have developed quarterly reporting. Client level outcome reporting will be more viable when the EHR is implemented.		
3H	Utilizes information from client perception of care surveys to improve care	M
San Bernardino received the summary data from the UCLA pilot counties and was able to report San Bernardino was one percentage point above the statewide average. They also reviewed the number of TPS surveys completed and understood they could not differentiate between adult and youth; consequently, in the future there is a plan to assure that youth receive the correct survey.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- San Bernardino was successful in transitioning the majority of their existing continuum into the ODS system when they initially implemented the Waiver with an even mix of outpatient, residential and narcotic treatment program (NTP) services. The NTPs offer all required MAT including Methadone, Buprenorphine, Naloxone (Narcan), and Disulfiram.
- While the total number of clients receiving non-methadone MAT is still rather low, San Bernardino is doing well at retaining clients in services. Approximately 94 percent of clients with non-methadone MAT services received three or more services, which is higher than the statewide percentage of 41 percent.
- MAT services are provided at the four certified county-operated outpatient programs utilizing psychiatrists to provide MAT with training and consultation by the Addiction Physician who is board-certified in Addictionology.
- San Bernardino hired an Addiction Physician to support the expansion of non-methadone MAT that includes required MAT as well as Naltrexone (Vivitrol). They will be continuing their Clinical PIP for a second year with an expanded focus to include all non-methadone MAT services throughout the continuum.
- San Bernardino has started an ED Bridge Partnership with ARMC for ED access to Buprenorphine and linkage to continued treatment with NTPs. They also have a two-way mutual agreement for referral processes with Global Medical Detox, a hospital that provides Voluntary Inpatient Detox (VID) located in Menifee, Riverside available to beneficiaries from San Bernardino.
- San Bernardino has seven Community-Based Recovery Service Centers that provide a supportive substance-free environment where persons in recovery and those seeking recovery can work to secure resources that will help them sustain and strengthen their recovery efforts.
- San Bernardino has established contracts with three Recovery Residence providers which provide 33 available beds that are used to assist clients to step down from residential treatment into a lower level of care. In addition, they have an array of clean and sober housing provided by many providers in their community.

Opportunities:

- During FY 2018-19 SARC completed 5,254 screenings but was unable to effectively manage the volume of calls and authorize residential services in a timely manner. However, San Bernardino recognized the problems and hired

seven new staff to assist with screening and case management. They are also currently making changes to improve the SARC process flow and shorten the screening form.

- San Bernardino has not yet implemented recovery services. However, they have defined the services and billing procedures, and contract providers are ready to begin these services as soon as the Board of Supervisors approves the plan on October 22, 2019.
- San Bernardino does have a definition for urgent conditions but is not yet able to track timeliness for these services. Appropriate data fields are being designed into the new electronic health record so that tracking timeliness of urgent conditions can be tracked, and trainings on the clinical processes are being developed.

Timeliness of DMC-ODS Services

Strengths:

- San Bernardino tracks the number of persons who exit withdrawal management and residential treatment and reports that 25 percent of this population transitions to other levels of care within seven days. The EQRO claims data reports on only those who leave residential treatment, excluding withdrawal management, and find only five percent move to a lower level of care post-residential within seven days.
- San Bernardino can measure timely access to county-operated clinics by phone and walk-in but not yet for contract providers-operated services. They will be developing a reporting mechanism for them in the upcoming second year of their Waiver implementation.

Opportunities:

- Timeliness was measured at the SARC with an access data base showing that there are delays for persons getting into residential treatment and confirmed by the staff and client focus groups; however, a plan to resolve this is being implemented.
- San Bernardino can track timeliness to first face to face for any provider if the client starts at SARC; however, they report that only 30 percent of adults and 13 percent of children currently meet their standard of ten days. Reporting for all providers will be implemented in the second year of the Waiver.
- San Bernardino does have a definition for urgent conditions but is not yet able to track timeliness for these services. Data fields for doing this are being designed into the new electronic health record and training on the clinical process is being developed.

- The EQRO claims data reports that only five percent of clients move to a lower level of care post-residential treatment within seven days.

Quality of Care in DMC-ODS

Strengths:

- San Bernardino has a Continuum of Care that includes all required levels of care. San Bernardino has a specific DMC-ODS Quality Improvement Performance Plan (QIPP) and evaluation that will be integrated with the mental health quality improvement plan next year.
- DBH SUDRS recently coordinated with mental health to train a cohort of Peers with mental health and/or substance use treatment experience to review consumer outcomes in order to increase the client voice in the QIPP process. They will be trained and supported to attend QIPP committee meetings as well as participating in local events such as Recovery Happens.
- San Bernardino began their ASAM training several years prior to their Waiver implementation with Dr. Mee-Lee with follow up webinar trainings. Approximately 200 county and provider contract staff participated and 77 percent on average completed all three modules.
- The Cultural Competency Plan update has strategies to reach DMC-ODS underserved populations including persons who identify as lesbian, gay, bisexual, transgender and queer (LGBTQ), youth and Latinx/Hispanic. These strategies include outreach activities, training providers in cultural competence and engaging the communities in creative ways.
- While the total number of clients receiving non-methadone, MAT is still rather low, San Bernardino is doing well at retaining clients in services. Approximately 94 percent of clients received three or more services, which is higher than the statewide percentage of 41 percent.
- Of 315 clients who received withdrawal management services, only 0.32 percent had three or more episodes with no other services as compared to 1.95 percent statewide.
- San Bernardino has developed excellent working relationships with their two health plans--Molina and Inland Empire--who coordinate with each other and through the Memorandum of Understanding (MOU) with the county.
- San Bernardino participates in the Inland Opioid Coalition that meets quarterly and includes participation from the DBH Addiction Physician. They have goals for safer prescribing, emergency response Narcan tool kits, and increased X-waivered providers to expand MAT and Naloxone distribution to the entire network of the Health Plans.

Opportunities:

- San Bernardino has no EHR, impacting review of data, but a plan for implementation in March 2020. It is critical that this effort remains adequately staffed in order to move forward with the current plan timing.

Client Outcomes for DMC-ODS

Strengths:

- San Bernardino participated in the Treatment Perception Survey and evaluated their overall data comparing their ratings by clients to those of other counties who had begun their Waiver services since 2017. The comparison showed them to be the same or higher in positive ratings across all of the five domains.
- San Bernardino presented these findings to contract providers, QIPP and Quality Management Action Committee (QMAC) in a balanced report, reminding contract providers that evidence of positive client satisfaction is not, in itself, sufficient to establish the effectiveness of treatment. San Bernardino identified other behavioral indicators that they plan to track to identify dissatisfaction including high drop-out rates, high no show rates and missed drug tests.
- San Bernardino CalOMS data shows the county serves a higher percentage of clients than statewide who are not in the criminal justice system (71 percent compared to 60 percent statewide).

Opportunities:

- San Bernardino providers rated a lower percentage of their clients at discharge as having satisfactory progress (38 percent) compared to the statewide average (52 percent).
- Although the TPS and ASAM have been successfully launched as part of the DMC-ODS waiver, San Bernardino has yet to use these tools and CalOMS to track client outcomes and drive quality improvement.
- San Bernardino has a low percentage of persons stepping down from residential treatment to lower levels of care. They currently have specific client data they can utilize to develop strategies and practices to increase this percentage.
- San Bernardino identifies stigma against MAT as a barrier for increased use. They have a plan to expand MAT services in the upcoming second year of their Waiver implementation.

Recommendations for DMC-ODS for FY 2019-20

1. The Screening Assessment and Referral Center (SARC) has been challenged to complete ASAM-based screening in a timely manner for referrals, resulting in lengthy times to first appointments in general and both vacant beds and treatment delays for residential and withdrawal management programs in particular.

   a. Redesign the screening tool to be shorter and rely on the contract providers to complete the full assessment.
   b. Train contract providers to complete the ASAM screener, as was initially planned and provide them the training and on-going technical assistance necessary for this change.

2. Implement the EHR on the schedule that is currently in place, as further delay will challenge mandated reporting requirements. Assure there are adequate staff in place for this critical project.

3. Continue the SARC redesign to increase efficiency, more effectively engage clients, and assist clients to reach treatment in a timelier manner. Include strategies for immediate access to assessment, specifically walk-in options, for those who do not have access to phones.

4. Continue the monthly meetings with contract providers that is a positive change. In addition, increase collaborative communication with the contract providers to facilitate making critical improvements in the DMC-ODS. Solicit feedback for a better understanding of the specific work flow processes at the client treatment level in order to have the change process be more successful.

5. Establish processes for contract providers to record and report timeliness metrics on timely access to treatment including for first offered and accepted appointment and first face-to-face appointment.

6. San Bernardino has successfully implemented a robust continuum of care but has yet to begin recovery services. Implement recovery services as planned after BOS approval on October 22, 2019.

7. Increase the use of CalOMS data while in transition to the EHR to review client and program trends and to make program improvements as a result of those reviews.

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

- Substance Use Disorder Executive Summary Report for FY 2018-19
- MAT Educational Brochure
- Prescription Drop Box Location Flyer

Attachment E: Continuum of Care Form

Attachment F: 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 Bernardino DMC-ODS
Opening session – Waiver implementation, 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
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments (MATs)
MHP coordination with DMC-ODS
Contract Provider Leadership group
Clinical line staff group interview – county and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family
Site visits such as residential treatment (youth, perinatal, or general adult), WM, access center, MAT induction center, and/or innovative program
Exit interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Maureen F. Bauman, LCSW, Lead Quality Reviewer
Karen Baylor, PhD, 2nd Quality Reviewer
Melissa Martin-Mollard, MFT, Information System Reviewer
Luann Baldwin, LCSW, Client/Family Member Consultant

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

Sites for San Bernardino's DMC-ODS Review

DMC-ODS Sites

San Bernardino County Department of Behavioral Health
303 E. Vanderbilt Way,
San Bernardino, CA 92415

County of San Bernardino Health Services
850 E. Foothill Blvd
Rialto, CA

Contract Provider Sites

Inland Valley Recovery Services
Upland Recovery Center
934 N. Mountain Ave, Suites A&B
Upland, CA 91786

Aegis Treatment Centers
125 West "F" Street
Ontario, A 91762

Table B1 - Participants Representing San Bernardino			
Last Name	**First Name**	**Position**	**Agency**
Alsina	Jennifer	Program Manager	SBC - Department of Behavioral Health
Almaraz	Gina	Quality Assurance Auditing Supervisor	Veterans Alcoholic Rehabilitation Program (VARP) Inc.
Avalos	Johnathan	Addiction Medicine Physician	SBC - Department of Behavioral Health
Belford	Alyce	Senior Program Manager	SBC - Department of Behavioral Health
Block	David	Psychiatrist II	SBC - Department of Behavioral Health
Blum	Anna	Alcohol & Drug Counselor	SBC - Department of Behavioral Health
Burrell	Niema	Supervising Automated Systems Analyst I	SBC - Department of Behavioral Health
Carranza	Edwin	Office Assistant III	SBC - Department of Behavioral Health
Kivett	Deanna	Vice President	Mental Health Systems
Carson	Kim	Health Care Analyst III	SBC - Department of Behavioral Health
Chagolla	Daniel	Chief Operations Officer	Cedar House Life Center for Change
Contreras-Monteon	Monica	Clinical Therapist I	SBC - Department of Behavioral Health
Cordova	Alexander	Alcohol & Drug Counselor	SBC - Department of Behavioral Health
Coyazo	Cecilia	Administrative Supervisor II	SBC - Department of Behavioral Health
Dishaw	Sean	Program Director	Veterans Alcoholic Rehabilitation Program (VARP) Inc.
Espinosa	Marina	Deputy Director	SBC - Department of Behavioral Health
Fee	Constance	Staff Analyst II	SBC - Department of Behavioral Health
Finneran	Nancy	Staff Analyst II	SBC - Department of Behavioral Health
Franklin	Terri	Deputy Director	SBC - Department of Behavioral Health

Table B1 - Participants Representing San Bernardino			
Last Name	**First Name**	**Position**	**Agency**
Frausto	Teresa	Medical Director	SBC - Department of Behavioral Health
Gonzaga	Lawrence	Behavioral Health County Programs Expert Liaison	SBC- Inland Empire Health Plan
Grace	Patricia	Supervising Automated Systems Analyst I	SBC - Department of Behavioral Health
Granillo	Elena	Clinic Supervisor	SBC - Department of Behavioral Health
Grey	Lisanne	Clinical Assistant	SBC - Department of Behavioral Health
Gruchy	Andrew	Deputy Director Regional Operations	SBC - Department of Behavioral Health
Gutierrez	Maribel	Cultural Competency Officer	SBC - Department of Behavioral Health
Haigh	Keith	Behavioral Health Informatics Manager	SBC - Department of Behavioral Health
Hale	Julie	Acting Senior Program Managers	SBC - Department of Behavioral Health
Harris	Toni	Mental Health Education Consultant	SBC - Department of Behavioral Health
Harris	Alicia	Program Manager II	SBC - Department of Behavioral Health
Headley	Jessica	Business Systems Analyst III	SBC - Department of Behavioral Health
Hougen	Timothy	Deputy Director	SBC - Department of Behavioral Health
Hughes	Tina	Chief Executive Officer	Inland Valley Recovery Services
Johnson	Erin	Staff Analyst II	SBC - Department of Behavioral Health
Jones	Mike	Deputy Sheriff	SBC – Sheriff's Department
Kelley	Veronica	Director	SBC - Department of Behavioral Health
Kennedy	Mark	Social Worker II	SBC - Department of Behavioral Health
Knight	Michael	Assistant Director	SBC - Department of Behavioral Health

Table B1 - Participants Representing San Bernardino			
Last Name	**First Name**	**Position**	**Agency**
Lucier	Heather	Alcohol & Drug Counselor	SBC - Department of Behavioral Health
Martin del Campo	Leonor	Supervising Automated Systems Analyst I	SBC - Department of Behavioral Health
Mattazaro	Shelly	Executive Director	Veterans Alcoholic Rehabilitation Program (VARP) Inc.
Mergener	Lois	Program Specialist II	SBC - Department of Behavioral Health
Montgomery	Victoria	Program Manager	Mental Health Systems
Mozell	Vincente	Regional Manager	Aegis Treatment Centers
Mungcal	Kristen	Program Manager I	SBC - Department of Behavioral Health
Nater	Randy	Behavioral Health Manager	Molina Health Care
Poulakos	Anthoula	Research & Planning Supervisor	SBC - Department of Behavioral Health
Rangel	Justine	Administrative Manager	SBC - Department of Behavioral Health
Reed-Drake	Sylvia	Program Manager II	SBC - Department of Behavioral Health
Rodriguez	Manuel Ted	Business Application Manager	SBC - Department of Behavioral Health
Saldana	Anthony	Staff Analyst II	SBC - Department of Behavioral Health
Sceranka	Diana	Nurse Manager	SBC - Department of Behavioral Health
Schreur	Christopher	Adult Psychiatrist	SBC - Department of Behavioral Health
Sesma-Ramirez	Sandra	Health Systems Analyst II	SBC - Department of Behavioral Health
Smith	Catherine	Mental Health Clinic Supervisor	SBC - Department of Behavioral Health
Suphavarodom	Tan	Deputy Director of Administrative Services	SBC - Department of Behavioral Health
Swink	Shannon	ADS Counselor	SBC - Department of Behavioral Health

Table B1 - Participants Representing San Bernardino			
Last Name	**First Name**	**Position**	**Agency**
Taylor	Joshua	Program Manager II	SBC - Department of Behavioral Health
Thomas	CaSonya	Assistant Executive Officer	SBC - Department of Behavioral Health
Watkins	Erica	Administrative Supervisor II	SBC - Department of Behavioral Health
Weaver	Tamara	Chief Quality Management Officer	SBC - Department of Behavioral Health
Williams	Stephanie	Supervising Social Worker	SBC - Department of Behavioral Health
Williams	Takisha	Clinic Manager	Aegis Treatment Centers
Yoshioka	Georgina	Deputy Director	SBC - Department of Behavioral Health
Yzaguirre	Gary	Alcohol & Drug Counselor	SBC - Department of Behavioral Health
Zatarain	Daniel	Alcohol & Drug Counselor	SBC - Department of Behavioral Health
Gonzalez	Sabrina	Alcohol & Drug Counselor	High Desert Center
Maldonado	Juanamae	Alcohol & Drug Counselor	High Desert Center
Mansfield	Salena	Alcohol & Drug Counselor	
Aragon	Jessica	Alcohol & Drug Counselor	VARP Inc/Gibson House for Women
Carson	Lacey	Alcohol & Drug Counselor	IVRS
Smith	Jennifer	Alcohol & Drug Counselor	IVRS
Henson	Marlene	Alcohol & Drug Counselor	Cedar House
Lundeberg	Julia	Chief Child Officer	Clare/Matrix
Canta	Maria	Compliance	WHS
Boreman	Carri	Admission SUD	St. John of God
Bailey	Christopher	Program Specialist	SUDRS
Funn	Nashira	PM I	QM-DBH
Wolkenhauer	Dianne	PM II	DBH

Table B1 - Participants Representing San Bernardino			
Last Name	**First Name**	**Position**	**Agency**
Hermosillo	Brian	RA II	DBH-RE
Weed	Jenifer	Training & Development Specialist	WET-DBH
Xiong	Shuie	Analyst	DBH-Comp
Pauper	Mike	Project Manager I	IT-DBH
Van	Kimberly	AS II	DBH
Smith	Jennifer	AOD Detox	IVRS
Shakelford	Rick	BSA/Security	DBH

Attachment C—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
DMC-ODS: San Bernardino	
PIP Title: Vivitrol Utilization & Outcomes	
Start Date 08/01/18: **Completion Date** 08/01/19: **Projected Study Period** (12 Months): **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** 09/24-26/19: **Name of Reviewer**: Maureen Bauman	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The PIP examines the administration of Medication Assisted Treatment - Vivitrol as a harm reduction, supplemental treatment approach in an effort to decrease the following: Quantity of opioids used; frequency of opioid use; cravings, withdrawal symptoms and effects of use; and the MDST Dimension 5 severity score that measures relapse.	

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 Bernardino develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The team included a program specialist, clinic supervisor, line staff, program manager and senior program manager, medical staff and assistants, quality management officer, research and evaluation staff and executive co-sponsorships. There was no representation from Center for Change or a consumer representative.
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	National Opioid data was reviewed from CDC including CA data with statistically significant increases in opioid related overdoses. San Bernardino saw a 94% increase in opioid overdoses between 2015 and 207 with 57 deaths in 2017. Currently SB has methadone and buprenorphine clinics but there are more restrictions for providers and clients. SB maintains that Vivitrol, despite the 7-day abstinence requirement, has easier access for both clients and providers, and offers more promising results. The increasing problem of opioid addiction seemed to call for another medication for intervention that was not already well in place.
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 PIP addressed improved outcome for consumers and an intervention that tested various aspects of the treatment experience in terms of relapse, amount of use in relapse, frequency and overall impact of cravings, withdrawal symptoms and effects of use
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)?	☒ Met ☐ Partially Met ☐ Not Met	The targeted population was quite small but included all populations at one treatment site that provides services for those involved in the criminal justice system. The PIP compared results for those who received Vivitrol MAT and those who did

Demographics: ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☒ Other living arrangements and engaged in criminal justice system	☐ Unable to Determine	not. They were required to have two pre- and post-Multi-Dimensional Screenings. The purpose of the PIP was to help this population manage their cravings for opioids by offering an opioid antagonist with optimal medication adherence consistent with evidence-based practices. The pilot included 5 persons each for control and treatment groups
	Totals 4	3 Met 1 Partially Met 0 Not Met 0 UTD
STEP 2: Review the Study Question(s)		
Will administering Vivitrol result in improved MDST outcomes including: E. Decrease in frequency of opioid use F. Decrease in quantity used G. Decrease in frequency of cravings, withdrawal symptoms and effects of use H. Decrease in dimension 5 severity score	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Study question was clear
	Totals 1	1 Met 0 Partially Met 0 Not Met 0 UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☒ Other criminal justice involved at one program site	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The group study was particularly small but did include the criteria identified for all persons participating in one location
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: two MDST were administered (pre- and post-treatment) to those who received SUD	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Those meeting the criteria that were at a specific site were included.

treatment at a specific site, half of whom also received MAT through Vivitrol.		
	Totals 2	2 Met 0 Partially Met 0 Not Met 0 UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* A. Decrease in frequency of opioid use B. Decrease in quantity used C. Decrease in frequency of cravings, withdrawal symptoms and effects of use *D.* Decrease in dimensions 5 severity score	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Use of MDST was selected as it includes dimensions that the literature indicates provides insight when determining the effectiveness of vivitrol. All indicators were objective, clearly defined and the measures were outlined in some detail
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study will measure the impact of a medication on health and functional status with the expectation that persons able to remain in recovery more successfully, will be more satisfied with their treatment and ultimately their life.
	Totals 2	2 Met 0 Partially Met 0 Not Met 0 UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Sampling methods were not applied

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	Sampling methods were not applied
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	Sampling methods were not applied
	Totals 3	0 Met 0 Partially Met 0 Not Met 3 NA 0 UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data collected to produce results for the selected indicators: • Frequency of opioid use • Quantity of opioid use • Cravings, withdrawal symptoms and effects of use • Relapse, continued use, or continued problem potential In addition, the client who received Vivitrol and their respective injection dates will be tracked and analyzed in order to assess validity
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: MDST completed based on client report	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	MDST data
6.3 Did the study design specify a systematic method of collecting valid and reliable data	☒ Met ☐ Partially Met ☐ Not Met	Specific and systematic method of collecting data was described.

that represents the entire population to which the study's indicators apply?	☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Outcomes tool ☐ Level of Care tools ☒ Other: MDST	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The same tool was used at assessment and six months later. Only those who had the pre and posttest were considered
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study was designed to review data for accuracy initially. In addition to completing the analysis that was described in detail the PIP team planned to discuss the progress of Vivitrol referrals and administration at every PIP team meeting. The number of referrals remained extremely low in this study.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Dr. Jonathan Avalos and Jennifer Alsina Title: Addiction Medicine Physician II/Program Manager I Role: Oversee project *Other team members:* Names: numerous staff from SUDRS, Medical Team, Quality Management and Research and Evaluation	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Qualified staff were used to collect the data
	Totals 6	5 Met 1 Partially Met 0 Not Met 0 UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The interventions were reasonable and addressed the initial barriers identified.

Describe Interventions: Administration of Vivitrol – consultation with SUD physician, consent and review process • Provided education on harm/risk with opioid use • Provide education/counseling on alternative • Establish opioid use as a medical condition • Conduct drug test (to validate no detox) • Review consent process with client Vivitrol Injection • Frequency of use • Quantity used • Frequency of cravings, withdrawal symptoms, effects of use • Relapse, continued use or continued problem potential		
	Totals 1	1 Met 0 Partially Met 0 Not Met 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The analysis was performed according to the plan
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 findings are presented clearly and accurately

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*: MDST administered every 6 months *Indicate the statistical analysis used*: *Indicate the statistical significance level or confidence level if available/known: use SAS Enterprise Guide*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data was analyzed as planned however the numbers were so low that it was not possible to complete statistical significance testing. Need to continue to get increased numbers and strategies include • Monitor data collection more closely at provider site specifically dates for MDST and injection dates • Consider a different tool that more clearly measures the indicators and will be more effective at tracking outcomes • Problem with inconsistency with Vivitrol MAT as consumers can discontinue at any time
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:*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Limitations were described and new interventions were identified Suggest also considering additional MAT tracking as the numbers for Vivitrol were so low. Also, looking at what characteristics are resulting in success for these clients
Totals 4		2 Met 2 Partially Met 0 Not Met 0 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	Data repeated at 6-month intervals with the same source data and same methodology however the interval at the provider level did not always occur as planned. In addition, client choice eliminated some people from the study reducing the number of people served. DMC-ODS cannot confidently state that the changes observed are "real" and caused by the intervention

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 sample was so small that although there were some documented improvements and some documented no change (with no deterioration), it was not conclusive
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 sample was too small to make a determination of internal validity.
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 sample was too small
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Sample was too small
	Totals 5	0 Met 2 Partially Met 0 Not Met 3 UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: The PIP demonstrated the difficulty of establishing the new Vivitrol MAT option available to consumers. San Bernardino plans to make some improvements in this PIP including: • More closely monitor data collection and send reminders as necessary when MDST assessments or Vivitrol injections are due Establish new interventions including: • Standardized education to program participants, care coordination including asynchronous "coaching "calls from care coordinators, and regular doctor visits for medication monitoring • Development of a new indicator that will measure Vivitrol engagement and functioning, well-being and/or satisfaction with both Vivitrol and treatment care
Recommendations: • San Bernardino should implement the new interventions recommended from the team but should also solicit information from consumers about the use of Vivitrol as part of this second year. • Expansion of MAT options should be considered to expand this study. • Expansion of this PIP to additional sites in order to better assure that the numbers will allow analysis and conclusion of the results. • Expansion to all MAT services to track the San Bernardino expand MAT in all locations.

PIP item scoring

16 Met

6 Partially Met

3 Not Applicable

3 Unable to Determine

PIP overall scoring

((16 x 2) + 6) / (25 x 2) = 76.0%

Attachment D—County Highlights

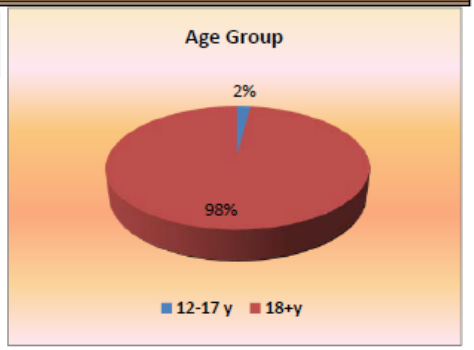
Substance Use Disorder Executive Summary Report for FY 2018-19

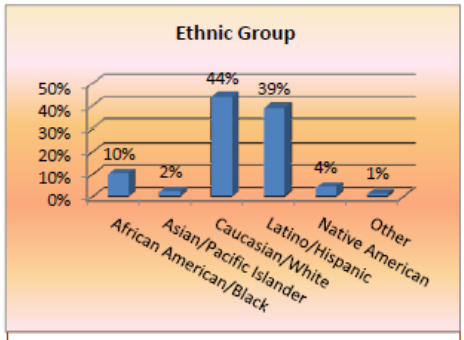
San Bernardino County Behavioral Health

Substance Use Disorder (SUD) Executive Summary Report for Fiscal Year 2018-19

Unduplicated clients:	No	%
Total	6,625	100%

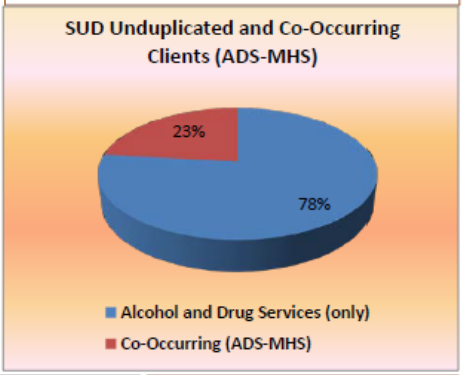
For the FY1819, 6,625 unduplicated consumers were served at 121 reporting units. From them, 56% were male and 43% female. Adults (18+ years) received 98% of the total consumers, and minors (12-17 years) represented 2% of the consumers served. The average number of services and hours per consumers was 96 and 491, respectively. In addition, a total of 10,853 episodes were open at any time and 6,545 (60%) were closed during the Fiscal Year.

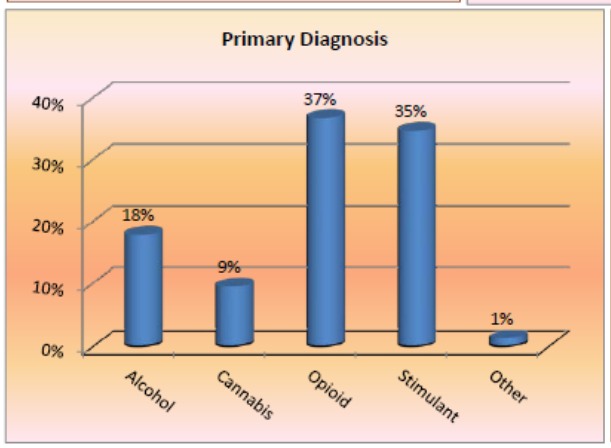




By ethnicity, the three most common groups assisted were Caucasians (44%), Latinos (39%), and African Americans (10%). In general, the percentages by ethnic group are approximately the same of the FY1718 (see summary table).

From the total unduplicated consumers, 5,091 (78%) received Alcohol and Drug Services only and 1,534 (23%) also received services in the Mental Health System. These figures have no significant differences related to the fiscal year 2017-18 (see summary table).





For diagnosis 37% of the open episodes had Opioid followed by Stimulant (35%) (Amphetamine, Cocaine, Caffeine, etc.), Alcohol (18%), and Cannabis (9%). Other (1%) includes Hallucinogens and Polysubstance, as well as when a Mental Health diagnosis is coded as primary. The comparison with the FY1718 presented approximately the same percentages (see summary table).

Source: ADS-SIMON database as of 8/8/2019

Research and Evaluation, mg, 8/9/2019

SAN BERNARDINO COUNTY | Behavioral Health

SUD summary table for FY 2018-19 and comparison with FY 2017-18

	FY 2018-19		FY 2017-18	
Discharge Reasons for Closed Episodes (CALOMS):	6,545	100%	8,399	100%
Completed treatment plan/goals & referred	1,457	22%	1,758	21%
Completed treatment plan/goals & not referred	324	5%	367	4%
Death	17	0%	25	<1%
Incarceration	86	1%	91	1%
Left before completion with satisfactory prog. & Not Referred	1,208	18%	1,975	24%
Left before completion with satisfactory prog. & Referred	454	7%	512	6%
Left before completion with unsatisfactory prog. & Not Referred	1,770	27%	2,241	27%
Left before completion with unsatisfactory prog. & Referred	1,228	19%	1,429	17%
Other/ Unknown	1	<1%	1	<1%

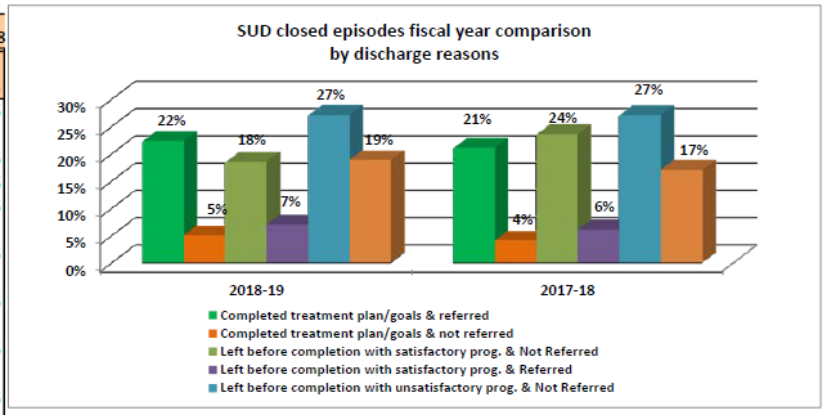
SUD Unduplicated and Co-Occurring clients (**)				
Total	6,625	101%	6,840	100%
Alcohol and Drug Services (only)	5,091	78%	5,328	78%
Co-Occurring (ADS-MHS)	1,534	23%	1,512	22%

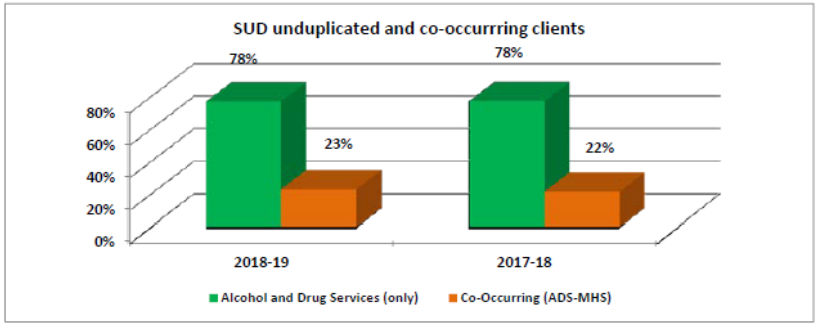
(**) SUD clients served at MH RUs during the period

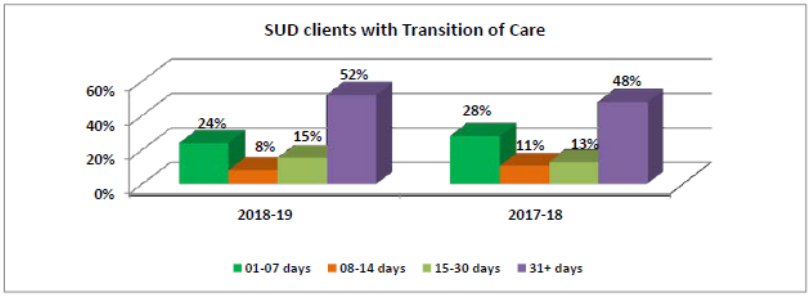
Transition of Care (***)	1,563	100%	2,178	100%
01-07 days	376	24%	613	28%
08-14 days	131	8%	238	11%
15-30 days	241	15%	283	13%
31+ days	815	52%	1044	48%

(***) Time lapse between episode re-opening in relation to the closing of a previous episode of the same client. The last episode in the series may be closed or not. Clients are unduplicated within time periods but may be duplicated between periods if they have returned more than once.

SUD comparison indicators FY 2017-18 and 2018-19







MAT Educational Brochure

About DBH

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to providing effective behavioral health services that promote wellness, recovery and resilience for individuals, families and communities.

DBH provides culturally appropriate mental health and substance use disorder treatment for all age groups, including children and youth who may be seriously emotionally disturbed, adults and older adults who are experiencing a serious and persistent mental illness, and individuals who are experiencing substance use disorders.

DBH provides behavioral health treatment to individuals in San Bernardino County who have no insurance or are on Medi-cal.

Learn more by visiting **www.sbcounty.gov/DBH.**

For 24/7 access to substance use disorder services call
(800) 968-2636
(909) 386-9740

For 24/7 access to behavioral health services call
(888) 743-1478

For all phone numbers, TTY users please dial 7-1-1.

In an EMERGENCY, call 9-1-1.

SBCounty.gov/DBH

Medication Assisted Treatment for Substance Use Disorders

SAN BERNARDINO COUNTY | Behavioral Health

Revised 7/18

What is addiction (substance use disorder) and how can medication help?

Addiction (also called a substance use disorder) is a chronic disease. Some people can't simply stop using drugs or alcohol for a few days and be cured. Some people need long-term or repeated care to stop using completely.

The good news is someone who is suffering from addiction can experience recovery with the help of medications that are designed to treat an alcohol or opioid substance use disorder.

Medication Assisted Treatment (MAT) involves the use of medications that are approved by the Federal Food and Drug Administration and prescribed by a doctor.

Medication is provided along with behavioral therapies by trained professionals.

MAT programs provide a safe and controlled level of medication to overcome the use of alcohol or opioids.

MAT may assist in relieving withdrawal symptoms and reducing cravings for drugs and/or alcohol.

MAT medications include:

- Methadone
- Buprenorphine
- Naltrexone
- Disulfiram
- Naloxone

A **common misconception** about MAT is that it substitutes one drug for another. **This is not true!**

Research has shown when provided at the proper dose, the medications used in MAT have no adverse effects on mental capability, physical functioning, or employability.

Need more information? Call us now.

DBH's Substance Use Disorder and Recovery Services helps those who are having trouble with alcohol, drugs or both.

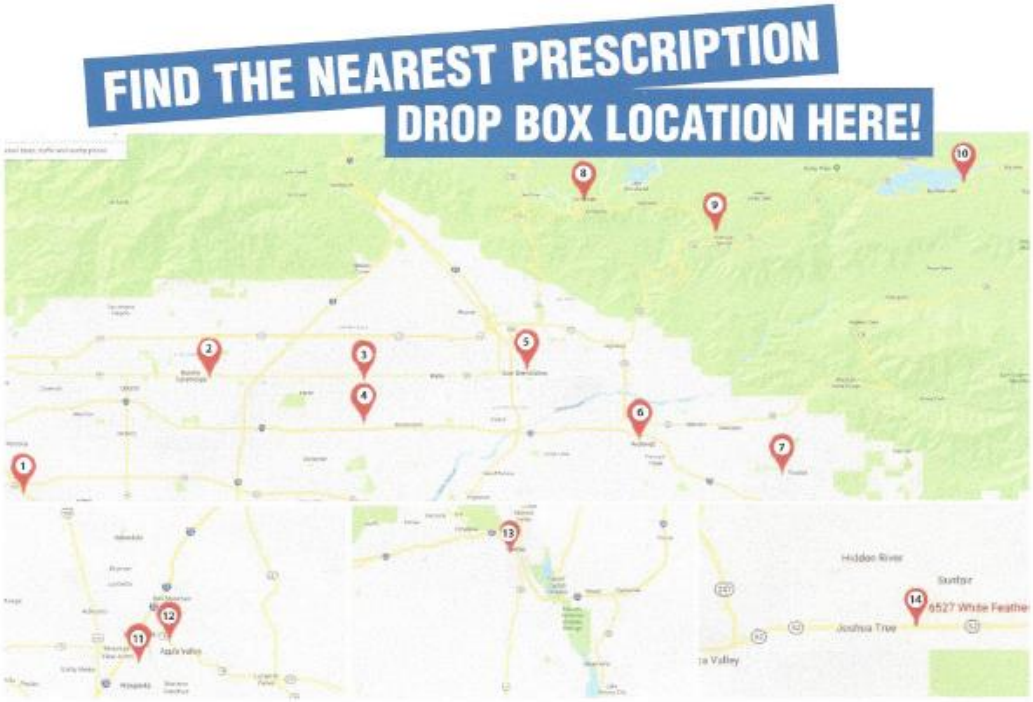
We will assess your individual needs and provide you with substance use disorder treatment and the proper MAT services that meet your needs.

If you would like more information on MAT or any other substance use disorder services or programs, please call (800) 968-2636 or (909) 386-9740.

Priority admission to substance use disorder treatment is given in the following order:

1. Pregnant injecting drug users
2. Pregnant substance user
3. Injecting drug users
4. All others

Prescription Drop Box Location Flyer



1. Chino Hills Police Station
   14077 Peyton Dr.
   Chino Hills

2. Rancho Cucamonga Police Department
   10510 Civic Center Dr.
   Rancho Cucamonga

3. City of Fontana Police Department
   17005 Upland Ave.
   Fontana

4. Kaiser Fontana 24 Hr. Pharmacy
   9961 Sierra Ave.
   Fontana

5. San Bernardino Police Department
   710 North D St.
   San Bernardino

6. CVS Pharmacy
   101 Redlands Mall
   Redlands

7. Yucaipa Police Station
   34144 Yucaipa Blvd.
   Yucaipa

8. San Bernardino's Sherriff Station - **Twin Peaks**
   26010 Highway 189
   Twin Peaks

9. Running Springs Fire Department
   31251 Hilltop Blvd.
   Running Springs

10. Brenda Boss Family Resource Center
    41820 Garstin Dr.
    Big Bear Lake

11. Walgreens Hesperia
    17051 Bear Valley Road
    Hesperia

12. San Bernardino Sheriff's - **Apple Valley**
    14931 Dale Evans Pkwy.
    Apple Valley

13. San Bernardino Sheriff's - **Needles**
    1111 Bailey Ave.
    Needles

14. San Bernardino County Sheriff's - **Morongo Basin**
    6527 White Feather Rd.
    Joshua Tree

Institute for Public Strategies · mhs MENTAL HEALTH SYSTEMS · REACH OUT Strengthening Communities · Rim Family Services · SAN BERNARDINO COUNTY

Attachment E—Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: San Bernardino County Review date(s): September 24-26, 2019
Person completing form: Alyce Belford
Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: 96%

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 processes and coordination of care:

The Department of Behavioral Health (DBH) Substance Use Disorder and Recovery Services (SUDRS) operates the Beneficiary Access Line (BAL)

Case Management- Describe if it's done by DMC-ODS via centralized teams or integrated into DMC certified programs or both:
Monthly estimated billed hours of case management: 138

Comments:

DBH provides care coordination (case management) services for clients in residential treatment services, for Intensive Outpatient Treatment (IOT), Outpatient Treatment and Recovery Services, Contracted providers will provide care coordination services for clients enrolled in their program.

Recovery Services – Support services for clients in remission from SUD having completed treatment services, but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing, relapse prevention, peer support.
Pick 1 or more as applicable and explain below:

1) Included with Access sites for linkage to treatment
2) Included with outpatient sites as step-down
3) Included with residential levels of care as step down
4) Included with NTPs as stepdown for clients in remission

Total Legal entities offering recovery services: Enter the number of total legal entities.
Total number of legal entities billing DMC-ODS: 0
Choices: Enter choice(s) here.

Comments:

San Bernardino County DBH's plan has been approved by DHCS. We have three agencies prepared to begin services pending Board of Supervisor approval.

Level 1 WM and 2 WM: Outpatient Withdrawal Management – Withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).
Number of Sites: 0
Total number of legal entities billing DMC-ODS: 0

Estimated billed hours per month: 0
How are you structuring it? - *Pick 1 or more as applicable and explain below*

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

Choice(s): Enter choice(s) here.

Comments:

San Bernardino County DBH has included Level 1WM and 2WM on the upcoming initiatives.

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

Number of sites: 5
Total number of legal entities billing DMC-ODS: 4
Number of beds: Enter number of beds.
Estimated billed hours per month: 9842
Pick 1 or more as applicable and explain below:

1) Hospitals
2) Freestanding
3) Within residential treatment center

Choice(s): Within residential treatment center

Comments:

San Bernardino County DBH has an aggregate pool of funds for Withdrawal Management and Residential Treatment Services. This allows for fluidity of placements and funding does not become a barrier for individual providers. This also allows for new providers to join the DBH network as we hold a continuous Request for Qualifications (RFQ); this will enable additional providers to join at any time within or outside San Bernardino County geographic lines. Therefore, identification of the number of beds does not fall within the current fiscal bed management system. For FY 18/19, for Level 3.2WM, the count of services utilized was 4690 by 684 unique clients, totaling 13 beds utilized; the County system is not limited by bed count.

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

Total legal entities in county: 2
In county NTP: Sites 4 Slots: 1760
Out of county NTP: Sites 2 Slots: 1075
Total estimated billed hours per month: 4600
Are all NTPs billing for non-methadone required medications? ____yes ____no9
Comments:

Aegis Treatment Centers added an additional NTP site at the end of FY 18/19 located in Redlands, CA, their billing hours may not be entirely reflected within these numbers.

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

Total legal entities: 1 Number of sites: 3
Total estimated billed hours per month: 1

Comments:

53 units of service

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

Total legal entities: 9 (adult) 6 (adolescent) Total sites: 17 (adult) 9 (adolescent)
Total number of legal entities billing DMC-ODS: 9 (adult) 6 (adolescent)
Average estimated billed hours per month: 2576

Comments:

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.

Estimated billed hours per month: 728
Total legal entities: 7 (adult) 5 (adolescent) Total sites for all legal entities: 13 (adult) 9 (adolescent)
Total number of legal entities billing DMC-ODS: 7 (adult) 5 (adolescent)
Average estimated billed hours per month: 728

Comments:

Level 2.5: Partial Hospitalization – 20 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient treatment but not 24-hour care.

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

Comments:

DBH does not currently offer this level of care

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

Total sites for all legal entities: 6
Total number of legal entities billing DMC-ODS: 4
Number of program sites: 6
Total bed capacity: Enter total bed capacity.

Average estimated billed bed days per month: 3317

Comments:

San Bernardino County DBH has an aggregate pool of funds for Withdrawal Management and Residential Treatment Services. This allows for fluidity of placements and funding does not become a barrier for individual providers. This also allows for new providers to join the DBH network as we hold a continuous Request for Qualifications (RFQ); this will enable additional providers to join at any time within or outside San Bernardino County geographic lines. Therefore, identification of the number of beds does not fall within the current fiscal bed management system. For FY 18/19, for Level 3.1, the count of services utilized was 3322 by 148 unique clients, totaling 9 beds utilized; the County system is not limited by bed count.

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.

Total sites for all legal entities: 1
Number of program sites: 1
Total number of legal entities billing DMC-ODS: 1
Total bed capacity: Enter total bed capacity.
(Can be flexed and combined in some settings with 3.5)

Comments:

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

Total sites for all legal entities: 8
Number of program sites: 8
Total number of legal entities billing DMC-ODS: 5
Total bed capacity: Enter total bed capacity.
(Can be flexed and combined in some settings with 3.5)

Comments:

San Bernardino County DBH has an aggregate pool of funds for Withdrawal Management and Residential Treatment Services. This allows for fluidity of placements and funding does not become a barrier for individual providers. This also allows for new providers to join the DBH network as we hold a continuous Request for Qualifications (RFQ); this will enable additional providers to join at any time within or outside San Bernardino County geographic lines. Therefore, identification of the number of beds does not fall within the current fiscal bed management system. For FY 18/19, for Level 3.5, the count of services utilized was 53070 by 1442 unique clients, totaling 145 beds utilized; the County system is not limited by bed count.

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??) __X__yes _____no

Number of program sites: 1

Total number of legal entities billing DMC-ODS: 0
Number of legal entities: 0
Total bed Capacity: Enter total bed capacity.

Comments:

The County's referral system for level 3.7 is Global Medical Detox located in Menifee, Riverside County, CA. San Bernardino County has collaborated with Global Medical Detox to develop a comprehensive referral process between our agencies and regularly refer clients who meet the medical necessity for level 3.7 inpatient services. Global Medical Detox bills their services for Voluntary Inpatient Detox (VID) through the FFS Medi-Cal benefit.

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? _____yes ___no access)

Number of program sites: Enter total number of program sites.
Total number of legal entities billing DMC-ODS: Enter the total number of legal entities billing.
Number of legal entities: Enter total number of legal entities.
Total bed capacity: Enter total bed capacity.

Comments:

San Bernardino County DBH does not offer this level of care directly. Individuals who are screened to need level 4 are referred to the nearest hospital.

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

Total sites for all legal entities: 3
Number of program sites: 8
Total bed capacity: 49

Comments:

The previous fiscal year 17/18 indicates a cost per bed is $27 a day; for FY 18/19 using this cost per bed day, the County has a total of 49 bed capacity.

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

No

Attachment F—Acronym List Drug Medi-Cal EQRO Reviews

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

HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IMAT	Term doing MAT outreach, engagement and treatment for clients with opioid or alcohol disorders
IN	State Information Notice
IOM	Institute of Medicine
IOT	Intensive Outpatient Treatment
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOC	Level of Care
LOS	Length of Stay
LSU	Litigation Support Unit
MAT	Medication Assisted Treatment
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
PED	Provider Enrollment Department
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan

PIP	Performance Improvement Project
PM	Performance Measure
PP	Promising Practices
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
RN	Registered Nurse
ROI	Release of Information
SAMHSA	Substance Abuse Mental Health Services Administration
SAPT	Substance Abuse Prevention Treatment – Federal Block Grant
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
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