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

SANTA CRUZ DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
May 26-27, 2021

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SANTA CRUZ DMC-ODS REPORT

Beneficiaries Served in Fiscal Year (FY) 2019-20: 1,416
Santa Cruz Threshold Language(s): Spanish
Santa Cruz Size: Medium size county
Santa Cruz Region: Central Coast
Santa Cruz Location: California Central Coast Region
Santa Cruz Seat: City of Santa Cruz
Santa Cruz Review Process Barriers: None

Review Special Characteristics

This review was originally scheduled for March of 2021 during the time of a resurge of the COVID-19 pandemic. The resurge was a public health crisis for many counties who had to temporarily reassign staff to pandemic-related responsibilities. Consequently, staffing for behavioral health departments was stretched thin in some counties. The California Department of Health Care Services (DHCS) asked the California External Quality Review Organization (CalEQRO) to make flexible arrangements for counties requesting them during this time. Santa Cruz requested a two-month postponement in their review dates, and this was approved by DHCS and CalEQRO. The review of Santa Cruz's Drug Medi-Cal Organized Delivery System (DMC-ODS) was rescheduled to May 26-27, 2021.

This review took place during the COVID-19 pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, CalEQRO worked with Santa Cruz to design an alternative to the usual in-person on-site review format by arranging for all group interview sessions to be held by video conference. Santa Cruz was able to submit all the required documents and supplementary materials prior to the review dates, and to arrange for full participation in the group interview sessions.

Introduction

Santa Cruz officially launched its DMC-ODS in January 2018 for Medi-Cal recipients as part of California's 1115 DMC Waiver. Santa Cruz was one of two initial launch counties in California's central coast region and eighth statewide. The Santa Cruz County Substance Use Disorders Services (SUDS) is part of the Behavioral Health Services (BHS) Division of Santa Cruz County Health Services Agency (HSA). In this report, "Santa Cruz" shall be used to identify the Santa Cruz County DMC-ODS program unless otherwise indicated.

Santa Cruz County is in California's central coast region. It is bordered by San Mateo County to the north, Santa Clara County to the east, Monterey and San Benito counties to the south, and the Pacific Ocean to the west. According to the U.S. Census Bureau, the county has a total area of 607 square miles of which 445 square miles is land and 162 square miles is water. It is the second-smallest county in California by land area

and third smallest by total area. The county is situated on a wide coastline with over 29 miles of beaches. Ten miles inland are the Santa Cruz Mountains. Agriculture is concentrated in the coastal lowlands at the northern and southern ends of the county. The two largest cities in the county are the City of Santa Cruz, and Watsonville.

Santa Cruz is a medium size county in population with 273,213 residents according to the 2019 U.S. Census Bureau Quick Facts. Slightly more than half the population are female. Most of the population (56.8 percent) are white, and the next largest race/ethnicity groups are Hispanic/Latino at 34.0 percent and Asian at 5.3 percent. The population age distribution is 19.0 percent under 18, 63.7 percent between 18-64, and 17.3 percent 65 and over.

During this FY 2020-21 Santa Cruz review, the CalEQRO reviewers found the following overall significant changes, initiatives, and opportunities related to DMC access, timeliness, quality, and outcomes related to the second-year implementation of Santa Cruz's DMC-ODS services. More details from the EQRO-mandated review are provided in the full report. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2019-20.

How Beneficiaries Access Care

There are some best practices important to DMC-ODS programs in how they organize their access to care. To understand whether a county is doing these, it is important to know how they have organized their access systems. In addition, the special terms and conditions (STCs) of the 1115 Waiver have specific requirements for the 24-hour beneficiary access line or as many describe it their "Access Call Center". The Access Call Centers play different roles in different counties in the linkage of clients to treatment depending on the size of the county and the design of the access points. To evaluate this element of quality, it is important first to know how this DMC-ODS has chosen to organize its access system to bring beneficiaries into the treatment system via screenings, assessments, and engagement in treatment.

Santa Cruz established their system of care for substance use treatment with multiple points of entry to make access easy. Persons seeking substance use treatment who are uncertain where to go can call the BHS Access line, which is open 24/7 through a toll-free number. The Access team staff are cross-trained to provide screenings for both mental health and substance use treatment requests during weekday business hours, and the Santa Cruz Answering Services is also cross-trained to address both types of requests after hours on weekdays and during weekends.

Access Call Center staff conduct brief screenings and then use American Society of Addiction Medicine (ASAM) patient placement criteria to make a referral for a full assessment, usually at the site that the screener believes will be the most appropriate place for the caller to begin treatment. In making the referral, the screener reviews the slot management tool for openings and helps provide a warm handoff to the provider program to ensure successful coordination.

The Access Call Line uses several types of software to help streamline and monitor timeliness metrics. They use Avaya call center software to monitor call volume, call wait time, dropped calls, and other call metrics. Santa Cruz reports their average wait time is only 23 seconds, and their dropped call rate at 4.2 percent is well within industry standards. The Call Line uses a newly developed module from Santa Cruz's electronic health record (EHR) vendor called the Screening, Referral and Disposition Log (SRDL) to enter basic pre-admission data for the caller that can be linked to later admission data for determining timeliness from first call to first appointment.

The Access Center also provides a limited number of walk-in assessments, based upon availability. Assessments are more comprehensive than screenings. The assessor makes a referral based upon their assessment findings, ASAM patient placement criteria, and consideration of the client's preferences.

Prospective clients seeking treatment can also contact a provider directly to arrange an appointment for a full assessment. Each provider program is able to accept calls from prospective clients, schedule first appointments for a full assessment, register the person as a client in the systemwide EHR, and make referrals into treatment. All provider programs are trained in use of ASAM criteria. Although most provider programs are contracted, they all use the same EHR system for both practice management and clinical record entries to facilitate easier care coordination. Providers are expected to use the SRDL for entering such data as date of first request for treatment so they can contribute to the tracking of timeliness for their program and the overall countywide system of substance use care.

Santa Cruz is a medium size county in population but small geographically. It covers a continuum of care through a small number of large providers, each of whom operate several levels of care. With this as a context, many people in the county seem familiar with the existing providers near them and inclined to contact them directly rather than going through the call center for guidance. Because most provider organizations operate multiple levels of care, the provider organization conducting the assessment can usually place the new client in an appropriate level of care with the same provider organization.

Continuum of Care Overview

The STCs require an implementation plan with phased levels of care based on the ASAM-defined continuum, expanding over time treatment options for clients to access based on their individual needs. Each year the CalEQRO reviews in depth the current services and capacity and plans for changes in the services by levels of care or capacity including consideration of locations, special needs, age groups, etc.

Santa Cruz has an extensive continuum of care that covers all the components required by the DMC-ODS Waiver STCs. The services are also spread geographically across the county so that Santa Cruz meets the state Network Adequacy standards for time and distance proximity of services. Conveniently for the county and for clients, the services

are provided by relatively few (five) main DMC-ODS contractor organizations, each of whom offers multiple levels of care. The DMC-ODS certified-treatment programs that are offered in the county include residential withdrawal management (ASAM level 3.2 WM), adult residential treatment (ASAM levels 3.1 and 3.5), perinatal residential treatment, intensive outpatient, adult and youth outpatient, narcotic treatment program (NTP), and recovery support services. Most of these levels of care offer MAT, individual and group counseling, and case management services.

Santa Cruz is in initial stages of launching several types of services. They completed a contract with a provider organization in a nearby county for some limited residential treatment bed capacity for specialized treatment of clients with co-occurring serious mental illnesses (ASAM level 3.3). They are exploring an investment in Recovery Residence beds for clients in outpatient treatment without a safe place to stay. They are at initial stages of launching Recovery Support Services with more activity than has yet been billed.

Each DMC-ODS network provider launched telehealth services in Spring 2020 as a response to the COVID-19 pandemic and the Governor's Shelter-In-Place Executive Order. Traditional in-person SUD treatment services at most outpatient treatment settings were discontinued for client and staff safety precautions. Residential 3.2 WM and residential treatment 3.1 and 3.5 settings shifted community living practices to support client and staff safety precautions and utilized telehealth and teleconferencing services for residents to communicate with community partners. Santa Cruz is conducting a performance improvement study of changing utilization patterns and client satisfaction with telehealth services, and preliminary data indicates positive client ratings for connectedness to their counselors, overall treatment cost savings to clients, convenience, and overall satisfaction.

Santa Cruz has an especially strong offering of MAT services through its NTP and through its other DMC-ODS providers. Santa Cruz provides non-methadone MAT to 29.7 percent of their clients compared with the statewide average of 6.3 percent. This statistic does not include the substantial numbers of clients who receive MAT through their primary care physicians.

Santa Cruz works closely with the two hospitals and six primary care clinics who specialize in serving the Medi-Cal and safety net populations. One of the hospitals operates an active Emergency Department (E.D) Bridge Program that provides MAT in the hospital and refers to primary care clinics for follow-up, and the other hospital is planning to launch a similar program. The county has five contracted Federally Qualified Health Clinics (FQHCs) and one county-operated FQHC Look-Alike, all of whom serve Medi-Cal clients. Each of the clinics uses an evidence-based model for integrating behavioral health clinicians into their primary care teams. They each offer evidence-based Screening, Brief Intervention, Referral and Treatment (SBIRT) for substance use disorders and provides non-methadone MAT. They are also responsive partners with Santa Cruz in providing timely physical health exams for clients who need them upon starting SUD treatment.

Case Management/Care Coordination Model

Case management and coordination of care in a managed care model based on the ASAM-defined continuum of care is a critical service. DMC-ODS programs have approached this element of the care system in vastly different ways. Because it has such a major impact on the clients and their outcomes, it is important to understand how the DMC-ODS has chosen to organize this service as part of the continuum of care. In many ways, it is the glue that makes the system work as a whole for the client versus siloed program elements. Case management services include advocacy, linkage, support, and practical assistance based on a foundation of a therapeutic alliance with the client with SUD. Given the levels of impairment and stages of change experienced, many clients need these case management supports especially in initial stages of treatment to be successful in initiation and engagement, and ultimately in progress and positive outcomes.

Santa Cruz provides decentralized case management embedded in and billed by each provider organization. Because the contracted provider organizations offer multiple levels of care the case management tasks of facilitating transitions in care is made much easier than in most counties. Clients experience the transitions in their care when within the same provider organization as less disruptive than if they were required to enter treatment at a different site with an entirely different organization.

Santa Cruz developed a strongly collaborative organizational culture, and participates actively in meetings, partnerships, and coalitions with a wide range of county and non-profit agencies and initiatives (see Key Component #1C in this report). They also facilitate an ongoing network provider meeting as a regular platform to discuss and resolve network coordination items, including coordination of care between treatment providers and ancillary services. These collaborations make it easier for case managers to link their clients to other services outside the DMC-ODS, including housing, transportation, physical health services, and mental health services.

Santa Cruz has deployed and billed for a very robust set of case management services. They served 1,416 clients in FY 2019-20 and report an estimated average number of billed 15-minute units of case management per month at 8,935. These numbers do not include other types of case management activity that are not billable under the DMC-ODS. Such examples include the active E.D. Bridge Program for care coordination of clients transitioning from the hospital to outpatient care with a severe addiction, and people in the county jail needing assistance with post-release planning for SUD treatment in their communities.

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.

DHCS contracted with 30 separate counties and seven Partnership counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act.

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

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

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

DMC-ODS Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which Santa Cruz meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of Santa Cruz 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

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1 Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.
2 Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

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

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

CalEQRO also conducts 90-minute client focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries. The client experiences reported on the TPS are also compared to the results of the in-person client focus groups conducted on all reviews. Groups include adults, youth, parent/guardians from various 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 reviews also include meetings during in-person or virtual sessions with line staff, supervisors, contractors, stakeholders, agency partners, local Medi-Cal Health Plans, primary care, and hospital providers. These sessions and client 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 assesses the research-linked programs and STCs of the Waiver as they relate to best practices, enhancing access to Medication Assisted Treatment (MAT), and developing and supervising a competent and skilled workforce with the ASAM criteria-based training and skills. The DMC-ODS should be able to establish and further refine an ASAM Continuum of Care modeled after research and optimal services for individual clients based upon their unique needs. Thus, each review includes a review of the Continuum of Care, program models linked to ASAM fidelity, MAT models, use of evidence-based practices, use of outcomes and treatment informed care, and many other components defined by CalEQRO in the Key Components section of this report that are based on CMS guidelines and the STCs of the DMC-ODS Waiver.

Discussed in the following sections are changes from the last year and 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.

PRIOR YEAR REVIEW FINDINGS

In this section, the status of last year's (FY 2019-20) EQRO review recommendations are presented, as well as changes within the DMC-ODS's environment since its last review.

Status of Prior Year Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made a number of recommendations for improvements in the DMC-ODS's programmatic and/or operational areas. During this current FY 2020-21 site visit, CalEQRO and DMC-ODS staff discussed the status of those prior year recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the DMC-ODS has either:

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

Not Met is assigned when the DMC-ODS performed no meaningful activities to address the recommendation or associated issues.

Prior Year Key Recommendations

Recommendation #1: While Santa Cruz has achieved substantial development of a full continuum of care, it should continue its work in further expansion of service capacity by:

- Completing its contracting for new DMC-ODS certified services at the ASAM level of residential treatment 3.3.
- Launching and billing for recovery support services for clients.
- Developing a specific plan with milestones and timelines for establishing recovery residence beds to meet critical needs for this critical service for those post-residential and others who need outpatient levels of care but do not have stable housing.

Status: Partially Met

- Santa Cruz completed contracting for level 3.3 treatment services in January of 2021. Santa Cruz County contracted with Horizon Services Inc, a provider in

Alameda County who has well-established ASAM level 3.3 services in two residential settings. We are currently in the process of training Horizon Services Inc staff on our EHR system and are preparing to train the Santa Cruz DMC-ODS provider network on how to assess for and refer to ASAM level 3.3 residential treatment.

- Santa Cruz County launched and is billing for Recovery Support Services (RSS) for clients. Developing RSS was a year-long collaborative process completed by a subcommittee comprised of staff representing multiple agencies across our DMC provider network. RSS was officially launched in March 2021 by two DMC-ODS providers and has approximately five persons who began receiving those services. For FY 2021-22, Santa Cruz plans to expand RSS so that it is provided by all DMC-ODS providers in Santa Cruz County.

- Santa Cruz has yet to formulate a specific plan for establishing recovery residence beds. They explain that this is one of many projects delayed due to the more immediate necessity of responding to the COVID-19 pandemic. Santa Cruz reports they have set as a priority for FY 2021-22 to plan for establishing recovery residence beds.

Recommendation #2: Complete the installation at the Call Center of Avaya, the newly configured Avatar SRDL, and the automated phone tree, and train staff in their use.

Status: Met

- Santa Cruz County Quality Improvement (QI), in collaboration with County Information Technology (IT) and the Call Center team, completed the installation of the Avaya Call Center software configuration in September 2020 and continued to monitor the data and modify the automatic phone tree choices through March 2021 to ensure accuracy of call identification.

- Santa Cruz County QI provided staff training to Call Center staff and improved the call workflow.

- Santa Cruz County QI staff recorded phone tree choice prompts/script in both English and Spanish.

- Santa Cruz County QI staff updated the SRDL to clearly identify call type, urgency level and other call details, and created revised staff training materials.

- Santa Cruz County QI and HSA IT developed an EHR SRDL timeliness report for staff, management, and QI to review performance outcomes.

Recommendation #3: Use the data generated from Avaya and the newly configured SRDL to generate reports for quality improvement regarding:

- Call Center metrics.

- Timeliness of appointments for urgent conditions.

Status: Met

- Call Center metrics: Santa Cruz generates reports regularly through Avaya software and submitted a sample to CalEQRO for this review.

- Timeliness of appointments for urgent conditions: Santa Cruz County described in the Timeliness Assessment document how they are now able to track response data for urgent requests. They also submitted associated data reports to CalEQRO for this tracking function.

Recommendation #4: Implement technologies to enable transmission of ASAM Criteria Level of Care (LOC) Referral Data to UCLA from Access Call Center screenings.

Status: Not Met

- Santa Cruz County BHS relaunched the Mental Health Plan (MHP)/DMC-ODS Network Avatar EHR Improvement Committee in January 2021, after an unexpected lengthy delay due to other COVID-19 response priorities. The committee is chaired by the QI Business System Analyst and consists of county and contract partners who utilize the county EHR system.

- An EHR Improvement Committee priority since launch is the development of a DMC-ODS Pre-Admit episodic capacity, similar to the existing MHP version, which aims to capture the ASAM Criteria LOC screening and referral activities through the SRDL and LOC form modification so that the data is transitable to UCLA along with the currently submitted treatment LOC data.

- There are to be sequestered and consent Pre-Admit episodes for beneficiary information sharing protection and linked to Outpatient LOC billable services for Case Management and Assessment (Individual Counseling HCPC codes).

- This many-month workgroup project requires network stakeholder workflow modification, form design, data extract and report configuration, as well as user/staff training and activity monitoring reports.

Recommendation #5: Incorporate more SUD-related goals and objectives into the integrated QI Workplan.

Status: Met

- The Santa Cruz County BHS Integrative QI Workplan was redesigned for FY 20-21 to incorporate newly adopted BHS Values and Guiding Principles to ground the workplan goals, and clear indicators were inserted that demonstrate when a QI Workplan goal is SUD specific, mental health specific or both as it applies to a

BHS agency-wide goal, such as access to care and quality of care. Of the current 11 goals, eight are both, one is SUD-specific and two are mental health-specific.

Recommendation #6: Incorporate more SUD-related cultural competence activities as examples in the Cultural Competence Plan and add SUD wording in subheadings where mental health now appears alone.

Status: Partially Met

- The Santa Cruz County incorporated more SUD-related cultural competency data elements, activity examples throughout the BHS integrative Culturally and Linguistically Appropriate Service (CLAS) Plan.

- The CLAS Plan revisions included the changes to subheadings to clearly identify integrated BHS, SUD-specific and mental health-specific items.

Recommendation #7: Begin piloting Power BI software for data dashboards to give Santa Cruz managers the opportunity to use reports more regularly for quality improvement and management decision making.

Status: Partially Met

- The Power BI software has been developed and piloted for Santa Cruz County SUDS managers and supervisors. It will be reviewed by Santa Cruz County executive leadership in late April 2021 with plans for it to go live in May 2021.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

- Director of SUDS position for Santa Cruz County was vacant for the majority of FY 20-21.
- Many of Santa Cruz County staff were redeployed to support the COVID-19 pandemic response for Santa Cruz County.
- The SUDS administration team staff were reduced to 50 percent for most of FY 20-21 due to employee leaves.
- Santa Cruz County's BHS workforce experienced a 7.5 percent furlough reduction in FY 2020-21, equating to a reduction of 19.5 workdays.
- DMC-ODS Network providers continued to face challenges related to COVID-19 pandemic, including staffing shortages, reduced client capacity and shifts to providing services via telehealth rather than in-person.

Past Year's Initiatives and Accomplishments

- Santa Cruz hired a new Director of SUDS with an April 19, 2021, start date.
- Santa Cruz executed new contracts for level 3.3 services, youth NTP services, and a youth 3.1 residential treatment program to meet Network Adequacy requirements.
- Recovery Support Services launched and is actively serving clients.
- Santa Cruz County Recovery Wave website was updated and redesigned. The webpage offers a more modern aesthetic, is easier to navigate, reflects current treatment/harm reduction language and has updated contact information for Santa Cruz County providers.
- The SUDS Power BI dashboard pilot was launched.

Santa Cruz Goals for the Coming Year

- Fully launch the Power BI dashboard.
- Expand RSS to all DMC-ODS providers.

- Complete the contracting already in progress for expansion of NTP capacity.

- An MAT expansion project is currently underway courtesy of a grant from Health Management Associates. This project evaluates the SUDS ecosystem and identifies the strengths and barriers of the current MAT providers. After identifying barriers, the short-term intent is for Santa Cruz to help providers set SMART goals and provide them with technical assistance to help reach their goals. Longer-term, the intent is to increase MAT access in Santa Cruz County.

PERFORMANCE MEASURES

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

1. CalOMS Treatment Data Collection Guide:

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

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

3. ASAM LOC Data Collection System:

   https://www.dhcs.ca.gov/individuals/Documents/MHSUDS_Information_Notice_18046.pdf

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

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

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

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

- Total costs per beneficiary served by each county DMC-ODS by ethnic group.

- Cultural competency of DMC-ODS services to beneficiaries.

- Penetration rates for 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.
- Timely access to medication for Narcotics Treatment Program (NTP) services.
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percentage of clients with three or more Withdrawal Management (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 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 3 of Waiver Services

This is the third year that Santa Cruz has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 2019-20), and from UCLA for TPS, ASAM LOC Referral Data, and

CalOMS data from FY 2019-20. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may be a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2019-20 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2019-20

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

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

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

The penetration rates by age group are higher in Santa Cruz compared to medium sized counties and statewide. Overall, Santa Cruz's penetration rate is over twice the statewide rate (2.48 percent compared to 1.10 percent).

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

Santa Cruz				Medium Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	8,698	86	0.99%	0.33%	0.33%
Ages 18-64	41,813	1,211	2.90%	1.62%	1.34%
Ages 65+	6,548	119	1.82%	1.20%	0.81%
TOTAL	**57,059**	**1,416**	**2.48%**	**1.35%**	**1.10%**

Table 2 below shows Santa Cruz'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. The average approved claim was $6,027 in FY

2019-20 compared to $4,930 last fiscal year. Total approved claims increased from $7.2 million in FY 2018-19 to over $8.5 million in FY 2019-20.

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

	Santa Cruz		Statewide
Age Groups	**Total Approved Claims**	**Average Approved Claims**	**Average Approved Claims**
Ages 12-17	$211,497	$2,459	$2,049
Ages 18-64	$7,572,597	$6,253	$4,632
Ages 65+	$750,701	$6,308	$4,863
TOTAL	**$8,534,795**	**$6,027**	**$4,534**

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. Santa Cruz's Medi-Cal eligible population is 49.4 percent Latino/Hispanic; however, only 22.7 percent of the clients served fall into this race/ethnicity category. Conversely, 28.8 percent of the eligible population are White, but this race/ethnicity group comprises 46.5 percent of clients served. Individuals who identified as more than one race or selected "Other" are grouped in the "Other" category. Over 18 percent of eligibles fall into this category, as well as 26.5 percent of clients served.

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

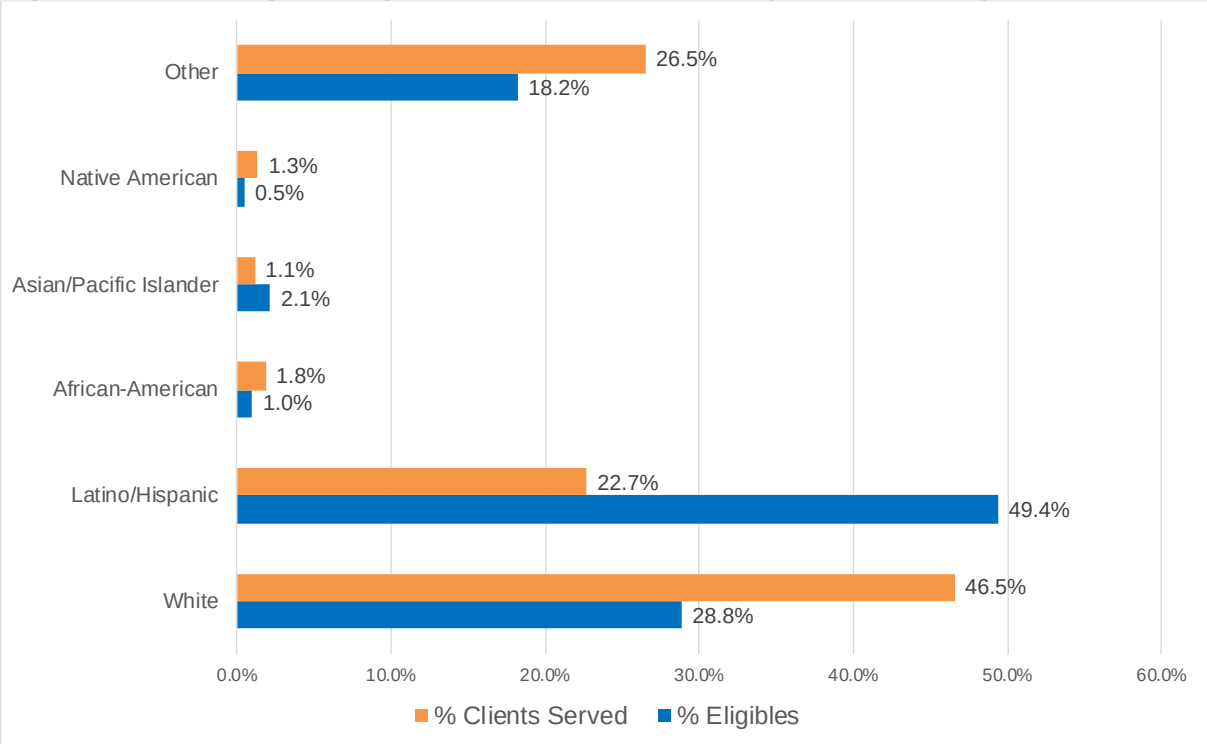


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Penetration rates by race/ethnicity are similar to rates reported last fiscal year. Across all race/ethnicity categories, Santa Cruz has higher penetration rates compared to like-sized counties and statewide.

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

Santa Cruz				Medium Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	16,454	659	4.01%	2.43%	2.09%
Latino/Hispanic	28,169	321	1.14%	0.79%	0.77%
African American	564	26	4.61%	1.65%	1.46%
Asian/Pacific Islander	1,224	16	1.31%	0.34%	0.19%
Native American	265	19	7.17%	2.22%	1.91%
Other	10,384	375	3.61%	1.69%	1.38%
TOTAL	**57,060**	**1,416**	**2.48%**	**1.35%**	**1.10%**

Table 4 below shows Santa Cruz's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. The Affordable Care Act (ACA) is the primary eligibility category for clients in Santa Cruz. Family Adult and Disabled are the next most common eligibility categories. The youth eligibility categories have small numbers of clients served and thus low penetration rates (Foster Care, Other Child, and Medicaid for Children's Health Insurance Program, or MCHIP). Penetration rates by eligibility category are higher compared to statewide rates.

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

Santa Cruz				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	6,298	237	3.76%	1.90%
Foster Care	140	9	6.43%	2.47%
Other Child	5,323	60	1.13%	0.34%
Family Adult	10,405	278	2.67%	1.16%
Other Adult	8,608	31	0.36%	0.13%
MCHIP	3,658	31	0.85%	0.24%
ACA	22,538	836	3.71%	1.75%

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

Table 5 below shows Santa Cruz's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Santa Cruz's average approved claims by adult eligibility category are higher than statewide claims across all eligibility categories.

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

Santa Cruz				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	6,298	237	$5,927	$4,534
Foster Care	140	9	$2,843	$1,583
Other Child	5,323	60	$2,371	$1,947
Family Adult	10,405	278	$5,222	$3,812
Other Adult	8,608	31	$6,789	$4,066
MCHIP	3,658	31	$2,072	$2,048
ACA	22,538	836	$6,263	$4,683

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

Table 6 shows the percentage of each service category comprising the total of client episodes, which includes some duplication of clients when they receive treatment sequentially from more than one service category. Table 6 also includes the average approved dollar amount claimed by service category. For this reason, the total number of client episodes at 2,242 is higher than the total number of unduplicated clients listed in Table 1 at 1,416. Table 6 provides a summary of service usage by clients in FY 2019-20. The service category that clients used the most was NTPs (28.7 percent) followed by Outpatient (19.6 percent) and residential treatment (19.1 percent). It is notable that the non-methadone MAT service category comprised 18.2 percent of all client episodes, which is the highest percentage for any county statewide.

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

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	644	28.7%	$4,607
Residential Treatment	428	19.1%	$8,405
Res. Withdrawal Mgmt.	207	9.2%	$1,713

Service Categories	# of Clients Served	% Served	Average Approved Claims
Ambulatory Withdrawal Mgmt.	0	0.0%	$0
Non-Methadone MAT	409	18.2%	$539
Recovery Support Services	9	0.4%	$267
Partial Hospitalization	0	0.0%	$0
Intensive Outpatient Tx.	105	4.7%	$3,513
Outpatient Services	440	19.6%	$2,329
TOTAL	**2,242**	**100.0%**	**$6,027**

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

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

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

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

Clients in Santa Cruz were able to receive their first dose of methadone within a median time of one day, which is well within the state standard and statewide average.

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

Santa Cruz				Statewide		
Age Groups	**Clients**	**%**	**Avg. Days**	**Clients**	**%**	**Avg. Days**
Ages 12-17	-	0.0%	n/a	8	0.0%	<1
Ages 18-64	548	100.0%	<1	33,420	80.0%	<1
Ages 65+	-	0.0%	n/a	8,345	20.0%	<1
TOTAL	**548**	**100.0%**	**<1**	**41,773**	**100.0%**	**<1**

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

Services for Non-Methadone MATs in Non-DMC-ODS Settings

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

As noted previously in this report, Santa Cruz has a robust set of non-methadone MAT services provided in non-DMC-ODS settings. These settings include the two hospitals that serve Medi-Cal clients, one of which has an active Emergency Department Bridge Program with a substance use navigator to help guide patients into further MAT and SUD counseling upon discharge from the hospital. Santa Cruz's five FQHC sites and one FQHC Look-Alike site each have licensed behavioral health clinicians fully integrated into their primary care teams to provide SBIRT and other counseling services while physicians provide MAT.

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 Santa Cruz 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 the EQRO.

Based on FY 2019-20 claims data, 402 (33.2 percent) of Santa Cruz clients received non-methadone MAT and 185 (15.3 percent) had three or more services. This statistic was calculated as an unduplicated count of clients and is a higher rate than any other county statewide.

Two DMC-ODS contract providers operate non-NTP based MAT programs as part of their residential treatment programs, and one provider offers non-methadone MAT services at their NTP locations.

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

Santa Cruz					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	1	1.2%	1	1.2%	8	0.2%	5	0.1%
Ages 18-64	402	33.2%	185	15.3%	6,243	6.9%	2,940	3.2%
Ages 65+	17	14.3%	11	9.2%	461	4.4%	164	1.6%
TOTAL	**420**	**29.7%**	**197**	**13.9%**	**6,712**	**6.3%**	**3,109**	**2.9%**

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

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

The DMC-ODS Waiver emphasizes client-centered care, one element is the expectation that treatment intensity should change over time to match the client's changing condition and treatment needs. This treatment philosophy is in marked contrast to a program-driven approach in which treatment would be standardized for clients according to their time in treatment (e.g., week 1, week 2, etc.).

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

Follow-up services that are counted in this measure are based on DMC-ODS claims data and include outpatient, Intensive Outpatient Treatment (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 Fee for Service (FFS)/Health Plan Medi-Cal claims data at this time.

Overall, 19.5 percent of Santa Cruz clients had a transition admission following residential treatment in FY 2019-20, which was on par with the statewide average of 19.8 percent. Santa Cruz's primary SUD treatment providers each offer multiple levels of care so that transitions are easier to facilitate.

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

Santa Cruz (n= 549)			Statewide (n= 30,523)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	27	4.9%	2,325	7.6%
Within 14 Days	47	8.6%	3,179	10.4%
Within 30 Days	58	10.6%	4,007	13.1%
Any days (TOTAL)	**107**	**19.5%**	**6,038**	**19.8%**

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 for FY 2019-20. Santa Cruz completed the installation of the Avaya Call Center software configuration in September 2020 and are now able to track various metrics such as percentage of dropped calls and time to answer calls. The low call volume reflects the Santa Cruz system that encourages clients to contact providers directly without going through the call center unless they are uncertain of which provider to contact. Unlike in most counties, most of Santa Cruz's contracted providers operate multiple levels of care and, upon conducting an ASAM Criteria-based assessment, can triage the client to the indicated level of care most appropriate for the client's needs.

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

Santa Cruz	
Average Volume	12.4 calls per month
% Dropped Calls	4.2%
Time to answer calls	23 seconds
Monthly authorizations for residential treatment	Not a function of the call center.
% of calls referred to a treatment program for care, including residential authorizations	72% of callers are linked to treatment through the Access Line

Santa Cruz	
Non-English capacity	Santa Cruz County Behavioral Health Access and after-hours answering service staff consist of threshold language bilingual staff (Spanish). Both groups also have access to the SCCBHS Language Service Associates (LSA) interpretive phone services for language needs beyond threshold languages. LSA also has the ability to offer video teleconferencing when requested. All DMC network providers have access to the LSA phone interpretive services, funded by SCCBHS.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial number of DMC-ODS services in Santa Cruz. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $12,973 in approved claims per year. The table lists the average approved claims costs for the year for Santa Cruz HCBs compared with the statewide average. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services repeatedly 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.

In Santa Cruz, 7.1 percent of clients met the threshold for classification as high-cost beneficiaries and comprised 21.7 percent of total claims.

Table 11a: High-Cost Beneficiaries by Age, Santa Cruz, FY 2019-20

Santa Cruz						
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages12-17	86	1	1.2%	$19,346	$19,346	9.1%
Ages 18-64	1,211	93	7.7%	$18,381	$1,709,411	22.6%
Ages 65+	119	6	5.0%	$20,895	$125,370	16.7%

Santa Cruz						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
TOTAL	**1,416**	**100**	**7.1%**	**$18,541**	**$1,854,127**	**21.7%**

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

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

Statewide					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	5,044	23	0.5%	$18,325	$421,464
Ages 18-64	92,245	5,205	5.6%	$19,453	$101,253,831
Ages 65+	10,622	212	2.0%	$19,362	$4,104,810
TOTAL	**107,911**	**5,440**	**5.0%**	**$19,445**	**$105,780,104**

Residential Withdrawal Management with No Other Treatment

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

Of the 204 clients who received residential WM, 2.5 percent received three or more episodes and no other treatment. This is somewhat less than the statewide average of 3.61 percent and suggests that clients in residential WM 3.2 receive effective discharge planning and case management follow-up to help connect them to SUD treatment.

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

Santa Cruz			Statewide	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	204	2.5%	8,344	3.61%

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.

The data for Table 13 is absent most of the data which can be due to many possible reasons. Among them, Santa Cruz continues to track the initial screening findings on paper which then gets scanned into the client chart and is not easily amenable to data aggregation and analysis. For the initial assessments, the majority have a “Missing Indicated Level of Care” that suggests a problem with staff entry of the required data. Additionally, during the review conversations with management revealed an issue with the way these data are mapped from the EHR into the UCLA submission form, resulting in these errors of empty data fields. Santa Cruz is working to resolve these issues to have more accurate and complete data for next fiscal year.

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

Santa Cruz ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	0	0.0%	309	21.4%	1	5.9%
Patient Preference	0	0.0%	26	1.8%	0	0.0%
Level of Care Not Available	0	0.0%	1	0.1%	0	0.0%
Clinical Judgement	0	0.0%	2	0.1%	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	0	0.0%	0	0.0%	0	0.0%
Lack of Insurance/Payment Source	0	0.0%	0	0.0%	0	0.0%
Other	0	0.0%	5	0.3%	0	0.0%
Reason Missing	0	0.0%	1	0.1%	0	0.0%
Missing Indicated Level of Care	0	0.0%	1,097	76.1%	16	94.1%
TOTAL	**0**	**0.0%**	**1,442**	**100.0%**	**17**	**100.0%**

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

Initiating and Engaging in Treatment Services

Table 14 displays results of measures for two early and vital phases of treatment-initiating and then engaging in treatment services. They are part of a set of newly adopted measures by CalEQRO for counties in their second year of DMC-ODS implementation. An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them. Research suggests that those who are able to engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. Several federal agencies and national organizations have encouraged and supported the widespread use of these measures for many years.

The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client's SUD is identified. Since CalEQRO does this through claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. This second day or visit, when within 15 days of the initial DMC-ODS service, is what in this measure is defined as "initiating" treatment.
CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service.

Santa Cruz adult clients have higher initiation and engagement rates compared to statewide. However, youth clients have lower rates for initiation and engagement compared to statewide rates.

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2019-20

	Santa Cruz				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	1,315		82		94,638		4,860	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	1,234	93.8%	59	72.0%	83,341	88.1%	3,903	80.3%
Clients who then engaged in DMC-ODS services	1,006	81.5%	37	62.7%	64,919	77.9%	2,766	70.9%

Table 15 tracks the initial DMC-ODS service used by clients to determine how they first accessed DMC-ODS services and shows the diversity of the continuum of care. NTP/OTP was Santa Cruz's leading service entry modality with 596 clients, followed by Outpatient Treatment with 357 clients and Residential Treatment with 251 clients.

Table 15: Initial DMC-ODS Service Used by Clients, FY 2019-20

Santa Cruz			Statewide	
DMC-ODS Service Modality	**#**	**%**	**#**	**%**
Outpatient treatment	357	25.6%	34,589	34.8%
Intensive outpatient treatment	60	4.3%	4,488	4.5%
NTP/OTP	596	42.7%	35,559	35.7%
Non-methadone MAT	-	0.0%	221	0.2%
Ambulatory Withdrawal	-	0.00%	22	0.02%
Partial hospitalization	-	0.00%	26	0.03%
Residential treatment	251	18.0%	17,541	17.6%
Withdrawal management	133	9.5%	6,387	6.4%
Recovery Support Services	-	0.0%	665	0.7%
TOTAL	**1,397**	**100.0%**	**99,498**	**100.0%**

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

Retention in Treatment

Table 16 is a measure of how long the system is able to retain clients in its DMC-ODS services, and counts the cumulative time that clients were involved across however many types of service they received sequentially without an interruption of more than 30 days. Defined sequentially and cumulatively in this way, research suggests that retention in treatment and recovery services is predictive of positive outcomes. To analyze the data for this measure, CalEQRO first identified all the discharges during the measurement year (in this case CY 2018), defined as the last billed service after which no further service activity was billed for over 30 days. Then for these clients, CalEQRO identified the beginning date of the service episode by counting back in time to the date before which there was no treatment for at least 30 days. The claims data used for these calculations covers 18 months of utilization data, going back six months prior to the year in which discharges are counted. Clients in outpatient programs are counted as having 7 days per week if they had at least one outpatient visit in a week.

The mean (average) length of stay for Santa Cruz clients was 115 days (median 75 days), compared to the statewide mean of 131 (median 85 days). 43.7 percent of clients had at least a 90-day length of stay; 22.0 percent had at least a 180-day stay, and 12.9 percent had at least a 270-day length of stay. These percentages are lower than statewide percentages for DMC-ODS counties.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2019-20

Santa Cruz			Statewide	
Clients with a discharge anchor event	1,214		99,817	
Length of stay (LOS) for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	115	75	131	85
	#	%	#	%
Clients with at least a 90-day LOS	530	43.7%	48,055	48.1%
Clients with at least a 180-day LOS	267	22.0%	27,414	27.5%
Clients with at least a 270-day LOS	156	12.9%	16,527	16.6%

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential withdrawal management readmissions within 30 days of discharge. Of 256 admissions into residential WM in Santa Cruz, 3.1 percent were readmitted within 30 days of discharge as compared to the 11.03 percent statewide average for all DMC-ODS counties. This substantial difference suggests that Santa Cruz is attending to discharge planning and case management follow-up towards stepdown treatment more effectively than most counties statewide.

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2019-20

Santa Cruz			Statewide	
Total DMC-ODS admissions into WM	256		10,895	
	#	%	#	%
WM readmissions within 30 days of discharge	8	3.1%	1,202	11.03%

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

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the Santa Cruz and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2019-20. The majority of clients served by DMC-ODS services in Santa Cruz have an Opioid Use Disorder (52.6 percent), higher than the statewide percentage of 45.7 percent. Alcohol Use Disorders and Other Stimulant Abuse are the next most common diagnosis codes for clients at 21.0 percent and 17.5 percent, respectively.

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2019-20

Diagnosis Codes	Santa Cruz		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	21.0%	$7,598	17.0%	$5,359
Cannabis Use	6.8%	$3,092	9.0%	$2,331
Cocaine Abuse or Dependence	0.8%	$7,277	2.0%	$5,224
Hallucinogen Dependence	0.1%	$18,595	0.2%	$5,209
Inhalant Abuse	0.0%	$0	0.0%	$6,609
Opioid	52.6%	$6,404	45.7%	$5,089
Other Stimulant Abuse	17.5%	$6,889	24.3%	$4,736
Other Psychoactive Substance	0.1%	$2,109	0.1%	$6,259
Sedative, Hypnotic Abuse	0.6%	$6,451	0.5%	$5,226
Other	0.5%	$859	1.0%	$3,088
Total	**100.0%**	**$3,168**	**100.0%**	**$4,786**

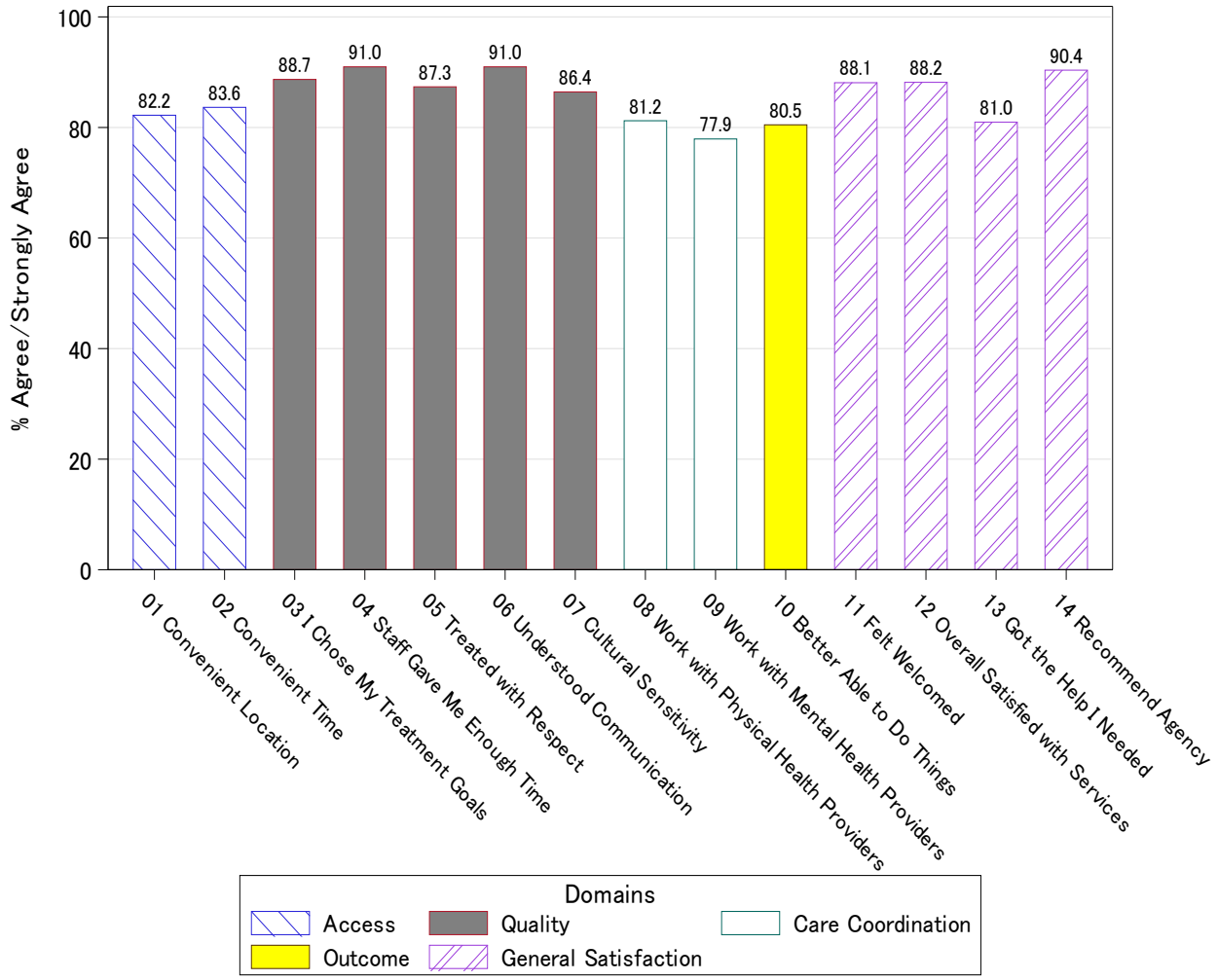
Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

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 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.

Ratings across domains for the 169 adult respondents were high. The lowest rated items were Work with Mental Health Providers (77.9 percent) and Better Able to Do Things (80.5 percent). Santa Cruz also reviews and shares the data results analyzed by treatment program and engages with specific provider programs if there appear to be opportunities for program and/or system policy improvements.

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



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

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

Tables 19-21 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 Santa Cruz will need to consider and with which agencies they will need to coordinate. Based on CalOMS data, Santa Cruz clients have higher rates of homelessness, criminal justice involvement and unemployment than the statewide averages for these situations.

Table 19: CalOMS Living Status at Admission, FY 2019-20

Admission Living Status	Santa Cruz		Statewide	
	#	%	#	%
Homeless	462	38.3%	32,027	28.7%
Dependent Living	323	26.8%	28,474	25.5%
Independent Living	421	34.9%	51,036	45.7%
TOTAL	**1,206**	**100.0%**	**111,537**	**100.0%**

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

Admission Legal Status	Santa Cruz		Statewide	
	#	%	#	%
No Criminal Justice Involvement	675	56.0%	68,737	61.7%
Under Parole Supervision by CDCR	15	1.2%	2,255	2.0%
On Parole from any other jurisdiction	6	0.5%	1,676	1.5%
Post release supervision - AB 109	412	34.2%	30,671	27.5%
Court Diversion CA Penal Code 1000	2	0.2%	2,111	1.9%
Incarcerated	0	0.0%	711	0.6%
Awaiting Trial	95	7.9%	5,324	4.8%
TOTAL	**1,205**	**100.0%**	**111,485**	**100.0%**

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

Table 21: CalOMS Employment Status at Admission, FY 2019-20

Current Employment Status	Santa Cruz		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	107	8.9%	13,156	11.8%
Employed Part Time - Less than 35 hours	102	8.5%	8,637	7.7%
Unemployed - Looking for work	218	18.1%	33,128	29.7%
Unemployed - not in the labor force and not seeking	779	64.6%	56.616	50.7%
TOTAL	**1,206**	**100.0%**	**111,537**	**100.0%**

The information displayed in Tables 22-23 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 22 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment.

Santa Cruz's administrative discharge rate of 40.2 percent was substantially lower than the statewide average of 47.1 percent, suggesting that counselors are forming strong therapeutic alliances with clients and arranging exit interviews that provide opportunities for ongoing discharge planning conversations.

Table 22: CalOMS Types of Discharges, FY 2019-20

Discharge Types	Santa Cruz		Statewide	
	#	%	#	%
Standard Adult Discharges	656	50.9%	49,577	42.1%
Administrative Adult Discharges	518	40.2%	55,467	47.1%
Detox Discharges	72	5.6%	10,420	8.8%
Youth Discharges	42	3.3%	2,415	2.1%
TOTAL	**1,288**	**100.0%**	**117,879**	**100.0%**

Table 23 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 diverse types of reasons.

Santa Cruz providers rated on average more than half their clients (51.4 percent) as having made satisfactory progress at the time of discharge. This was a higher percentage than the statewide average of 45.8 percent.

Table 23: CalOMS Discharge Status Ratings, FY 2019-20

Discharge Status	Santa Cruz		Statewide	
	#	%	#	%
Completed Treatment - Referred	322	26.0%	20,317	17.6%
Completed Treatment - Not Referred	106	8.3%	6,759	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	68	5.3%	17,115	14.8%
Left Before Completion with Satisfactory Progress – Administrative Questions	151	11.8%	8,734	7.6%
Subtotal	*647*	*51.4%*	*52,925*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	259	20.2%	16,693	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	346	27.0%	44,609	38.6%
Death	4	0.3%	235	0.2%
Incarceration	12	1.0%	1,058	0.9%
Subtotal	*621*	*48.5%*	*62,595*	*54.1%*
TOTAL	**1,280**	**100.0%**	**115,520**	**100.0%**

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

Performance Measures Findings: Impact and Implications

Access to Care

- Penetration rates by age, race/ethnicity, and eligibility categories were higher in Santa Cruz compared to statewide, evidence that clients are finding their way into services.

- While the penetration rate for Hispanic/Latinos of 1.14 percent is higher than the statewide rate of 0.77 percent, there is still disproportionate access to services for

this group. While 49.4 percent of the total Medi-Cal eligible population is Hispanic/Latino, only 22.7 percent of clients are in this race/ethnicity group.

Timeliness of Services

- Days to first dose of methadone were within one median day.

- For transitions post-residential, 8.6 percent of Santa Cruz clients had a transition to a lower level of care within 14 days as compared to the somewhat higher statewide average of 10.4 percent. Overall, within any days, 19.5 percent had a follow-up service, on par with the statewide rate of 19.8 percent.

Quality of Care

- Non-methadone MAT is a strength in Santa Cruz with 29.7 percent of all clients receiving at least one dose as compared to the statewide average of 6.3 percent. There is a drop off of clients receiving three or more doses (13.9 percent) but that compares favorably with the statewide average of only 2.9 percent. Also, there are many non-DMC sites where clients might be continuing to receive their addiction medicine without it showing in DMC-ODS claims data.

- Congruence of LOC referrals with ASAM Criteria-based findings is an important quality measure; currently, Santa Cruz does not track the initial screening results and there is a glitch in the system that is resulting in “missing indicated LOC” results. Thus, the data is not usable for QI efforts.

- Initiation and engagement rates are higher in Santa Cruz than statewide for adults. For youth, both initiation and engagement rates are lower which suggests an area for improvement.

- Results of the TPS indicated that clients have positive perceptions of the quality of their treatment, with more than 80 percent of clients rating most items favorably. The lowest rated item (77.9 percent) involves clients with co-occurring mental health needs expressing the wish for better coordination of care with mental health providers.

Client Outcomes

- Approximately 80 percent of clients rated themselves as better able to do the things they want as a result of their treatment.

- Providers used the CalOMS discharge summary to rate 51.4 percent of their clients as having made satisfactory progress by the time of their discharge in FY 2019-20. This compares favorably with the statewide average of 45.8 percent during the same period, and to Santa Cruz’s average of 48.2 percent in the previous year of FY 2018-19.

INFORMATION SYSTEMS REVIEW

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

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

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

ISCA Table 1 shows the percentage of DMC-ODS budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous two-year period, as well as the corresponding DMC-ODS and statewide averages. The ratings indicate that Santa Cruz invests a lower percentage of its budget in IT operations for DMC-ODS than the statewide average.

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

Entity	FY 2020-21	FY 2019-20	FY 2018-19
Santa Cruz	1.3%	1.14%	1.22%
Medium	N/A	1.54%	2.74%
Statewide	N/A	2.40%	3.16%

The budget determination process for information system operations is:

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

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

ISCA Table 2: Business Operations

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

- Primary IS support is from the internal IS team. If there is an issue with Avatar that requires involving the vendor, the IS team will open a ticket with Netsmart for that issue.

- The county IS department has a training for staff on cyber security and do phishing attacks to make sure staff are in compliance with their training requirements. Additionally, the HIPAA compliance officer sends out information on a regular basis to staff to assist with compromise situations.

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

ISCA Table 3: Distribution of Services by Type of Provider

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

Summary of Technology and Data Analytical Staffing

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

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	7	1	2	2
2019-20	7	2	0	2
2018-19	5	0	0	1

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

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	3	0	1	1
2019-20	4	0	0	0
2018-19	4	1	0	1

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

- Two positions were vacated by staff taking early retirement packages and recruitment to fill those positions cannot begin for two years per County policy on early retirement.

- The IT Business System Analyst position was filled, and that staff member has taken on key responsibilities such as coordinating the Avatar User Group.

Summary of User Support and EHR Training

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

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	12	27	39
Clinical Healthcare Professional	12	167	179
Clinical Peer Specialist	0	0	0
Quality Improvement	13	3	16
Total	37	197	234

ISCA Table 7: EHR User Support

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

ISCA Table 8: New Users EHR Training

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

ISCA Table 9: Ongoing EHR Training and Support

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

Telehealth Services Delivered by County and Contract Providers

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

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 10: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	19
Number of county-operated telehealth sites	1
Number of contract providers' telehealth sites	11

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

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

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

- Prior to COVID-19, telehealth efforts were based on ensuring that monolingual clients and those with hearing/ ASL needs had appropriate access to care. The Shelter-In-Place order caught many people off guard where policies and priorities had to quickly shift to meet new and often changing demands. Santa Cruz received ongoing and updated guidance from DHCS regarding telehealth starting in mid-March through April.

- Prior to COVID-19, there were very few, if any, staff working remotely. As such, many were not equipped with the technology and infrastructure to work off site. To address this, BHS/HSA IT purchased additional and upgraded Microsoft Teams to HIPAA compliant licenses, provided additional training, expanded Microsoft Teams and in some cases, provided laptops and video cameras.

- From a billing perspective, Santa Cruz created a new Service Location code in the Avatar EHR, for providers to use when billing for SUD services that are rendered via telehealth. Santa Cruz created and disseminated documentation on the new telehealth coding and provided technical assistance and guidance around the use of telehealth. Santa Cruz also created and disseminated documentation regarding changes to COVID-19 impacted authorization processes and converted several consent forms to DocuSign format.

- From a system of care perspective, the BHS Leadership Team conducted weekly meetings and frequent correspondence between meetings with providers to keep them updated amidst changing health orders and guidance regarding COVID-19. These meetings were also a venue for technical assistance on accurately recording telehealth sessions. There was some confusion with providers, particularly those using their own EHR for MHS and SUDS, because Drug Medi-Cal requirements for telehealth services are different than those for SDMC Mental Health services.

- From an information dissemination perspective, the BHS Avatar webpage became a central location for QI notices. The website also began to serve as the Santa Cruz County COVID-19 information center for updates on client and staff safety guidelines, written information, and a listing of other available resources, and for all aspects of Public Health and BHS responses to the pandemic.

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

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

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Encompass	4
Janus	4
PVPSA	2
Sobriety Works	1

Current DMC-ODS Operations

- Santa Cruz continues to utilize the Avatar system, implemented in 2016, in an Application Service Provider (ASP) model with Netsmart Technologies as their provider.

- Santa Cruz participates in the Santa Cruz Health Information Organization.

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

ISCA Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar	EHR	Netsmart	4	Netsmart
SCHIE	Transcription service	SCHIE	20	Axesson
OrderConnect	Medication and Lab orders	Netsmart	4	Netsmart
County 800# Call Center Routing	Call routing	Avaya	<1	ISD

The DMC-ODS Priorities for the Coming Year

- Avatar Forms customizations (ongoing).
- Report Requests and automation (ongoing).
- Develop a DMC-ODS Pre-Admit program in Avatar.
- Provider Directory (dynamic).
- Online release and consent tracking.

Major Changes since Prior Year

- Uniform dataset for contractors.
- PMO Dashboard Outpatient Treatment Plan completion rate.
- Data warehouse optimization, Service extracts & Reporting Portal.
- Call Center Routing System (Avaya).
- SUDS Dashboard reports through PowerBI.
- DMC-ODS NACT delivery.
- DMC-ODS Supervisory compliance reports and widgets.

Plans for Information Systems Change

- No plans to replace current system (in place more than five years).

DMC-ODS EHR Status

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

ISCA Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☒	☐	☐	☐
Assessments		☒	☐	☐	☐
Care Coordination		☒	☐	☐	☐
Document Imaging/ Storage		☒	☐	☐	☐
Electronic Signature—DMC-ODS Beneficiary		☒	☐	☐	☐
Laboratory results (eLab)		☒	☐	☐	☐
Level of Care/Level of Service		☒	☐	☐	☐
Outcomes		☒	☐	☐	☐
Prescriptions (eRx)		☒	☐	☐	☐
Progress Notes		☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans		☒	☐	☐	☐
FY 2020-21 Summary Totals for EHR Functionality:		11	0	1	0
FY 2019-20 Summary Totals for EHR Functionality:		9	0	3	0

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

- Since last year, Santa Cruz was able to include Lab Results, Level of Care/Level of Service, and Referral Management as part of its EHR functionality.
- All contract providers have full access to the EHR for service documentation and billing.

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

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

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

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

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

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

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

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

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

EHR Vendor	Product	Count of Providers Supported
n/a	n/a	n/a

Special Issues Related to Contract Agencies

- Contract providers have full access to the county's EHR (Avatar). This has tremendous benefits for tracking timeliness, assessing capacity and service needs, as well as other quality elements. The downside is that contract providers indicated that they have other reporting requirements for other funders/contracts and the costs of those additional systems are not covered by the county.

Findings Related to ASAM LOC Referral Data, CalOMS, and TPS

ISCA Table 17: Findings Related to ASAM LOC Referral Data, CalOMS, and TPS

Findings Related to ASAM Level of Care Referral Data, CalOMS, and TPS	Yes	No
ASAM Criteria is used for assessment for clients in all DMC Programs.	x	
ASAM Criteria is used to improve care.		x
ASAM Criteria-based screening is entered directly into the EHR.	x	

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

Highlights or challenges of use of outcome tools above:

- ASAM-based criteria LOC referral data are sent to UCLA but there is a mapping issue that is resulting in the data being unusable for analysis and decision-making.

Overview and Key Findings

Operations and Structure

- The Avaya telephone system has been installed and Santa Cruz is able to capture critical indicators for the Access Line.
- There is a mapping issue with the ASAM Criteria-based data that IS leadership is working to resolve. Until this issue is corrected, Santa Cruz will be unable to analyze the data for trends and decision-making.
- The workflow for the pre-admit initial screening process needs to be determined before the technical pieces are built into the EHR.

Key Findings

- Currently, the lack of usable data from the ASAM Criteria-based screenings and assessments inhibits Santa Cruz from incorporating the information into the QI workplan for trending and decision-making.
- It is a strength of the county that contract providers all use Avatar and participate in the Avatar Improvement Group.
- Santa Cruz has started using Power BI to support data analytics.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Santa Cruz, the time and distance requirements are 60 minutes or 30 miles for substance use disorder outpatient services, and 60 minutes and 30 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

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

Review Sessions

CalEQRO conducted two client and family member focus groups, one stakeholder group interview, 11 staff and contractor group interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

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

Also presented to Santa Cruz for their consideration were five other types of access questions: disabled population, health plan transportation supports, telehealth services, mobile services, and coordinating care with native American Indian Health Services. Santa Cruz does not have any Native American Indian Health clinics in the county. Their responses to the other four questions were as follows:

Serving the disabled: Santa Cruz Health Services Agency, inclusive of DMC-ODS, offers disabled beneficiaries a variety of ADA accommodations, such as accessible hand-railed ramps and push button doors at BHS buildings for physical mobility challenges. For the visually challenged, the BHS also offers audio recordings of Beneficiary Handbooks (English and threshold Spanish languages) and has staff available to read other materials and brochures upon request; and for hearing challenges, BHS has an email address available to beneficiaries seeking services as well as for alerting the public of 711 as a communication resource. BHS has some staff who are ASL interpreters, and when not available staff can access contracted video teleconferencing services with ASL interpretation when a beneficiary is familiar with this language. Santa Cruz can also directly assist with linkage to 711 for additional communication support as needed. Santa Cruz network providers are required to adhere to ADA accommodations both contractually and in compliance with federal and state regulations. The BHS Quality Improvement division monitors adherence through certification/recertification site reviews, including policies, signage, and physical site walk-throughs. Also, QI can address ADA issues that present through a beneficiary's ADA and quality of care complaints or appeals.

Transportation supports: BHS has a well-established partnership defined in a Memorandum of Understanding (MOU) with Central California Alliance for Health, the county's single managed care plan (MCP). BHS' increased focus on transportation coordination activities have improved their access to and utilization of the MCP's transportation services. The MCP transportation service is available to all MCP Medi-Cal beneficiaries who need non-emergency assistance to get to treatment appointments, inclusive of DMC-ODS services. BHS and the MCP mutually participate in frequent agency hosted meetings to keep communication channels open and address coordination of care items. The MCP continues to expand and strengthen their capacity for transportation assistance and is receptive to hearing and incorporating feedback received form BHS and the DMC-ODS network. In addition, DMC-ODS network providers offer transportation to services when there is a need to support the individual's success in attending the appointment, comprehending the information shared by the treating provider, and/or conducting post-appointment follow-up actions. These DMC-ODS network providers coordinate services for MAT/NTP, outpatient, residential treatment as

well as PCP, mental health/psychiatry, dental, and more. Such services directly affect an individual's success in treatment participation and wellness outcomes.

Telehealth services: Telehealth services are not required for time and distance, but Santa Cruz began using them in response to public health safety precautions during the COVID-19 pandemic. In response to COVID-19, privacy issues have been eased/expedited to allow continued service via online platforms such as Zoom and MS Teams. These types of service delivery also enabled Santa Cruz to support those who need ASL services or have mobility issues.

Each DMC-ODS network provider launched telehealth services within each treatment entity in Spring 2020 as a response to the COVID-19 pandemic and Shelter in Place order and traditional in-person SUD treatment services at most LOC treatment settings were discontinued for client and staff safety precaution. Residential settings and 3.2 WM utilized telehealth and teleconferencing services with community partners, but mostly shifted community living practices within the residential settings to support client and staff safety precautions. Telehealth service data indicate there was a range of telehealth use by clients depending on technology and personal comfort variables.

Mobile services: Santa Cruz County BHS was granted California Health Facility Financing authority (CHFFA) funds for the purchase of a customized service van for expanding access to confidential and urgent care within the south county region of the county. The van is designated for the BHS Mobile Emergency Response Team (MERT), consisting of BHS licensed/licensed eligible staff and a Peer Specialist partner, who respond to urgent service needs of adult and children/youth residents. BHS submitted an additional grant proposal for expanding the service to other regions within the county and is awaiting approval.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

Santa Cruz DMC-ODS PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. One Clinical and one Non-Clinical PIP were reviewed and validated, as shown below.

PIP Table 1: PIPs Submitted by Santa Cruz

PIPs for Validation	Number of PIPs	PIP Titles
Clinical PIP	One	COVID-19
Non-Clinical PIP	One	Addressing Outpatient/Intensive Outpatient DMC-ODS Admissions Decline

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	Santa Cruz
PIP Title	COVID-19
PIP Aim Statement	Will the programmatic utilization of telehealth and telephone treatment modes increase the beneficiary’s experience of treatment accessibility, engagement, helpfulness, and overall quality of care satisfaction? The time periods for the study will include the six months prior to Shelter in Place orders (September

DMC-ODS Name	Santa Cruz
	1, 2019-February 29, 2020), the initial six months following when Shelter in Place orders went into effect (March 1, 2020-August 31, 2020), and the subsequent months to the end of the PIP study period (September 1, 2020-June 2022).
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): The SUD client population in this study includes all DMC-ODS beneficiaries receiving services in Santa Cruz's county-operated and contracted network of outpatient treatment programs for the DMC-ODS. The date range for clients receiving services will be September 2019-May 2022. Their age distribution is 18 years and older. Their race/ethnicity mix will be a combination of Caucasian, Latino, African American, Asian, Native American, Pacific Islander and Other. All recipients will have a primary diagnosis of a Substance Use Disorder with the possibility of also having a secondary mental health diagnosis that is mild or moderate.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): • DMC-ODS outpatient group sessions via telehealth and telephonic modes. • DMC-ODS individual counseling session via telehealth and telephonic modes. • DMC-ODS case management via telehealth and telephonic modes.

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Providers were given standardized training in how to effectively use telehealth modes of delivering outpatient treatment services. The training included technological aspects of the telehealth platforms utilized (Microsoft Teams and Zoom) as well as clinical skills on how to delivery treatment effectively through telehealth. The combined trainings totaled 12 hours for every staff member. • Direct service providers who deliver clinical services meet with their supervisors on a weekly basis to discuss strengths and challenges of delivering services through telehealth modalities. Teams meet on a weekly and monthly basis with supervisors and managers to discuss overall impacts of telehealth services and troubleshoot any difficulties arising for service delivery in this mode.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Total number of clients served.	9/1/20 to 2/29/20	N=1052	3/1/20 to 8/31/20	N=813	Reduced post-COVID-19	n/a
Percent of total sessions per service modality (i.e., group counseling, individual counseling, case management)	9/1/19 to 2/29/20	Not yet analyzed	3/1/20 to 8/31/20	Not yet analyzed	n/a	n/a
Patterns of service mode of delivery: percent of services delivered through a) in-person, b) phone, and c) telehealth	9/1/19 to 2/29/20	a) N = 5056 88.0% b) N = 688 12.0% c) N=0 0.0%	3/1/20 to 8/31/20	a) N = 1969 39.3% b) N = 1261 25.1% c) N = 1783 35.6%	Patterns changed post-COVID-19	n/a
Percent of total scheduled services which had no shows	9/1/19 to 2/29/20	N= 5729 17.8%	3/1/20 to 8/31/20	N = 4985 14.9%	Reduced	n/a
Beneficiary satisfaction with connectedness to their counselor for services a) in-person, b) telehealth	3/15/20 to 4/11/10	a) N =23 87.0% b) N=25 88.0%	n/a	n/a	n/a	n/a

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Beneficiary satisfaction with effectiveness of treatment through a) in-person, b) telehealth	3/15/20 to 4/11/10	a) N=25 84.0% b) N=24 87.5%	n/a	n/a	n/a	n/a
Beneficiary satisfaction with sensitivity of their counselor to their cultural background through a) in person, b) telehealth	3/15/20 to 4/11/10	a) N=24 87.5% b) N=23 91.3%	n/a	n/a	n/a	n/a
Beneficiary overall preference for receiving services a) in-person, b) telehealth	3/15/20 to 4/11/10	a) N=25 52% b) N-25 76%	n/a	n/a	n/a	n/a
Beneficiary assessment that telehealth delivery of treatment costs them extra money to buy needed equipment	3/15/20 to 4/11/10	N=25 16.0%	n/a	n/a	n/a	n/a
Beneficiary assessment that telehealth saves them money on costs related to getting services.	3/15/20 to 4/11/10	N = 25 84%	n/a	n/a	n/a	Other (specify) :

Was the PIP validated?	☒ Yes	☐ No

Validation phase:

☐ PIP submitted for approval

☐ Planning phase

☐ Implementation phase

☐ Baseline year

☒ First remeasurement

☐ Second remeasurement

☒ Other (specify): The first remeasurement for this PIP's utilization measures followed the beginning of COVID-19 pandemic-related health safety precautions and introduction of telehealth services. Consequently, the first remeasurement was actually a new set of baseline measures under an entirely different set of circumstances than the first baseline.

This PIP's client survey measures were first administered after the introduction of COVID-19 pandemic-related health safety precautions and telehealth services. As such, these first survey measures established an initial baseline.

Validation rating:

☐ High confidence

☐ Moderate confidence

☒ Low confidence

☐ No confidence

Note: The COVID-19 pandemic is a huge factor not just impacting the telehealth-related findings but prompting the change to telehealth. Therefore, the first remeasurement is in effect a second type of baseline measure. Subsequent remeasurements are needed to determine the usefulness of telehealth as a means of service delivery.

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

EQRO recommendations for improvement of PIP: The PIP is in the initial stages of measurement and should be continued. The survey should be administered regularly to all clients. The survey and utilization data analyses should be reported quarterly. Technical assistance should be sought through the newly hired PIP consultant and through CalEQRO. Options should be formulated for ongoing use of telehealth after the pandemic, depending upon the findings of the PIP.

The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: The CalEQRO Lead Reviewer met with the Santa Cruz PIP team members to provide TA for four sessions in December 2020, two sessions in April 2021, two sessions in May 2021 and one session in June 2021. Santa Cruz provided write-ups of the PIP design which the CalEQRO Lead Reviewer studied, edited, and commented upon with recommendations.

Non-clinical PIP

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

DMC-ODS Name	Santa Cruz
PIP Title	Addressing Outpatient/Intensive Outpatient DMC-ODS Admissions Decline
PIP Aim Statement	By the end of FY 2021-2022 (June 30, 2022), Santa Cruz will provide targeted community outreach and beneficiary education materials to improve client access to care for adults seeking Santa Cruz County DMC-ODS outpatient / intensive outpatient (OP/IOP) treatment services. By doing so, Santa Cruz intends to increase OP/IOP program admissions by 40% from admission numbers in FY 2020-2021 Q1, returning to near the pre-COVID-19 194 admissions in Q1 FY19-20.
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): The PIP focuses on DMC-ODS adult (age 18+) beneficiaries who meet ASAM LOC criteria for OP/IOP at a DMC-ODS network provider program. Individuals will be Santa Cruz County residents living within the North to South regions.	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Develop training presentations and beneficiary educational materials for potential referral sources to use in helping beneficiaries access treatment who are not directly seeking treatment through DMC-ODS network gates, and to educate and reduce stigma associated with seeking behavioral health care. The trainings will explain the range of SUD treatment services that are available and how to access/refer people to them for treatment. The educational materials will be bilingual brochures to leave with agencies to provide to potential clients. • Provide community outreach to potential referral sources who are familiar with Medi-Cal beneficiaries and their substance use treatment needs. These sources will include selected mental health treatment providers, substance use prevention providers, and correctional entities.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number of referrals resulting in an initial intake session for adult OP/IOP from any of the agencies to whom Santa Cruz conducted a PIP outreach activity.	Not yet imple-mented	n/a	n/a	n/a	n/a	n/a
Number of initial intake sessions to adult OP/IOP programs	a) 7/1/19 to 9/30/19 b) 7/1/20 to 9/30/20	a) 194 b) 115	n/a	n/a	n/a	n/a

Was the PIP validated?	☒ Yes	☐ No

Validation phase:

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

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence Note: The drop in admissions appears due to the COVID-19 pandemic. External factors including the gradual receding of the pandemic and an increased acceptance of telehealth will likely result in some increase in admissions. Santa Cruz researched which referral sources were previously most effective and there is moderate confidence that outreach to them will help increase referrals in the near future. However, the PIP outreach interventions have yet to be implemented. "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Proceed with the interventions. Diligently track the: 1) names of the agencies to whom Santa Cruz outreached, 2) number of attendees at each training, 3) referral source for each new OOP/IOP intake session.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: The CalEQRO Lead Reviewer met with the Santa Cruz PIP team members to provide TA for two sessions in May 2021 and one in June 2021. Santa Cruz provided write-ups of the PIP design which the CalEQRO Lead Reviewer studied, edited, and commented upon with recommendations.

*PIP is in planning and implementation phase if NA is checked.

CLIENT FOCUS GROUPS

CalEQRO conducted two 90-minute client and family member focus groups during the Santa Cruz DMC-ODS site review. As part of the pre-site planning process, CalEQRO requested the focus groups with six to eight participants each, the details of which can be found in each section below. The groups were conducted through video conference technology in keeping with health safety precautions during the COVID-19 pandemic.

The client/family member focus group is a vital 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 an extension of survey questions that are completed by the focus group participants prior to the focus group. Their responses and the subsequent discussion with them 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: Clients in Medication Assisted Treatment

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

The Santa Cruz Adult MAT Stakeholders Group consisted of all males, with one in the 18-24 age group and five in the 25-59 age group. Five of the participants identified as Caucasian and one as Latino/Hispanic. All spoke English. Four of the six participants started treatment within the past year.

Number of participants: six

Participants were first asked to complete an online survey prior to the convening of the group. The survey instructions requested each participant to rate each of nine items on a five-point scale (using feeling facial expressions, not numbers) using 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 survey instructions explained that the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The survey instructions further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. These instructions were repeated by the focus group survey facilitators, who used the survey questions as a guide for the focus group discussion.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.8	4-5
2. I got my assessment appointment at a time and date I wanted.	4.8	4-5
3. It did not take long to begin treatment soon after my first appointment.	5	5
4. I feel comfortable calling my program for help with an urgent problem.	4.5	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.3	3-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	5	5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.7	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	5	5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	5	5

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

- Suboxone is an improvement over methadone. I had several relapses during the past ten years.

- My transfer to a permanent MAT program from Encompass Pathways is counter-productive to my recovery as a human being.

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

- “She (sic: counselor) helps me with my medication, moving forward with my recovery, and help support me with all my problems no matter the scope of them.”

- “Behavioral Health could be more involved, Probation is helpful, but could use education to be more helpful.”

- “It is almost like I am in limbo when I get out of Residential.”

Recommendations for improving care included the following:

- “Maintenance to help push a long-term approach more than short-term.”

- “Help us even after we leave rehab…any type of way.”

Interpreter used for focus group 1: No

Focus Group Two: Adult Clients in Residential Treatment

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

CalEQRO interviewed a group of Adults in Residential Treatment from three different programs: Janus RTC, Janus Perinatal, and New Life Program. All eight survey respondents fell within the 25-59 age range. Three identified themselves as Latin-Hispanic, with one of these three also identifying as Native American. One identified as Asian Pacific Islander and four as Caucasian. Seven of the eight respondents participated in the focus group, three of whom were males and four females. Six of the seven reported having started services with the past year.

Number of participants: eight

Participants were first asked to complete an online survey prior to the convening of the group. The survey instructions requested each participant to rate each of nine items on a five-point scale (using feeling facial expressions, not numbers) using 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 survey instructions explained that the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The survey instructions further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. These instructions were repeated by the focus group survey facilitators, who used the survey questions as a guide for the focus group discussion.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.3	4-5
2. I got my assessment appointment at a time and date I wanted.	3.7	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.4	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.4	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.3	4-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.4	4-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.5	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.3	4-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.5	4-5

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

- “This has saved my life.”
- “My counselor provided everything I needed to help me with my treatment plan and gave me the proper information for my recovery.”
- “The program did not entirely meet us where we were during COVID-19; families could not visit.”

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

- “Everything works good for my personal treatment plan.”

Recommendations for improving care included the following:

- None noted.

Interpreter used for focus group two: No

Client Focus Group Findings and Experience of Care

Overview

- Although the participants in the residential treatment focus group commented favorably about their access to treatment, their survey response average ratings for access to treatment was lower than for the other eight questions.
- Clients remarked that the approach can differ among the various residential treatment programs to relapsing clients, with some programs seeming to have stricter policies than others. New Life was remarked as the strictest program.
- Residential treatment clients with an accompanying MAT regimen remarked that the doses seem higher and of a longer duration in treatment than they think would be most effective for their recovery.

Access Feedback from Client Focus Groups

- Participants did not report any unduly extensive waiting periods for admission into either MAT or residential treatment. In fact, one residential treatment client reported being admitted into residential treatment within a couple of hours following her call requesting treatment.

Timeliness of Services Feedback from Client Focus Groups

- According to the residential treatment survey ratings, “getting my assessment appointment when I wanted it” was scored lower than all other items.

Quality of Care Issues from Client Focus Groups

- Satisfaction with counselor was high according to verbal responses and the survey results.

- Programming suggestions included: more physical activity, additional transition supports, and family/parental programming was needed in outpatient and Residential levels of care.

- Clients are grateful for the services received and acknowledge the necessity of the treatments provided for their early recovery.

- Sustained recovery supports could utilize more cooperation from criminal justice, mental health, and job/educational training and placement. Housing is a challenge in Santa Cruz with the exorbitant cost of living there. Physical health service providers seem to provide the most cooperation and assistance with SUD recovery services in this county.

Client Outcomes Feedback from Client Focus Groups

- Clients in both focus groups uniformly rated the outcome item in the client survey positively that read “Because of the services I am receiving, I am better able to do things that I want.” Survey respondents in the focus group of clients receiving MAT uniformly gave this item their highest rating.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	PM
Santa Cruz has a single Cultural Competence Plan to address both mental health and substance use issues. The Plan covers standards for Culturally and Linguistically Appropriate Services (CLAS) and promotes many culturally competent principles for behavioral health services. During the previous two reviews, CalEQRO remarked that the Plan seemed predominantly focused on mental health services and needed more inclusion of substance use services to achieve balance. In response, the current Plan Update reflects a noticeable increase in focus on substance use services and the DMC-ODS, but still requires more work to achieve the balance and integration that it aspires to reflect. Two of the chapter titles in the Plan refer only to mental health, and the references to “mental health” and “MHP” are approximately double the references to “substance use”, “DMC-ODS” and “SUD”. Part of the reason for this is simply the larger set of mental health services compared to substance use services. Nevertheless, some further attention to specific inclusion of SUD in the Plan seems warranted. The Plan includes data analyses to determine which types of demographic subgroups are under-represented among clients separately for mental health and for substance use. The Plan notes in particular the under-representation of the		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
Latino/Hispanic population as clients in treatment. The Plan describes a range of cultural competence-related activities including outreach to the under-represented subgroups in their communities, staff trainings in cultural competence and cultural humility, and monitoring of how providers are implementing CLAS standards. Santa Cruz set as a priority for both their county-operated and contract provider services to have bilingual staff for both administrative and clinical operations, and they have been successful in doing so. Santa Cruz also arranges translations of all essential client materials into Spanish, both on the county website and in hard copy handouts. These efforts create a welcoming and engaging treatment culture for new clients from diverse racial, ethnic, and linguistic backgrounds. Santa Cruz makes a special effort to provider culturally sensitive outreach and treatment services in the Watsonville area where a large Latino/Hispanic community resides. They also participate in many county-wide coalitions that address the needs of diverse demographic subgroups. Santa Cruz aspires to measure the effectiveness of their cultural competence interventions. Doing so would be a positive step towards informing management and stakeholders of their effectiveness and of areas where that effectiveness can be improved.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
Santa Cruz County is categorized as medium size because of its population size, but it is geographically small and therefore is less challenged to provide a full continuum of care throughout its geographical regions. An AAS request was not necessary. Santa Cruz offers the full spectrum of required DMC-ODS treatment services. Supplementary to those required services, Santa Cruz is planning the expansion of its residential treatment program offerings to include ASAM LOC 3.3. Santa Cruz also intends to begin contracting for Recovery Residence beds but has not been able to do so yet. Santa Cruz tracks its admissions, service encounters, and post-discharge transition rates to other levels of care. It tracks its numbers of providers, residential beds, outpatient, and intensive outpatient slots, and NTP slots. Santa Cruz worked with their EHR vendor to recently develop and launch a SRDL module for SUD services that enables monitoring of system caseload levels and transitions. They also recently piloted Power BI for dashboards that will enable management to monitor and study many types of access patterns.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
Note: for this KC, the DMC-ODS is referred to as “Santa Cruz DMC-ODS” instead of just “Santa Cruz” to distinguish it from other county agencies with which they collaborate.		

KC Table 1: Access to Care Components	
Component	**Quality Rating**
Primary care providers (PCP)/Clinics: Santa Cruz County offers six primary care clinics that primarily serve the Medi-Cal population—five FQHCs and one county-operated FQHC Look-Alike. Each of these clinics has integrated behavioral health clinicians into the primary care team for effective provision of behavioral health therapies including SBIRT. Santa Cruz DMC-ODS has arrangements with several of the clinics to prioritize DMC-ODS beneficiaries by reserving space so that physical exams can be accessed quickly and efficiently. Additionally, during the COVID-19 pandemic Santa Cruz DMC-ODS established a workflow with the county-operated clinics so that people wanting to enter residential treatment could get a COVID-19 test needed prior to entry. Additionally, many Santa Cruz DMC-ODS programs refer to a variety of the primary care clinics for long term support with MAT services. Hospitals and Emergency Rooms: Santa Cruz DMC-ODS meets monthly with local hospitals and their emergency departments in the High utilizer Group (HUGS). This group identifies frequent users of hospitals and Emergency Departments to assess the needs of the patients to ensure effective care coordination and thereby prevent unnecessary utilization. If someone is identified to have SUD related challenges, the group identifies a lead to reach out to the patient and provide support including a SUD treatment referral as appropriate. The Emergency Department at the main hospital in the City of Santa Cruz has a Bridge program that supports clients starting MAT while in the emergency department and connecting them to other MAT providers in the community upon discharge. Mental Health Programs: Santa Cruz DMC-ODS providers work closely with mental health programs across the network. All clients entering SUD treatment are assessed for mental health needs and referrals are made to mental health professionals as needed. Many of the clients with mild to moderate substance use conditions are referred to a FQHC or county operated FQHC Look-Alike Clinic. These primary care clinics each have an integrated behavioral health team. Clients may also be referred to Beacon which coordinates the county health plan's behavioral health network of individual clinicians serving Medi-Cal beneficiaries. Clients who have severe mental health conditions are referred to County's Access team for a full assessment and linkage to mental health support as needed. Santa Cruz DMC-ODS cites several challenges to providing care for SUD clients with co-occurring severe mental health conditions. They explain that such clients need intensive outpatient or residential treatment to be successful but the main service modality for these levels of care are group settings. If a client is not able to engage in groups due to disabling mental health symptoms, it makes it difficult for treatment programs to provide the level of support needed. Santa Cruz is currently trying to	

KC Table 1: Access to Care Components	
Component	**Quality Rating**
obtain certification from DHCS for residential treatment level 3.3 to provide co-occurring treatment. Santa Cruz cited some of the challenges in documenting co-occurring treatment. They explained that documenting treatment for a SUD is mandatory for every note because of billing through the DMC-ODS, so a session cannot be documented as focused entirely on a mental health condition. Consequently, they explained that client records may under-report the incidence of co-occurring disorders and efforts to treat both disorders concurrently. Child Welfare/Human Services: Santa Cruz DMC-ODS has an MOU with child welfare that facilitates referrals from Family Children's Services (FCS) to Santa Cruz DMC-ODS for individuals with identified SUDS needs. Referrals are made for assessment and linkage to treatment when applicable. Additionally, Santa Cruz supports parents involved in Family Preservation Court who are involved with FCS and at risk of losing custody of their children or seeking reunification. Santa Cruz County recently received a County Touchpoints grant through Health Management Associates which aims to increase access of MAT services to child welfare involved families who have SUDS related needs. Educational systems: Santa Cruz SUDS department provides individual and group counseling to schools in Pajaro Valley through contracts with Pajaro Valley Prevention and Student Assistance (PVPSA). Through these contracts The Seven Challenges curriculum is offered to schools as an Evidence Based Treatment for SUD early intervention and treatment based in school settings. Santa Cruz SUDS department recently collaborated with PVPSA to train a new cohort of Santa Cruz City School interns in The Seven Challenges curriculum in order to support increasing SUD early intervention and treatment across the school district. Law enforcement/criminal justice: Santa Cruz DMC-ODS frequently collaborates with law enforcement and criminal justice entities to ensure that persons involved with criminal justice have timely access to SUD services. For clients in custody, this is accomplished by DMC-ODS network providers providing ASAM assessments to persons in the county jail who express interest in SUD treatment. This allows for seamless transitions for those in jail to appropriate treatment programs upon release from custody. Public Health/Health Department: Santa Cruz DMC-ODS collaborates frequently with the Whole Person Care (WPC) initiative which aims to support Medi-Cal beneficiaries with complex care needs. Santa Cruz DMC-ODS attends stakeholder meetings and participates in a variety of trainings and initiatives facilitated by WPC in an effort to improve outcomes for vulnerable clients with SUDs. The WPC initiative is part of Santa Cruz County's Public Health Division. Additionally, during the COVID-19	

KC Table 1: Access to Care Components	
Component	**Quality Rating**
pandemic Santa Cruz/s DMC-ODS network collaborated frequently with the Public Health Department to ensure that SUD treatment providers at all levels of care were able to continue offering SUD services in line with Shelter in Place orders. Managed Care Plan: Santa Cruz DMC-ODS and QI leadership participate at least quarterly in a coordinating meeting with their local Managed Care Partner, Central California Alliance for Health (CCAH), also known as the “Alliance”. Both parties have a strong working relationship and can contact each other as needed when care barriers/issues arise. Community Based Organizations: Santa Cruz DMC collaborates regularly through monthly network meetings, trainings, and grant opportunities. They currently have three grant opportunities that each focus on expanding MAT access to specific populations. These grants have engaged multiple Community Based Organizations on a weekly, monthly and/or quarterly basis. Faith Based Organizations: New Life is a faith-based organization and an entity that was recently certified by DMC-ODS. New Life staff frequently participate in a variety of meetings and have long been a provider of SUD treatment in Santa Cruz County. Housing Authority/Affordable Housing Programs: Santa Cruz DMC-ODS collaborates with the Housing Authority and other affordable housing programs through two different programs. One of these programs is the Homeless Outreach Proactive Engagement & Services (HOPES) that facilitates outreach and linkage to persons experiencing homelessness and who often have SUD as a primary diagnosis. HOPES frequently connects people to other programs in the community that works with Housing Authority and other housing programs to support persons who are experiencing homelessness. It was initially launched and managed though the criminal justice system, and leadership of the program was eventually changed to the SUDS Department after recognizing the high incidence of addictions within the homeless population. Whole Person Care is the other program which facilitates collaboration between the SUDS Department and the Housing Authority. Santa Cruz DMC-ODS makes referrals and participates in steering committee meetings through the WPC initiative. WPC offers a variety of services to Medi-Cal recipients who have complex care needs, and they work directly with the Housing Authority to arrange specialized housing vouchers for supporting Medi-Cal recipients in obtaining affordable housing.	

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	PM
Santa Cruz had been monitoring this aspect of timeliness data through separate logs and spreadsheets while working with their EHR vendor to create a new module that would integrate these entries into the EHR system shared by all providers. The new module, called the SRDL, is intended to streamline and enhance the accuracy of data entry for these initial screening, referral, and disposition processes. Santa Cruz piloted the module during the last fiscal year, was in the midst of debugging it during this review and expects to have providers fully trained in implementing the module at the beginning of FY 2021-22. Santa Cruz is in the fortuitous position of having arranged for all contracted treatment providers to be using the same EHR. One of the many advantages of this arrangement is that valuable timeliness data can be obtained throughout the entire service system and more easily aggregated, analyzed, and reported for quality improvement and other management purposes. However, to achieve this aim the initial training on data entry must cover all provider organizations to ensure they are entering data into the new fields accurately and consistently. Santa Cruz is aware of this and “gearing up” for that training and for subsequent ongoing monitoring. One of the initial monitoring efforts is spearheaded by QI through a Timeliness Workgroup with stakeholders to review and modify workflows and determine further training needs. Another monitoring effort is to establish staff/supervisor monitoring practices for the purpose of creating a continuous monitoring loop at the user level, not only at the current QI system level. The Quality Improvement Committee (QIC) Steering Committee includes consideration of these efforts during its quarterly meetings and intends for QI to offer TA more frequently than quarterly to Santa Cruz network providers. Santa Cruz’s data results using their former approach to data entry and analysis indicated that the first intake session was offered an average of 8.4 days from the time of first client request for routine conditions, which is within the statewide standard of 10 business days. The average time from first request to first actual session was 11.2 days, which is slightly above the statewide standard.		

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	PM
The first two paragraphs of the response to Key Component # 2A address the change in how timeliness data for initial request and admission into services are recorded and tracked. These changes pertain equally to this Key Component #2B. Santa Cruz's NTP provider shifted from their previous approach for tracking this data to one that deployed the new SRDL module. While there were many new clients during the year of measurement, insufficient data was entered in the new SRDL module and reported to draw any conclusions.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	PM
The first two paragraphs of the response to Key Component #2A address the changes in how timeliness data for initial request and admission into services are recorded and tracked. These changes pertain equally to this Key Component #2C. Santa Cruz's average reported timeliness from first request to first service for urgent conditions was 112 hours, which far exceeds the state standard of 48 hours or even 72 hours for services requiring authorization. Santa Cruz should explore the reasons for the lengthy response time and proceed to reduce it.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	M
The first three Key Component measures in this Timeliness section involve a first request for treatment that occurs prior to registering as a client, and a subsequent intake and/or assessment session that occurs after registering as a client. These two "moments" in the process of beginning treatment are vital to link but not easy since the first request is typically logged in a different system than the EHR, and this is why the SRDL module was important to install. In contrast, Key Component 2D involves the timeliness of transitions in treatment that occur after the client is registered; as such, all the client's relevant encounter data are in the EHR for easier data retrieval and analysis. Santa Cruz used these data with somewhat different criteria than used by CalEQRO and found a 24 percent transition rate to other services within 7 days of discharge. CalEQRO used a claims-based method with narrower criteria for stepdown services and found the seven-day rate for transitions to be 4.9 percent for Santa Cruz and 7.6 percent for statewide. In comparing the transition rate without a post-discharge day limit other than within the year of measurement, CalEQRO found the Santa Cruz rate of 19.5 percent to be almost exactly the same as the statewide rate of 19.8 percent. Unlike most counties, most of Santa Cruz's residential treatment providers also have IOT and outpatient services that make stepdown transitions easier to facilitate.		

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2E	Tracks and Trends Data on Follow-up and Re-Admission to Residential Withdrawal Management	M
Similar to Key Component 2D, this Key Component measure is derived from encounter and claims data already in the EHR and is therefore easier for counties to measure than in Key Components 2A, 2B and 2C. Santa Cruz found their post-discharge readmission rate to withdrawal management within 30 days to be 3.0 percent, which is almost exactly the same as the finding of 3.1 percent by CalEQRO. These percentages are significantly lower than the statewide average of 11.0 percent. The Santa Cruz provider of residential withdrawal management level 3.2 WM also has stepdown residential treatment and outpatient treatment in the same facility, so we would expect to see smoother transitions post-discharge that would serve as a preventative effect on readmissions.		
2F	Tracks Data and Trends No Show Data for Initial Appointment	M
Santa Cruz is more proactive than many counties in measuring no show rates for initial appointments. They use No Show A400 Service Code data from client EHR records, and count anyone who did not make their first scheduled appointment irrespective of whether they called in advance to cancel or reschedule. Santa Cruz set as one of the goals in their Clinical PIP to reduce No Shows, so they are watching this measure closely and using it for quality improvement purposes.		

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
Santa Cruz developed a QI Workplan with an integrated focus on both mental health and substance use services. In response to CalEQRO recommendations from the previous year, they increased the substance use focus to create more balance with mental health, and also more clearly specified which goals pertained to mental health and which to substance use. Many of the goals focused on policy statements, compliance activities, and establishment of measurement and monitoring infrastructures. As such, these goals had yes/no targets. While continuing these activities, Santa Cruz should revise its next Workplan to feature quantitatively measurable goals that assume the establishment of basic measurement infrastructures. The QI division has a prominent place in the BHS organizational structure and executive management team. The QIC meets regularly and includes providers, clients, and other agency stakeholders. The QI staff are stretched thin with a primary focus on compliance issues and less for system improvement functions. Santa Cruz would benefit from adding some QI staff, particularly a QI supervisor, to help address the expanded QI responsibilities required by the launch of the DMC-ODS.		
3B	Data is used to inform management and guide decisions	PM
Santa Cruz monitors many compliance and QI indicators and collects and reports on in many areas of access, timeliness, and quality of care. They have been held back somewhat in these endeavors by insufficient functionality in some of their EHR and related IT software. They have taken steps to address these obstacles by developing with their vendors an SRDL module in their EHR and a Power BI set of performance measure dashboards. They have some remaining debugging to do with the SRDL module and some further staff training in how to use these new software functionalities. In the coming year they should be fully implementing them and using the results in reports for quality improvement. Santa Cruz has taken on the challenging task of measuring and monitoring the fidelity with which clinical staff implement evidence based clinical practices. These include not only use of ASAM criteria, but also several other evidence-based practices mentioned in the Waiver Special Terms and Conditions. Santa Cruz should enhance its use of quantitative data in performance measures it can then use for setting QI Workplan target goals and later evaluating whether they are met.		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
Santa Cruz QI staff are stretched thin and should expand to meet the new DMC-ODS Waiver requirements for data monitoring. They might consider adding a QI supervisor to help lead and oversee data analyses and reporting functions for QI purposes.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
Santa Cruz organizational culture is collaborative, as detailed in Key Component #1B. The list of partnerships, coalitions, and collaborative initiatives are impressive. One of Santa Cruz's standout strengths are its contract providers with whom Santa Cruz works well to ensure quality services for clients. The same can be said for the county's health care providers. Santa Cruz built and continues to nurture these relationships through regular meetings and email exchanges. In addition, Santa Cruz actively seeks input from SUD clients and family members by including them in several committees and by continuing to maintain the county's Substance Use Disorder Commission which most other counties no longer have.		
3D	Evidence of an ASAM continuum of care	M
Santa Cruz has a sufficient continuum of care to enable effective use of ASAM tools and principles to monitor and guide SUD treatment. Santa Cruz offers withdrawal management, residential treatment for adults and youth, outpatient services for youth and adults, perinatal residential treatment, methadone through an NTP, non-methadone MAT through the NTP and through several other DMC-ODS and physical health service providers, case management, and recovery support services. Their clients would benefit from the inclusion of Recovery Residences in their continuum of care. Having a well-developed continuum of care allows for clients to transition from the most intensive to least intensive treatment available and provide optimal client centered care. Santa Cruz measures and monitors client engagement in, completion of, and satisfaction with each level of treatment they received. Santa Cruz collects CalOMS admission and discharge but has not yet set up a routine process of data analysis to identify care gaps and improve the quality of care. Santa Cruz has a sufficiently trained clinical workface and offers trainings to the network when available to enhance service delivery.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
Santa Cruz clients have access to and support for using medications within each level of DMC-ODS care through the service providers with whom they are working. All service providers are knowledgeable about MAT services and available MAT providers.		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
They are all able to support clients' linkage to and engagement with MAT services. The NTP is operated by the same provider organization that operates the residential withdrawal management facility. Clients in withdrawal at the facility are given the option of an addiction medicine to ease their withdrawal symptoms, and the medical director estimates that nearly 80 percent of clients accept that option. Upon discharge, clients are given the option of continuing with an addiction medication for maintenance MAT, and the same medical director estimates that nearly 80 percent of those who received an addiction medication during withdrawal choose to continue with it for maintenance dosing. Several DMC-ODS providers are also involved in the Hub & Spoke MAT service programs. Methadone, buprenorphine, disulfiram, and naloxone are available at all NTP sites. All non-methadone addiction medicines are available through clients' primary care physicians within contractor operated FQHC primary care clinics and county-operated FQHC Look-Alikes across Santa Cruz County. MAT prescribers follow the CURES Act to ensure safe prescribing practices. DMC-ODS Medical Directors have established a peer review meeting for treatment and chart monitoring, including MAT prescribing protocols and side effects and treatment monitoring within the medical records. MAT prescribers also participate in the Safe RX Committee focused on community education and safety campaigns. County Behavioral Health participate in the local prescriber Safe Rx Committee. The DMC-ODS leadership and QI team are alerted of overdose deaths and QI staff participate in sentinel event reviews to identify their causes in conjunction with the coroner/medical examiner. Santa Cruz Directors of SUD and of QI each oversee this monitoring and report the data to the DMC-ODS network providers and community as needed. SUD Prevention activities are well established in Santa Cruz County with a county-wide community taskforce who focus on safe use, education, drug use alternatives for youth, and business responsibility campaigns.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
In the fall of 2019, Santa Cruz network providers, including direct line staff and management, participated in a network wide ASAM training opportunity provided by Santa Cruz County BHS SUDS division. SUDS was able to obtain access to the Change Companies' ASAM e-module 2-part series and offered this to the DMC-ODs network. The county continues to have an active purchase order with the Change Companies so that all recently hired staff are able to complete the two-part ASAM criteria training series. In addition, each DMC-ODS network provider is required to ensure that all newly hired service staff complete comprehensive ASAM criteria training before conducting any DMC-ODS client services. As support for enhancing the clinical practice of implementing ASAM criteria, SUDS established an ongoing		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
ASAM case consultation group available for all DMC direct service providers. SUDS' DMC provider meetings are a monthly platform. The provider network is trained and contracted to provide individualized client centered care using ASAM principles and criteria. Most of the contracted provider organizations operate multiple levels of care and are able to transition clients smoothly from one level of care to another as their treatment needs change. The network offers a comprehensive continuum that includes withdrawal management, residential treatment, perinatal residential, a variety of outpatient programs, intensive outpatient programs, MAT, NTP, level 3.3 residential services as well as recovery support services. Santa Cruz designed ALOC and ASAM reassessment tools in their EHR. They also designed linkages, so the DMC Treatment Plan tool is able to identify which ASAM dimension and severity rating from the ALOC or ASAM reassessment tools is identified with each of the goals/objectives in the treatment plan. QI staff conducted monthly monitoring of sampled charts for how providers used ASAM criteria to determine LOC treatment planning, service delivery and transition of care. County QI staff also trained all DMC provider's QI staff on chart review functions and offered TA for them in how to provide chart review processes for their own provider organizations. Santa Cruz's policy is for clients to be maintained in treatment if relapsing or are transferred to another level of care it is deemed more clinically appropriate. Client feedback during the client focus groups suggested some variability in how this policy is implemented. Some residential treatment facilities may be more flexible than others in working with clients who have a slip in drug use while in treatment. One facility is perceived by some clients as especially strict with clients who slip or relapse while in treatment and will require a break in treatment with a period of abstinence and usually a referral to withdrawal management before, they can be readmitted into residential treatment.		
3G	Measures clinical and/or functional outcomes of clients served	M
Santa Cruz contract and county-operated provider programs collect and input CalOMS Admission and Discharge data into the County Electronic Health Record Patient Accounting System at a client's intake and discharge. This information is collected and compiled into reports for internal and external Substance Use Disorder stakeholders. Santa Cruz Information Technology staff generates reports that includes CalOMS Admission and Discharge data by provider. These reports are disseminated into the contract providers' secured password accessed portals. Providers and County cam use this information to analyze outcomes and make program decisions.		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
Santa Cruz installed and piloted Power BI as a data analytics visualization tool. They began producing their first data dashboard at the time of this review. Among the graphs and charts they generated are ones that display CalOMS discharge summary reports on provider rated outcomes of their clients. The dashboards have tremendous potential for studying client outcomes aggregated for the entire system of care and also reportable by treatment program and by diverse types of client demographic subgroups. Because the dashboard programming automatically pulls updated data, it can be used regularly to identify trends and provide direction for quality improvement initiatives.		
3H	Utilizes information from client perception of care surveys to improve care	M
QI staff manages the TPS survey process in collaboration with all DMC network programs and UCLA. QI receives the survey results and share with each specified program, specifically on individual reports and any identified items to review at program level for response to the client feedback. QI also shared results with QIC stakeholders and do a year-to-year analysis of changes and facilitate a discussion for identified changes and areas for improvements. QI has set a focus for improvement on increasing youth and Spanish responses so that Santa Cruz can better understand and be responsive to a more diverse and equity perception of treatment services.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Santa Cruz offers a full continuum of care with locations throughout the county that meet Network Adequacy time and distance standards for convenience and accessibility.

- Santa Cruz designed its system of care with multiple points of entry for easy access to treatment. They offer prospective clients who want guidance into treatment with an Access Call Center that provides ASAM criteria-based screen and referrals, and for those familiar with the provider network they offer direct entry by calling the provider organization for an assessment appointment. Provider organizations are few in number, so easy to navigate. Each organization offers multiple levels of care with easy transitions between levels as a client's needs change.

- Santa Cruz has a robust MAT program with an NTP provider and multiple DMC-ODS programs offering non-methadone MAT. Santa Cruz has the highest percentage of DMC-ODS clients receiving non-methadone MAT of any county at 29.7 percent compared to the statewide average of 6.3 percent. This does not include non-methadone MAT services provided through one hospital's E.D. Bridge Program, and through six primary care clinics who also offer SBIRT services.

- Penetration rates for Medi-Cal eligibles accessing substance use treatment are more than twice the statewide average overall and for most types of demographic subgroups.

- The high rate of SUDs among the homeless led to the county transitioning the leadership of the high-profile HOPES program from a criminal justice agency to BHS' SUDS. The intent is to facilitate improved access to substance use treatment services for the homeless population.

Opportunities:

- While the penetration rate for Hispanic/Latinos of 1.14 percent is higher than the statewide rate of 0.77 percent, there is still disproportionate access to services for this group. While 49.4 percent of the total Medi-Cal eligible population is Hispanic/Latino, only 22.7 percent of clients are in this race/ethnicity group. Santa Cruz should continue to explore effective ways to outreach to this demographic community and support their access to SUD treatment services.

- Santa Cruz began offering and billing for Recovery Support Services a few months prior to this review. They seem to have begun well and can now build upon that by encouraging more client participation and by documenting in the EHR and billing for those services consistently.

- Santa Cruz has a substantial homeless population with a high incidence of addictions but has yet to contract with a provider for Recovery Residence beds. This was a CalEQRO recommendation last year that Santa Cruz intended to do but was postponed due to the COVID-19 pandemic. As the pandemic gradually recedes, Santa Cruz should consider adding this important support to clients who participate in outpatient treatment and do not have a safe place to stay.

Timeliness of DMC-ODS Services

Strengths:

- During FY 2020-21 and in response to previous CalEQRO recommendations, Santa Cruz BHS installed several important software packages. Among those packages are two that focus on timeliness of processes: Avaya and SRDL. Santa Cruz installed Avaya for the access call center to generate automated reports measuring such call center metrics as call volume, average call waiting time and average dropped calls. BHS also installed SRDL as a new module within their EHR to track preadmission data such as date of first request for treatment and link it to date of first actual admit session.

- The NTP facilitated timely access for new clients to treatment. According to

- CalEQRO calculations using DMC-ODS claims data, the median time from first intake to first dose of methadone was less than one day.

Opportunities:

- Santa Cruz can soon make full use of the functionality offered by the recently installed SRDL module in Avatar. They are nearing completion of work with their software vendor to debug the module and then complete the staff training at the Call Center and provider sites in how to enter initial contact data into the new data fields and monitor those entries for consistency and accuracy. They should then develop more timeliness reports from these data for use by management.

- Santa Cruz should use data and quality improvement methods to improve timeliness for initial appointments for routine and urgent conditions.

Quality of Care in DMC-ODS

Strengths:

- Santa Cruz Substance Use Disorder Services (SUDS) has strong community partnerships with whom to collaborate in coordinating care for clients with SUDs. These include regular meetings and coalitions with physical and mental health services, criminal justice agencies, housing agencies, the single county health plan, education systems, and child welfare services. These collaborations provide a sturdy foundation for Santa Cruz case managers to provide a robust array of care coordination and case management services.

- Santa Cruz estimates billing an average of 8,935 15-minute units of case management services per month. Given 1,416 unduplicated clients served during FY 2019-20, the average monthly amount of case management services per client would be six 15-minute units of service. Although the actual units of service per client vary widely, these statistics of average amounts are impressive for this valuable treatment service.

- Results of the TPS indicated that clients have positive perceptions of the quality of their treatment, with more than 80 percent of clients rating most items favorably. The lowest rated item (77.9 percent, which is still positive) involves clients with co-occurring mental health needs expressing the wish for better coordination of care with mental health providers.

- Santa Cruz County has five contracted FQHCs and one county-run FQHC Look-Alike that serve the Medi-Cal population. Each clinic is using an evidence-based practice model of integrating behavioral health services into the primary care setting. This integration provides an excellent foundation for partnering with Santa Cruz for coordinated care and for direct provision of SBIRT and MAT services.

- Initiation into and engagement in treatment rates are higher in Santa Cruz than statewide for adult clients. This would suggest that a high percentage of clients at beginning stages of treatment are feeling connected to treatment and are not slipping through cracks in the system of care.

- Santa Cruz rates of transition from residential treatment to less intensive levels of care are similar to the statewide average of approximately 20 percent according to FY 2020-21 claims data. Most Santa Cruz providers operating residential treatment programs also operate outpatient programs so stepdown transitions in care should be easier than in most counties where residential treatment programs are stand-alone.

- Providers actively participate in the ongoing Avatar Improvement Group meetings to provide input on refinements to the EHR. It is important for any evolving EHR

design and implementation to invite input from clinicians involved in clinical treatment and documentation workflows, but not all counties follow this practice.

Opportunities:

- A hallmark of the Waiver STCs is an emphasis on client centered care through use of ASAM criteria to guide matching client conditions to types of treatment. A statewide measure of how well DMC-ODS counties are doing with this important practice is the ASAM Criteria LOC Referral Data, which measures the congruence between the indicated LOC based upon ASAM Criteria findings at screening or assessment and the actual LOC to which the client was referred. Santa Cruz had difficulties in obtaining consistent entries of this data by screeners and assessors, and technological difficulties with uploading the data for analysis by UCLA (the statewide evaluator for the DMC-ODS Waiver). As a result, Santa Cruz is unable to use this valuable data resource for monitoring their implementation of ASAM criteria-based client/treatment matching. It is important that Santa Cruz explore and address the barriers to fully entering and uploading this data.

- The Quality Improvement (QI) Workplan is oriented to compliance policy statements with yes/no goals that focus on basic quality management infrastructures and amounts of staff activities. The next workplan should be recast to focus on how those staff meetings and related activities could be used to improve timely access and quality of care for clients. The goals should be framed wherever feasible as quantitatively measurable rates of improvement in client experiences of access to and quality of care from baseline.

- Santa Cruz monitors many compliance and QI indicators and collects and reports on many areas of access, timeliness, and quality of care. They have been held back somewhat in these endeavors by insufficient functionality in some of their EHR and related IT software. They have taken steps to address these obstacles by developing with their vendors an SRDL module in their EHR and a Power BI set of performance measure dashboards. They have some remaining debugging to do with the SRDL module and some further staff training in how to use these new software functionalities. In the coming year they should be fully implementing them and using the results in reports to help guide improvements in quality of care.

- The QI staff are stretched thin with a primary focus on compliance issues and less bandwidth for system improvement functions. Santa Cruz would benefit from adding some QI staff, particularly a QI supervisor, to help address the expanded QI responsibilities required by the launch of the DMC-ODS and to help lead and oversee data analyses and reporting functions for QI purposes.

- The Cultural Competence Plan is substantially improved from the previous year in increased attention to substance use services but needs continuing work to achieve a better balance with the more predominant focus on cultural competence of mental health services.

- Initiation into and engagement in treatment rates are lower in Santa Cruz than statewide for youth. This would suggest that some youth clients at beginning stages of treatment are not feeling connected to treatment and may be slipping through cracks in the system of care. This may be an opportunity for treatment program and system of care improvements.

Client Outcomes for DMC-ODS

Strengths:

- Providers used CalOMS to rate their clients' progress at discharge, with aggregated results indicating that 51.7 percent of clients made positive progress as compared to the statewide average of 45.8 percent. Client self-reported ratings of their own outcomes were correspondingly positive, with 80.5 percent indicating they are better able to do things because of their SUD treatment.

- Santa Cruz operates its residential withdrawal management (3.2 WM) services within an organization that also operates multi-level residential treatment, outpatient treatment, and both methadone and non-methadone MAT services. Among the benefits of this configuration are more seamless discharge transitions from 3.2 WM to a treatment program. Santa Cruz statistics show that only 3.1 percent of Santa Cruz clients who had a 3.2 WM episode were readmitted within 30 days of discharge, as compared to 11.03 percent of clients statewide. The low readmission rate suggests that clients being discharged from residential level 3.2 WM are receiving case management assistance in connecting to treatment. /This is supported by the statistic that only 2.5 percent of Santa Cruz clients had three or more 3.2 WM episodes with no follow-up treatment as compared to the statewide average of 3.61 percent.

- Santa Cruz obtained, piloted, and began using Power BI, a data analytics visualization software for use in creating data dashboards. They included in their first dashboard some displays of outcome data derived from CalOMS ratings by providers.

Opportunities:

- Build upon the work thus far in developing a dashboard to refine it and utilize it for providing feedback to management and treatment programs. The potential of this and future dashboards is tremendous as an efficient and effective way to present outcome data for the overall system of care, for specific programs, and for specific demographic subgroups. This information can be useful for guiding quality improvement efforts.

Recommendations for DMC-ODS for FY 2020-21

1. Expand service capacity for at least two types of services:

- Build upon recent successes to expand the delivery and billing for Recovery Support Services.

- Resume the planning with milestones and timelines to contract for Recovery Residence beds.

2. Use the functionality offered by the recently installed Screening and Referral Disposition Log (SRDL) in Avatar by:

    - Completing work with their software vendor to debug the module.

    - Completing the training of staff at the Call Center and provider sites in how to enter initial contact data into the new data fields and monitor those entries for consistency and accuracy.

    - Developing more timeliness reports from these data and sharing them more regularly with management for use in quality management.

    - Using data and quality improvement methods to improve timeliness to initial appointments for routine and urgent conditions.

3. Identify and address the barriers to accurate and consistent completion by screeners and assessors of the data fields for the ASAM Criteria LOC Referral Data and uploading of the data for review and analysis by UCLA. Upon receipt of the results from the data analysis, use the results as a guide to quality improvement efforts. This recommendation includes a carryover of Recommendation #4 from the FY2019-20 report (referenced on page 16 of this report), with the implementation to be expanded from the call center to all DMC-ODS sites that conduct screenings and assessments.

4. The Quality Improvement (QI) Workplan is oriented to compliance policy statements with yes/no goals that focus on basic quality management infrastructures and amounts of staff activities. The next workplan should be recast to focus on how those staff meetings and related activities could be used to improve timely access and quality of care for clients. The goals should be framed wherever feasible as quantitatively measurable rates of improvement in client experiences of access to and quality of care from baseline.

5. The QI staff are stretched thin with a primary focus on compliance issues and less bandwidth for system improvement functions. Santa Cruz should add some QI staff, particularly a QI supervisor, to help address the expanded QI responsibilities required by the launch of the DMC-ODS and to help lead and oversee data analyses and reporting functions for QI purposes.

6. The Cultural Competence Plan is substantially improved from the previous year in increased attention to substance use services but needs continuing work to achieve a better balance with the predominant focus on the cultural competency of

mental health services. Santa Cruz should further increase inclusion of cultural competence goals specific to substance use prevention and treatment

7. Santa Cruz should build upon their recent dashboard pilot with Power BI by making refinements to it and then utilizing it as feedback to management and treatment programs for guiding quality improvement efforts.

ATTACHMENTS

Attachment A: CalEQRO Review Agenda

Attachment B: Review Participants

Attachment C: County Highlights: Santa Cruz did not submit highlights for inclusion.

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO Review Agenda

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

Table A1: CalEQRO Review Sessions - Santa Cruz DMC-ODS
Opening session – Changes in the past year, current initiatives, status of previous year's recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of performance measures
Quality improvement plan (goals, implementation activities, evaluation results), Cultural Competence Plan, Timeliness, Network Adequacy
Clinical line staff group interview
Information systems capability assessment (ISCA), EHR, other IT, fiscal/billing, and data usage (staffing, processes for requests and prioritization, dashboards, other reports
MAT client focus group
ASAM continuum of care and fidelity of implementing ASAM placement criteria
MAT provider group interview
Access to services staff group interview
Performance Improvement projects (PIPs)
Adult residential treatment client focus group
Contract provider management group interview
Coordination with Health Plan, hospitals and FQHCs
Wrap-up and exit sessions with feedback, discussion, and next steps

Attachment B: Review Participants

CalEQRO Reviewers

Tom Trabin– Lead Quality Reviewer
Melissa Martin-Mollard – Information Systems Reviewer
Luann Baldwin and Tammy Cates - Consumer/Family Member Consultants

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.

Table B1: Participants Representing Santa Cruz			
Last Name	**First Name**	**Position**	**Agency**
Agarwal	Meghna	SUD Counselor	Sobriety Works
Alves	Linda	Quality Improvement Director	Encompass
Anderson	Sara	BH Residential Director	Encompass
Annon	Robert	BH Supervisor	SCCBHS
Avila	Sära	Utilization Review Specialist (QI)	SCCBHS
Baccos, MD	Dimitri	Integrated BH Medical Director	SCCBHS
Bare	Adrianna	Sr. BH Administration Director	SCCBHS
Bell	Rikki	Clinician	Janus
Bergmann	Denele	SUD Counselor	Encompass
Bogren	Michael	Clinician	SCCBHS
Borbely	Christina	Sr. BH Trainer	SCCBHS
Bounds	Mranda	Clinical Staff	Janus
Broxton	Nancy	Clinician	PVPSA
Brunner	Sabrina	Clinician	Janus
Burt	Jeff	BH Patient Acct. Mgr.	SCCBHS
Chicoine	David	Utilization Review Specialist (QI)	SCCBHS
Conelly	Pam	COO	Encompass
Cooper	Sarah	CEO	Sobriety Works
Cosio	Linda	Quality Improvement Manager	PVPSA
Eslami	Cassandra	Sr. BH Acute & Crisis Serv Dir. & MHSA Coordinator	SCCBHS
Fernandez	Jorge	Health Services Agency IT Manager	SCCBHS
Fierman	Larey	Clinical Staff	Sobriety Works
Focha-Smart	Meg	Clinical Staff	Encompass

Table B1: Participants Representing Santa Cruz			
Last Name	**First Name**	**Position**	**Agency**
Franck, MD	Leelia	Medical Director	Encompass
Franzel	Bernadette	Outpatient Service Supervisor	Encompass
Friedman	Claire	Clinical Director	Sobriety Works
Galvan	Andres	Mental Health Client Specialist	SCCBHS
Gong	Michael	Clinical Staff	PVPSA
Griffen	Monja	Clinical Staff	Janus
Guzman	Kathy	Clinical Staff	Janus
Hastings	Jennifer	Physician Consultant	Health Improvement Partnership
Jordan	Anthony	Sr. BH SUDS Director	SCCBHS
Kern	Karen	Sr. BH Adult Mental Health Director	SCCBHS
Krauss	Nancy	MAT RN	Janus
Krebs	Cecila	MAT staff	Encompass
Lolley	Cybele	Sr. BH Quality Improvement Dir.	SCCBHS
Mast	Nancy	Utilization Review Specialist (QI)	SCCBHS
Mayo	Tristan	MAT Clinician	Encompass
McCormick	Eileen	Clinician	Encompass
McCuiston	Melissa	BH IT Business Analyst (QI)	SCCBHS
Mockus	Jennifer	Director of Case Management	CCAH/Alliance
Morrison	Maisy	Compliance	Janus
Murray	Craig	Whole Person Care	SCCBHS
Norton	Julie	Senior Staff Development Trainer	SCCBHS
Ochoa	Eric	Clinical Manager	PVPSA

Table B1: Participants Representing Santa Cruz			
Last Name	**First Name**	**Position**	**Agency**
Padilla-Chavez	Erica	CEO	Pajaro Valley Prev. & Student Assistance
Palau	Stacey	Director	New Life
Riedenauer	Jilian	Intake Coordinator	Encompass
Riera	Erik	BH Director	SCCBHS
Robertson	Subé	Utilization Review Specialist (QI)	SCCBHS
Ross	Sandra	Clinician	New Life
Russell	Lisa	Chief Programs Officer	Encompass
Saludes	Quentin	SUD Counselor	New Life
Sapena	Michelle	Administrative Analyst	SCCBHS
Solano	Nash	Care Coordinator	Dignity Health
Startz	Ricki Lee	Clinical Staff	Encompass
Steigner	Lindsay	Children Service Mgr.	Encompass
Sumner	Kelly	Senior Manager	Encompass
Susskind	Jennifer	PIP Consultant	Consultant
Swank	Casey	SUDS BH Manager	SCCBHS
Threlfall, MD	Alex	BH Chief of Psychiatry	SCCBHS
Todd	Lisa	Administrative Analyst	SCCBHS
Turnbull	Andrea	BH Acute Service Manager	SCCBHS
Wasielewski	John	Intake clinician	Sobriety Works
Wilhelm	Gina	Intake clinician	New Life
Williams	Amber	CEO	Janus
Wong	Gian	HSA IT Dev/App Analyst III	SCCBHS

Table B1: Participants Representing Santa Cruz			
Last Name	**First Name**	**Position**	**Agency**
Zeigler	Sarah	Clinician	Janus
Zinsmeyer	Mary	SUD Counselor	New Life

Attachment C: County Highlights

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

Attachment D: Acronym List Drug Medi-Cal EQRO Reviews

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

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

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