DMC-ODS Waiver
Santa Clara County, Quality Improvement and Data Support
Summary Report, QI Work Plan: Year Two 2018-19

Introduction

Santa Clara County Behavioral Health Services Department, Substance Use Treatment Services (SCC BHSD SUTS) has embraced a philosophy of client-centered and client-directed health care. Our focus has been to treat the “whole” person and provide services that are individually tailored to not only meet the needs of our beneficiaries but also attend to our beneficiaries’ choices in their health care. The SUTS Quality Improvement and Data Support Division (QIDS) is responsible for oversight of our comprehensive continuum of care providing quality management that incorporates quality assurance, utilization and capacity management, care coordination, beneficiary and provider relations, training and consultation, and data-driven, innovative creative quality improvement.

QIDS adheres to key standards of care that align with SAMHSA, NIDA, The World Health Organization, The Final Rule (Federal Regulations), Youth Treatment Guidelines, and the National Committee for Quality Assurance (NCQA). These standards include care that is:

- Available, accessible, welcoming, timely, and appropriate
- Ethical and Non-discriminatory
- Culturally Competent
- Client-centered (collaboratively-driven)
- Co-occurring capable with seamless coordination
- Scientific-based
- Supervised and monitored with clinical efficacy at the treatment and program levels
- Governed by integrated treatment policies that guide integrated services, approaches and linkages to ancillary services
- Quality management providing data supported monitoring and evaluation

SCC BHSD SUTS has been providing an organized system of delivery for over 20 years. Treatment level of care matching to client needs has been in the forefront of the SUTS system of care. The American Society of Addiction Medicine (ASAM) assessment, an evidenced based instrument, has been at the core for streamlining evaluation of client individual needs and
developmentally and clinically appropriate corresponding placement into a variety of the County’s substance use treatment services.

SCC BHSD SUTS began DMC waivered services on June 15, 2017. Phase One of our implementation process ensured that all providers were aware of the differences from the previous organized delivery system to a paradigm shift into a Managed Care Plan. Phase Two of our implementation process has addressed any gaps in provider services, troubleshooting concerns from year one of implementation, rolling out ODS-DMC residential services for pregnant women and withdrawal management services, adding more outpatient providers to the continuum of care thereby increasing resources and access, and expansion of MAT programs. The SUTS Research and Outcome Measurement (ROM) team, and the Quality Improvement Data Support team, have continued to produce quarterly reports and meet with providers to help them understand how they can use these quarterly performance metrics to maintain quality, improve data quality, reflect on individual and agency performance, and identify gaps, if any, in their programs. At six-month intervals, ROM continues to provide a “180 Scan,” six-month system wide-angled perspective, of the clinical processes, client outcomes, system performance, and system efficiency. The purpose of the scan continues to:

- Foster a culture of data driven system improvement in the SUTS system of care
- Provide managers, decision makers, clinicians, the Behavioral Health Committee, and others with a high-level view of how the system is functioning
- Develop a common understanding of the strengths and opportunities for change within the system

Further, a new Provider Monthly Report (PMR) has replaced the former “attestation” structure for monthly reporting by providers to their assigned Quality Improvement Coordinators (QICs). This change became effective July 1, 2019 (year three of the waiver) to more closely monitor capacity, referral and admission flow, and utilization and caseload management. The Year two implementation of the 1115 waiver has brought about many positive changes, as well as, challenges needing to be addressed. The following is a summary overview of the 2018-19 QI Plan objectives and their outcomes.
1. **BHQIC Committee**

The Behavioral Health Quality Improvement Committee (BHQIC) continued to meet bi-monthly throughout the second year of the waiver. The BHQIC is comprised of stakeholders from across the system of care, including: consumers, consumer’s family members, service providers including primary care, partners, such as health plans and hospitals, cultural competency committee members, housing and other ancillary service members, and QI representatives. Stakeholder membership changed as some members could no longer serve on the committee and vacancies developed. The BHQIC discussed membership and a focus to increase consumer and consumer family participation. The BHQIC discussions continue to address system reports, such as: Grievance/Appeal, Incident Reports, and specific policies necessary to both the 1115 and 1119 waivers, as well as integration efforts. Performance measures, QI Work Plans, and both the Mental Health and Substance Use Treatment Services PIPs were and continue to be central topics for this committee.

Another accomplishment for SCC BHSD was the completion of our new website. The system of care was introduced by way of a viral tour to the website in late Spring of 2019. Both the beneficiary and provider sections of the website are up and running; and, new information, change alerts, training materials, performance measures, and a placeholder for questions to be sent to the MCP, are all part of the up-to-date design.

2. **Access**

Access to more capacity was approved in SCC during the last fiscal year; implementation became effective on July 1, 2019. While more access has become available, it remains to be seen what the relationship between this increased capacity and timeliness will have in year three of the waiver. Timeliness, in general, still faces challenges. Past year discussions around timeliness with providers suggests many variables are contributing to these challenges. SCC BHSD SUTS produces quarterly data regarding timeliness between “first screening date to referral date (SUTS Gateway Call Center) and timeliness between “referral date to admission date (required 10 business days).” The timeliness to admission data demonstrated mixed results this past fiscal year [ref. 180 Scans, dated February 26, 2019 and September 10, 2019, posted on
BHSD website]. Adult outpatient clients admitted within the first 14 days of the screen date showed an average of 56% in the first half of the year with a decline to 51% in the second half of the year; for youth outpatient, 69% was the timeliness average in the first half of the year with a decline to 39% in the second half. However, adult residential showed improvement in this metric, with 70% average meeting the timeliness standard this past half year, a 15% increase from the first half of the year. Mixed results warrant further discussion and BHSD SUTS has several forums for this discussion to occur. The Quality Assurance and Performance Improvement (QAPI) meeting has already initiated discussions with provider QI/QA teams and the Innovative Partnership monthly meeting with representation from the entire system of care is aware of needed improvement. Providers have shared that changes in staff (resources) and the effects of their “open access” protocols may likely be contributing to the inability to consistently meet the timeliness standard. Providers have been encouraged to take these performance metrics and discuss them internally with their agencies to develop improvement plans and share results with SUTS. Technical assistance is available both through BHSD SUTS QI and support from the SUTS ROM team.

Gateway Call Center operations provide 24/7 access to both withdrawal management and residential services. The Gateway Call Center “after hour calls (evening and weekends)” are triaged through one contracted provider who then disperses the calls depending upon the need of the caller. One of the primary changes in the Gateway Call Center in 2018-19 is beneficiaries are no longer requested to call back if pending placement to a provider. The Call Center returns calls if needed, and with the addition of 220 outpatient slots, 30 intensive outpatient slots, and two new providers, it is hoped more access with greater ease into programs will become available.

Taking into consideration recommendations by 2018 EQRO and ROM’s analyses of data collected, the Gateway Referral Screening was also expanded by ROM in order to track the dispositions of all referrals. The Director of Research provided individual trainings with each provider in early summer in order to help providers understand how these and other changes would meld into each provider’s agency workflows in addition to helping providers understand the importance of knowing the disposition of referrals. Another positive change in access was the expansion of the consultation line which is a separate internal phone line housed at the
Gateway Call Center. The consultation line is answered by credentialed counselors and provides ease of access and consultation for other managed care plans with whom the county has MOUs, medical doctors and other medical professionals from primary care and hospitals, emergency psychiatric services, and psychiatrists seeking consultation on potential referral and placement of beneficiaries presenting with substance issues directly into withdrawal management and/or residential settings, as well as, screening for outpatient level of care placements. Complex, co-morbid, and high acuity cases needing care coordination and consultation are funneled through a seasoned Quality Improvement team of professionals working directly in conjunction with provider medical directors to determine appropriate treatment needs and subsequent placement into services.

With integration gradually progressing in SCC BHSD, efforts are under way to integrate the Gateway (SUTS) and Mental Health Call Centers. An integrated screening tool (IST) has been developed and SCC BHSD is in development of their EHR with Netsmart in which the IST will roll out.

3. Utilization Management

Authorization. SCC BHSD SUTS QI continues to meet its objectives with current requirements for authorization of residential level of care services. Requests for authorization are turned around within 24 hours, if not same day. In the second year of the waiver, 97% (n=1281) of authorization requests were approved and less than 1% were denied. Approximately 3% of the authorization requests were discussed in case consultation with a seasoned QIC to help determine best level of care for the beneficiary, be it residential or an outpatient setting with supportive housing. As mentioned in last year’s report, BHSD SUTS Quality Improvement and Data Support (QIDS) developed a standard assessment and authorization form (ALOC) which providers use to describe the medically necessary criteria (ASAM and DSM 5) for a client to enter residential level of care. Data Support reviewed ALOC data over the past year to provide our internal Utilization Management team with raw data concerning indicated residential level of care information (potential capacity needs and demand) for ASAM 3.3. and 3.5. A work group was formed early in the year including, contract providers, Clinical Standards, and QI staff who met over several months to develop both programming criteria and staff requirements necessary
to introduce these levels of care by June 30, 2020. Discussion with DHCS for rates for these levels is set to occur in early 2020. RFPs for Residential Programs are set to go out in the late fall of 2019, and both 3.3. and 3.5. levels of care expectations are outlined in the RFPs.

QIDS continues to conduct annual regulatory audits, specific to DMC-ODS and Title 22. Random selection of 5% of all charts, encompassing all clinicians providing direct service, is asked of each provider to ensure that ASAM and DSM 5 medical necessity criteria are continuing to be met for each providers’ level of cares into which clients have been placed. While the annual DMC-ODS audit revealed sporadic issues within different agencies (e.g., an unsigned progress note, a late treatment plan, etc.), there were no patterns or trends noted amongst providers or internal to their individual agencies. Administrative audits of all providers demonstrated some common issues, such as a need for updated policies, or in aligning with DHCS recommendations, personnel charts with medical director roles and responsibilities, medical director proof of continuing education in the field of addiction, and codes of conduct. There were no issues regarding medical necessity noted in any of these audits. Providers appear to understand the importance of meeting medical necessity for all levels of care.

This year, SUTS ROM also instituted a way for capturing the number of referrals made to providers which did not meet medical necessity for substance use treatment services. A portion of these ALOCs were reviewed by Clinical Standards Coordinators to determine if these referrals may meet the criteria for Recovery Services support if they did not meet the standards for treatment. SUTS QIDS will continue to gather information and discuss findings with providers’ clinical supervisors to promote the use of Recovery Services, if warranted.

SUTS ROM continues to monitor utilization capacity and utilization of service types, such as, but not limited to, individual versus group services, case management, and recovery services. Additionally, SUTS ROM examines client length of stay, slot utilization (capacity), no shows and cancellations, client completions of treatment, transfers to other levels of care from residential, and other performance metrics to depict a high-level view of the system utilization dynamics as well as individual provider performance. This data collection and analysis is disseminated to the system of care by way of quarterly performance reports and the bi-annual 180 scans [ref. BHSD website, 180 scans]. Services utilization data demonstrates although several different types of services are offered, individual services still appear to be higher than
group services, and case management services, while happening, are still very low. Additionally, the adult outpatient modality had an average 20% “no show” rate in the past fiscal year. This “no show” rate juxtaposed to low case management services initiated a conversation at the monthly QAPI meeting which led to SCC BHSD SUTS Clinical PIP. One of the providers shared at this meeting their attempts to engage clients by completing case management “up front,” at the first session with the client. SCC BHSD SUTS Clinical PIP is conducting a comparison study within one of the larger agencies where two clinicians will “do business as usual,” and two other clinicians will postpone certain intake requirements to engage client by addressing the client’s most pressing (case management) need, such as a sober housing referral, transportation needs, childcare, or another ancillary service. The PIP team’s hypothesis is if a client’s most pressing need is addressed in the first face-to-face session, the client will not only feel “heard,” but engage in further treatment. All utilization data coupled with data submitted by the providers in their Monthly Provider Reports (MPRs) are analyzed, and then, patterns and trends, strengths and challenges, are discussed with providers at the monthly QAPI and Data Quality meetings; and, for those providers who struggle to meet performance expectations, corrective action plans (CAPs) are made formal with requests for corrective responses and implementation plans. SUTS meets with each individual agency completing a CAP to provide feedback and assistance and encourage providers to complete internal PDSAs and quality improvement projects, which are then shared at these meetings.

**Care Coordination between the MCP and Mental and Physical Health.** A primary accomplishment in care coordination in 2018-19 was the finalization of MOUs being developed, approved, and implemented with other health plans (Santa Clara Family Health Plan and Anthem Blue Cross) in June of 2019. In order to better coordinate and facilitate care from these health plans primary care, BHSD SUTS QI assigned a QIC specifically to the plans. Since this level of collaboration is new to the health plans, meetings are being set up to explain ODS services to the plans and facilitate entry into services for their beneficiaries.

Another area connected to care coordination which was expanded occurred in the development of the Medical Collaboration. This collaboration meets monthly. The Medical Collaboration is comprised of psychiatrists, medical doctors with expertise in addiction medicine, providers’
medical directors, nurses and nurse practitioners, directors from QI and Addiction Medicine, program managers, QICs, and Clinical Standards. This Collaboration expanded efforts this year to examine high acuity and complex comorbid patient cases entering withdrawal management. This effort became the non-clinical PIP for SCC. Prior to implementation of a more rigorous screening process for withdrawal management entry, patients from EPS, the ED, and inpatient hospital were being referred to withdrawal management, and often, these patients’ medical and psychiatric symptomology surfaced and patients were having to be re-referred to other services as the level 3.2 WM could not address the high acuity needs with which they presented.

Between March and May of 2019, the Medical Collaboration tightened the screening process at the lead of the WM Medical Director, then EPS psychiatrists received training, and BHSD SUTS QI became more closely involved with the placement of these clients coming into WM 3.2. Tightening the screening process, it is hoped, will more appropriately place patients in WM 3.2 and support their success at WM 3.2 and transition to the next appropriate level of care, rather than resulting in setbacks or an inappropriate placement into care where the client is not ready to participate. The BHSD SUTS Director of Addiction Medicine continues to meet with doctors from the ED, Express Care, and Ambulatory, and any concerns in care coordination that develop are brought back to the Medical Collaborative to troubleshoot.

The largest expansion efforts in care coordination and service for BHSD SUTS occurred in MAT this year. Methadone maintenance in custody, expansion of MAT for both inpatient and outpatient medical facilities, such as ambulatory care, the training of all ED doctors to assure 24-7 emergency access to medication-assisted treatment, and preventative measures in the community distributing Narcan to all police departments, the VMC pharmacy automatically dispensing a Narcan kit with every prescription over 50mg of an opioid, and SUTS treatment providers being offered Narcan training and kits. Recently, SCC was awarded a grant for MAT serving youth; the Medical Collaborative is focusing discussion on the development of a mobile unit, subject-matter expert team of professionals to work with adolescents needing MAT assisted treatment for opioid and benzodiazepine use.

BHSD SUTS has four co-occurring providers. BHSD SUTS QI has assigned one of the QICs to organize a regular meeting with these providers to monitor internal care coordination (MH clients needing SUTS services, and SUTS clients needing MH services). The purpose of this
project is to determine any barriers to bidirectional care coordination. Further, it is our hope that the MCP will be able to observe and inform the process of integrated coordinated care plans. BHSD SUTS QI chose these four providers as a starting point since services for both SUTS and MH are co-located at their agency sites.

SUTS QICs continue to coordinate care for beneficiaries with high risk. The protocol that was developed and implemented for inpatient referral (Valley Medical Center) to SUTS residential or intensive outpatient treatment has now extended to other hospitals, such as, Stanford and El Camino, as well as, to EPS referral sites. QICs continue to facilitate transfer directly from the hospitals and EPS into these levels of care and connect treating doctors to the medical directors of these treatment providers.

Coordination with primary care has begun in several of the ambulatory clinics. Medical doctors have been trained in MAT and assigned social workers are placed at these clinics to screen for possible SUD and referral to treatment.

**Strategies to reduce avoidable emergency and inpatient services use.**

QIDS and ROM continue to identify high risk and high utilizers of frequent intensive service utilization. Initial results revealed that many clients who might be identified as high utilizers do not repeat services in residential, partial hospitalization, or intensive outpatient levels of care; however, these patients may be high risk due to high acuity and co-morbidity. SUTS QI began to descriptively examine the clients with high acuity coming from inpatient hospital settings, who may cross over into various systems (namely, primary care, Mental health, and SUTS care). Access to Healthlink and Unicare permitted individual case studies for better coordinated care after patients’ physical health issues were stabilized. Referrals are coordinated with QICs in warm handoffs to appropriate levels of substance use care once a patient’s physical health and/or mental health conditions are stabilized. It is the hope that stabilization of their other conditions will permit clients to benefit more from substance use treatment and possible prevent return to hospital emergency or inpatient services. Another strategy aimed at reducing return to emergency and inpatient services was the expansion of MAT and suboxone offered at the Emergency Department (ED) to help provide a bridge and referral to services out in the
community to MAT and possible NTP type service modalities. Further, Emergency Psychiatric Services (EPS) has two dedicated beds for direct entry into withdrawal management services should patients meet the medical necessity criteria for entry into this level of care. As mentioned earlier in this document, this year’s non-clinical PIP focuses on the processes in WM, tightening the screening criteria for client entry so that clients may benefit more from WM services and follow through to treatment services in another level of care once stabilized.

Most recently, BHSD SUTS QI has been made aware by providers of certain patients, in SUTS Residential and Withdrawal Management levels of care, whom have presented with need for mental health crisis stabilization. In lieu of these patients going to EPS, BHSD has formed a meeting to address alternative avenues for care. An integrated “Care Coordination” meeting has been established to consult on case-by-case basis avenues for these patients to easily access short term crisis stabilization and subsequent substance use treatment, if these patients meet the medically necessary criteria for entry.

**Provider Appeals.** Similar to last year, BHSD SUTS has not received any provider appeals regarding reimbursement claims or medical necessity determinations. BHSD SUTS has not developed its own provider appeal process as there are discussions at the greater integration level that the provider appeal process will be developed by BHSD business operations.

4. **Utilization Review**

In year two of the waiver, BHSD SUTS QI continued to meet the QI Plan objectives regarding ongoing utilization management (UM) and utilization review (UR) and supporting providers. A significant change in operations of UM and UR, as well as the expectation to meet performance metrics, was the introduction of formalizing the structure for corrective action plans (CAPs). The Director of Research created a template to assist providers in understanding the expectations of the CAP, but more importantly, to provide opportunities for providers to discuss internal change for improvement in meeting performance expectations and contractual obligations. BHSD SUTS staff holds regular meetings with providers working through CAP issues and provides technical assistance for providers to support change. Quarterly utilization reviews have
been in place for several years and QIDS has monitored internal peer utilization reviews as expected by Title 22 and 9 regulations, reviewed any corrective action plan and billing accountability, as well as, conducted annual clinical audits and reviewed subsequent corrective action plans related to those audits. State reports are submitted as requested. There have been no changes with this operational process. Future direction is the plan to have each provider’s assigned QIC meet with the provider after their URs, discuss any problematic issues, and bring these to the system QAPI meeting. The QAPI meeting has provided a forum to discuss individual agency’s internal QI and QA processes, any improvement studies they have undertaken, as well as, cross over into clinical application. A monthly clinical supervisor’s meeting occurs for all providers in the system of care; SUTS Clinical Standards is encouraging internal discussions with these two functionalities, QA/QI and Clinical staff in each agency, to work together as agencies address barriers to meeting UR requirements and/or performance outcomes.

**ASAM Fidelity Monitoring (ALOC).** ASAM fidelity is currently monitored in several ways. Annual chart review by the MCP and internal quarterly utilization review by providers examine ALOC information for completeness, matched level of care, and the thread from matched level of care to treatment plan diagnosis and dosage. ROM and Data Support examine continuity between ALOC admissions and corresponding ALOC discharges, authorization rates and timeliness, as well as, ALOC discharges based on ASAM criteria.

Of note for this past year is the initiation of beginning to examine quality of care more closely and improvements or lack of improvements in clients’ health status. This information is being gathered from ALOC data which depicts the clinical severity rating scales in all 6 dimensions of the ASAM. The higher the risk rating (i.e. the number “4” on the severity scale), indicates a more severe and problematic clinical rating with exception of Dimension 4, “Readiness to change,” in which a “4” represents a high level of motivation for the client to make changes [Ref. 180 scan September 10, 2019]. The initial findings for client health status were revealing and incite dialogue for both residential and outpatient providers. Although there may be some level of discrepancy or variance in interpretation of the severity scales idiosyncratic to each counselor, based on experience or other clinical skills, all clinicians have had the same “E-
module ASAM” training, therefore, they have all had the same instruction with regard to ranking the clinical severity scales. Results are displayed on the next two pages.

Residential treatment findings are promising. Across the dimensions, with exception of ASAM dimension 3, emotional/psychological/cognitive conditions, client health status appeared to improve as a result of treatment and severity rating scales decreased by time of discharge. Dimension 3 may often be of ongoing need to address and reach stabilization. Of significance is Dimension 5 and Dimension 6 where 50% of the clientele’s health status improved as these dimensions are the most likely to contribute to a return to residential level of care. Discussion and review of this data with an integrated forum of quality assurance and residential clinical staff plans to meet in mid-December 2019 or early January 2020.
Outpatient programs, on the other hand, reflected little to no change at all in client health status. Although, in general, the ASAM severity rating scales would be lower than those of the severity rating scales for clients in residential treatment, one would expect to see the severity scales dip lower. Outpatient providers were made aware of this information and a system of care discussion is planned for mid-December 2019 or early January 2020 to determine factors that may be contributing to this performance.

BHSD SUTS will continue to examine ALOC data for health status outcomes and is looking into other methods to ensure clients are having their needs met. SUTS QI and Clinical Standards are working closely with County Division Directors in a monthly clinical collaboration meeting, and current discussion is focusing on two interventions: 1) possible use of “Ipads” to be distributed to clients after each session inquiring as to whether they received the help they felt they needed at their session, and 2) the use of peer mentors to help clients navigate the behavioral health system of care.
5. BENEFICIARY AND FAMILY SATISFACTION

BHSD SUTS has continued to focus on client-centered treatment and client satisfaction with their treatment. The UCLA Client Perception Survey continued to be disseminated across the system of care throughout year two of waiver implementation. Collection of surveys occurred every Friday, and weekly reminders were distributed to all providers the day before they were due. SCC SUTS ROM had expanded the UCLA Client Perception Survey to include four areas of client outcomes (clients’ perceptions about these areas): (1) connection to school or employment, (2) income change, (3) housing status change, and (4) legal issues change, all of which remained in year two of the waiver. All clients are to be offered the opportunity to complete the survey prior to discharge; ROM has monitored the rate of completed surveys using services census data. Further, clients have been offered the survey within the first 30 days of their treatment.

The results of the survey submissions in year two continued to reflect an overall positive perception by clients of their treatment experiences. Clients who complete treatment have reported positive perceptions of treatment and improvement with housing opportunities and less difficulty with activities of daily living [ref. September 10, 2019 180 scan].

Grievance/Appeals/Fair Hearings. SUTS continues to track grievances, appeals, and State Fair hearings. In the second year of the waiver, there were a total of 18 grievances and 2 appeals filed. Almost all grievances were resolved within 30 days of receipt of the grievance and most to beneficiary satisfaction. Only 1 of the 18 grievances concerned access, specifically into withdrawal management, and the beneficiary was placed within 24 hours into the requested level of care. Two beneficiaries filed appeals regarding the NOABD they received from their SUTS programs claiming they had been wrongfully discharged from their programs. Both appeals were substantiated, resolved within 8 days (6 working days,) and both beneficiaries expressed satisfaction with their resolutions. SUTS QIDS has not identified any specific patterns or trends in grievances at this time. The nature of complaints varies, and each beneficiary is given an assigned QIC to investigate and address their grievance with a personal touch. SUTS also works with beneficiaries who request choice of programs and clinicians. Most requests are accommodated when clinically appropriate and possible. SUTS has honored all requests for a second opinion, two of which beneficiaries asked for the second opinion because they believed
they should not meet medical necessity for SUTS treatment. Both beneficiaries were given explanations that treatment is voluntary and although they may disagree with the opinion, licensed professionals determine medical necessity. QIDS met state standards for quarterly reporting Grievance and Appeals, and, submitted all grievance resolutions to County Reports submissions. With the BHQIC in place, SUTS QIDS reports out quarterly on grievance and appeals and beneficiary satisfaction.

6. Outcomes/Performance Measures
SUTS QI works with two different operational units conducting data collection, analysis, and reporting: (1) Research and Outcome Measurement (ROM) is responsible for data analysis concerning system performance measures and DMC-ODS metrics for the entire system of care, as well as grants and other projects; (2) Data Support (DS) is responsible for running reports and providing internal assistance to SUTS Quality Improvement Coordinators (QICs). ROM completes quarterly performance measures analyses (CPMs) and a wide-angle view of the system, the “180 scan,” every 6 months. Findings are presented to the system of care for both of these sets of measures. Additionally, as mentioned earlier, a new Monthly Provider Report (MPR) was developed and rolled out in July of 2019. Performance measures are written into provider contracts as a way to align providers with expected standards of care. Access, timeliness, medical necessity, and utilization review outcomes have been previously discussed in this report. Engagement performance measures remain.

SCC SUTS set the standard for 4 sessions in 30 days as a way to measure engagement. “No show” and cancellation rates have also been examined. SCC SUTS clinical PIP in year one of waiver implementation attempted to intervene and increase the 4 in 30 numbers as they appeared low. The intervention of a phone call was encouraged between face-to-face sessions number 1 and 2. Initially, there appeared to be a “beginner’ luck” outcome as the first data sets showed a 68% improvement with this measure in the case study provider participating in the PIP. Unfortunately, the numbers waned, and improvement did not occur over time. 4 in 30 numbers remained low across outpatient providers. QAPI took on several meeting discussions to determine possible barriers to reaching the 4 in 30 measure. Provider input revealed perhaps the barriers to engagement were not “clinical” per se, but rather, administrative barriers, such as,
over-impacted staff having to push sessions out due to high influx in open access processes, medical necessity taking longer than one session to determine, and not having an LPHA up front to determine medical necessity. These barriers did not appear to be clinical answers but rather structural and operational; providers at QAPI decided to adjust individually by making their own internal provider changes in workflows and processes to see if these changes would impact their 4 in 30 metrics. This year’s Clinical PIP is a direct result of these “4 in 30” conversations at QAPI forums. During one of the QAPI meetings, a provider who consistently meets the 4 in 30 metrics shared their process of completing case management in the very first session with the client as a factor the agency believes contributes to their success in meeting the 4-n 30 engagement metric. This year’s Clinical PIP evolved from this discussion and proposes a case study of comparison groups with one large provider. The study group will conduct the intervention of completing case management based on client need in the first face-to-face session with their clients. The control group will conduct “treatment as usual,” with no changes in their workflow process. It is hoped that by addressing the immediate and most pressing needs of clients in the first session, these clients will then be able to participate in treatment more fully, feel engaged in treatment, and will not only increase returns to sessions but reduce the percentage of “no shows.”

Appropriate and Timely Interventions when Occurrences Raise Quality of Care Concerns. SCC SUTS has a very structured process for tracking both incident reports and grievances. These processes are supported by policy and procedure. Those areas where quality of care concerns arise would be found in the analyses of trends and patterns identified in grievances and incident report logs. Since the inception of the waiver, no trends or patterns have been noted in either of these logs. Timeframes for grievance resolution are met well before the State standard of 90 days and nearly all resolutions are to beneficiary satisfaction. Depending upon the severity of an incident report (IR), resolutions and corrective action generally involve agency specific examination of their internal policy and procedure, business operations, or program protocols. In year two of waiver implementation, BHSD integrated the IR process which is now overseen by Risk Management. A new integrated policy was developed, and meetings are scheduled to design a uniform tracking mechanism for both Mental Health IRs and SUTS IRs. The SUTS
QIDS Division Director works closely with the Risk Manager when IRs may cross between the two specialties. IRs in SUTS are reviewed by the QIDS Division Director and any patterns or trends are also reported every other month to the BHQIC. Again, no trends or patterns have been identified since inception of the waiver that would raise quality of care concerns. If quality of care concerns were to arise, policy dictates that a root-cause analysis be completed by risk management. SUTS QIDS continues to examine policies and protocols that may also need revision in response to DMC-ODS standards and clinical quality. Should quality of care concerns arise with providers, in general, QIDS will request providers to review their protocols and report evidence-based practices as the center of their interventions in response to improvement. Provider level reviews are expected to be supported with documentation.

Mechanisms Addressing Clinical Issues Affecting Beneficiaries System Wide. SCC BHSD SUTS has developed both a clinical and non-clinical PIP that measure performance but focus on beneficiary improvement of their experience in various levels of treatment. The PIPs are shared across the system of care in a variety of meetings: BHQIC, QAPI, IP, and Data Quality. The Waiver Advisory Committee (WACC) also meets weekly as concerns arise, be they with an individual provider, or the system. WACC has been designed to address DMC-ODS issues as they arise: some of these may be DHCS-related release of Information Notices (IN) or All Plan Letters (APL) that could affect either operations or clinical areas in various programs. SUTS QI has a team of Clinical Standards Coordinators who review the system’s standards of care, offer clinical consultation, facilitate a monthly Clinical Supervisor’s meeting, and work closely with SUTS QI in addressing potential needed improvement in clinical quality. There are monthly clinical collaboration meetings with Program Division Directors, Quality Improvement Division Director, and Clinical Standards Coordinators. The most recent meeting (October 2019) addressed the Peer Navigator Development/Training Plan which is set to be sent to DHCS in the beginning of 2020 for approval. BHSD SUTS believes that peer navigators will fill a necessary gap for clients in reaching their appointments, understanding the importance of their recovery, and generally helping clients navigate a complicated system of health care.

In year two of the waiver, SUTS established three very important meetings held monthly to address system wide clinical issues: (1) the Medical Collaboration, which is comprised of medical doctors from throughout the system of care, nurses, nurse practitioners, psychiatrists,
QICs, Clinical Standards, and management and discusses system care coordination between physical health and substance use treatment; this collaboration continues to expand to include ambulatory, ER, and EPS; (2) the clinical collaboration meeting, which brings program division directors and quality improvement together to address system clinical improvements; and, (3) care coordination/case consultation monthly meeting between SUTS, MH, and EPS – this meeting discusses case consultations to address the individual needs of high acuity clients crossing many systems of care and appropriate level of care placement for clients with co-occurring needs. All these meetings, in addition to the already established DMC-ODS supported meetings, contribute to improved quality measures for clients across the system.

7. Data Monitoring and Reporting

SUTS is fortunate to have two data reporting units working with Quality Improvement. ROM analyzes greater system data and performance measures which have been built into provider contracts and has supported compliance efforts with performance metrics required by the ODS-DMC. ROM offers recommendations that are analytically based for potential system and agency changes. ROM has also made its analysts available and assigned to individual agencies to discuss interpretation of data and data quality concerns. ROM continues to conduct quarterly reports [ref. CPM report] and the 180 scan [ref. to 180 scan] completed bi-annually. Results are presented quarterly to the system of care regarding their individual performance measures, and bi-annually regarding system performance. Within QIDS is the Data Support (DS) unit. DS analysts run reports, provide specific data requests to support the QICs within in the unit, and support ROM. Effective July 1, 2019, a new monthly mechanism for provider report-out replaced the former attestations that providers had submitted. The Provider Monthly Report (PMR) was developed because ROM discovered that the provider attestations (regarding their data) were not congruent with the data run by ROM. The PMR covers referrals and admissions data, ALOC admissions, transfer, and discharges, open and discharged clients, length of stay data, and caseload and utilization. Individually assigned QICs, supported by ROM analysts, hold discussion with point persons of each provider to discuss their monthly submissions. Discussions aim to note strengths of the programs and support needed areas for improvement, as well as, help providers have a visual of their internal operations from the MCP perspective. This new monthly reporting structure will be part of year three waiver evaluation as it is too new to its
inception to provide any current feedback. DATAR and CalOMS continue to be reported through DS. In year two of the waiver, DS provided monthly on-going CalOMS trainings to help with a common understanding of specific elements requested in CalOMS data collection, orient new providers to the CalOMS requirements, and help any existing providers with errors they may be experiencing. As mentioned in the year one waiver QI Plan evaluation summary, CalOMS data had been indicating that providers were exhibiting confusion regarding their clinical determinations versus CalOMS defined categories. ROM supported DS by developing and distributing a “Clinician’s Guide to CalOMS” to support DS efforts in their training and streamline understanding and definitions of specific CalOMS elements across the system of care for more consistency. Reports are accessible through the new BHSD website.

8. DMC Trainings
In the 2018-19 year, SUTS QIDS continued to provide DMC-ODS and other required trainings (Attachment A). BHSD SUTS provided an annual DMC-ODS update across the system of care, two DMC-ODS documentation trainings, and a specific on-boarding training for two new providers to the system of care. SCC Learning Partnership (LP) is the platform for most trainings in BHSD and LP posts all training materials; however, all trainings, training materials, and presentations provided through SUTS are also accessible through the BHSD website. Electronic Alerts are sent out regularly to inform the system of care with DHCS Information Notices, All Plan Letters, and instructions for implementation of system changes. Trainings continue to be offered in a variety of categories, including but not limited to: DHCS and the Waiver, evidence-based practices (Cognitive Behavioral, Seven Challenges, Motivational Interviewing, Relapse Prevention, Trauma Informed, Stages of Change, ASAM E-module and Dr. Mee-Lee specific trainings), Clinical Documentation Manual, SUTS Orientation to the System of Care, Co-Occurring Clinical Supervision, Co-Occurring ASAM Assessment, Treatment Planning, CLAS Standards and Cultural Competency. BHSD SUTS utilizes its Innovative Partnership (IP) meeting as the conduit through which active dialogue may occur across the system of care to address varying interpretations from providers who attend trainings or have questions surrounding new DMC-ODS requirements.
Conclusion

Evaluation of year two of the waiver has demonstrated positive expansion, problem resolution for various gaps in the system of care, efforts to improve both access and engagement, as well as, initiation of evaluation of quality of care. While there have been many strengths with the addition of two new providers, expansion in MAT, refinement of reporting mechanisms and creation of meetings to address the quality and integrity of data, there is need for continuous improvement in performance metrics and outcomes. Conversations to troubleshoot barriers to timeliness standards have already begun. Mechanisms to more fully understand utilization of capacity and different service types amongst providers, as well as, disposition of all referrals is being carefully examined as challenges have arisen. Most importantly, efforts are under way to better understand and evaluate the clinical quality of services being offered to ensure beneficiaries are not only receiving the services that they need but that the quality of those services contributes to their success in treatment.

Year three of the waiver in SCC invites the roll out of two more levels of residential treatment, ASAM 3.3. and 3.5 into the continuum of care, the development of a SUTS peer navigator program, greater expansion into primary care, improved technology with the implementation of a new EHR system, and the establishment of a Bay Area regional forum with neighboring counties to share ideas and resources as the 1115 waiver is extended.