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**DRUG MEDI-CAL ORGANIZED DELIVERY
SYSTEM EXTERNAL QUALITY REVIEW**

NAPA DMC-ODS REPORT

Prepared for:
**California Department of
Health Care Services**

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March 3 – 4, 2020

TABLE OF CONTENTS

NAPA DMC-ODS EXECUTIVE SUMMARY	6
Introduction	6
Access.....	6
Timeliness	7
Quality	8
Outcomes	9
Client/Family Impressions and Feedback.....	9
Recommendations	10
Barriers to this Review	10
EXTERNAL QUALITY REVIEW COMPONENTS	11
Validation of Performance Measures	11
Performance Improvement Projects	12
DMC-ODS Information System Capabilities.....	12
Validation of State and County Client Satisfaction Surveys	12
Review of DMC-ODS Initiatives, Strengths and Opportunities for Improvement	13
PRIOR YEAR REVIEW FINDINGS.....	14
Status of Prior Year Review of Recommendations	14
OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES.....	19
Changes to the Environment.....	19
Past Year's Initiatives and Accomplishments	19
Napa Goals for the Coming Year	22
PERFORMANCE MEASURES.....	24
HIPAA Guidelines for Suppression Disclosure:.....	25
Year Two of Waiver Services	25
Performance Measures Findings—Impact and Implications	45
Key Information Systems Capabilities Assessment Information Provided by the DMC-ODS	47
Summary of Technology and Data Analytical Staffing.....	47
Current Operations.....	48
Priorities for the Coming Year	49
Major Changes since Prior Year	49
Other Significant Issues	50
Plans for Information Systems Change	50
Current Electronic Health Record Status.....	50
Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey	51
Drug Medi-Cal Claims Processing	52
Special Issues Related to Contract Agencies.....	52
Overview and Key Findings.....	52
NETWORK ADEQUACY	53

Network Adequacy Certification Tool (NACT) Data Submitted in April 2019.....	54
Plan of Correction to Meet NA Standards	54
PERFORMANCE IMPROVEMENT PROJECT VALIDATION.....	56
Napa PIPs Identified for Validation.....	56
Clinical PIP—Enhancing Engagement and Retention in Treatment.....	56
Non-Clinical PIP- Increasing care transitions to recovery services and reducing SUD relapse experiences.	58
PIP Findings—Impact and Implications.....	62
CLIENT FOCUS GROUPS	64
Focus Group One: Adult SUD Outpatient.....	64
Focus Group Two: Napa Adult Residential Treatment	66
Client Focus Group Findings and Experience of Care	67
PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS	69
Access to Care.....	69
Timeliness of Services	69
Quality of Care	70
DMC-ODS REVIEW CONCLUSIONS.....	73
Access to Care.....	73
Timeliness of DMC-ODS Services	74
Quality of Care in DMC-ODS	74
Client Outcomes for DMC-ODS	75
Recommendations for DMC-ODS for FY 2019-20	76
ATTACHMENTS.....	77
Attachment A—On-site Review Agenda.....	78
Attachment B—Review Participants.....	79
Attachment C—PIP Validation Tools.....	83
Attachment D—County Highlights	106
Attachment E—Continuum of Care Form	107
Attachment F—Acronym List Drug Medi-Cal EQRO Reviews.....	116

LIST OF TABLES

Table 1: Penetration Rates by Age, FY 2018-19
 Table 2: Average Approved Claims by Age, FY 2018-19
 Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19
 Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19
 Table 5: Average Approved Claims by Eligibility Category, FY 2018-19
 Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19
 Table 7: Days to First Dose of Methadone by Age, FY 2018-19
 Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2018-19
 Table 9: Timely Transitions in Care Following Residential Treatment, FY 2018-19
 Table 10: Access Line Critical Indicators, January 2019-December 2019
 Table 11a: High Cost Beneficiaries by Age, Napa, FY 2018-19
 Table 11b: High Cost Beneficiaries by Age, Statewide, FY 2018-19
 Table 12: Withdrawal Management with No Other Treatment, FY 2018-19
 Table 13: Congruence of Level of Care Referrals with ASAM Findings
 Table 14: Initiating and Engaging in DMC-ODS Services, FY 2018-19
 Table 15: Initial DMC-ODS Service Used by Clients, FY 2018-19
 Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2018-19
 Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2018-19
 Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19
 Table 19: CalOMS Living Status at Admission, CY 2018
 Table 20: CalOMS Legal Status at Admission, CY 2018
 Table 21: CalOMS Employment Status at Admission, CY 2018
 Table 22: CalOMS Types of Discharges, CY 2018
 Table 23: CalOMS Discharge Status Ratings, CY 2018

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19
 Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA

ISCA Table 1: Distribution of Services, by Type of Provider
 ISCA Table 2: Summary of Technology Staff Changes
 ISCA Table 3: Summary of Data Analytical Staff Changes
 ISCA Table 4: Primary EHR Systems/Applications
 ISCA Table 5: EHR Functionality
 ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings

PIP Table 1: PIP Validation Review
 PIP Table 2: PIP Validation Review Summary

KC Table 1: Access to Care Components

KC Table 2: Timeliness of Care Components

KC Table 3: Quality of Care Components

Attachment Table B1: Participants Representing Napa

NAPA DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2018-19 — 339

Napa Threshold Language(s) — Spanish

Napa Size — Small

Napa Region — Bay Area

Napa Location — Napa

Napa Seat — Napa

Napa Onsite Review Process Barriers — None

Introduction

Napa officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in December 2017 for Medi-Cal recipients as part of California's 1115 DMC Waiver. This is the second EQRO review of Napa County. In this report, "Napa" shall be used to identify the Napa DMC-ODS program unless otherwise indicated.

The Napa County Alcohol and Drug Services (ADS) division is part of the county's Health and Human Services Agency (HHSA). ADS has one location in the city of Napa which serves as both the administrative offices and service location.

Napa is a small county that borders with Lake, Solano, Sonoma and Yolo. Napa has a population of approximately 141,005 with 53 percent white, 34 percent Hispanic or Latino, 2 percent African American, 8 percent Asian/Pacific Islander and 3 percent Other. Napa's overall health rating is 8th out of 58 counties in California according to the County Health Ratings website. Napa was one of the original counties established in California and was created in 1850. Napa is known for its wine industry and has over 400 wineries.

During this FY 2019-20 Napa review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to DMC access, timeliness, quality, and outcomes related to the second year of Napa's DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2018-19.

Access

Napa has two full-time equivalent (FTE) staff dedicated to answering the access call phone number during normal business hours. Napa has a Memorandum of Understanding (MOU) with Bright Heart Health to operate the Access Call Center on evenings, weekends and holidays. Napa continues to use an Excel spreadsheet to log in the calls. This spreadsheet is on a shared drive, and it is aggregated monthly, and the

data is sent to the Supervisor and Quality to review. Napa does perform test calls on a monthly basis to review their strengths and areas for improvement.

Napa is still trying to find a vendor to modernize their Access Call Center system. Napa is exploring options for this software and have consulted with other counties regarding their software. They did get several bids in the past year which were not feasible.

Napa has walk-in capability for screening and assessments one day a week. There are two intake appointments during this time. Clients expressed frustration at the long lines prior to the opening of the building and the potential challenges in obtaining one of the two appointments. For all of calendar year 2018 and 2019, Napa had walk-in appointments two days per week that served four beneficiaries each day. In January 2020, the Licensed Practitioner of the Healing Arts (LPHA) resigned and Napa had to reduce the walk-in capacity. Napa plans to increase walk-in capacity once they can hire a replacement for this position. Napa also began offering stand-by services two days per week starting in November 2019. The stand-by services are provided if the staff's scheduled appointments do not show up for their scheduled appointments.

Napa refers to the primary care federally qualified health center (FQHC) to provide medication-assisted treatment (MAT) services. The FQHC is located on the same campus as Behavioral Health and Public Health. This is especially helpful with care coordination.

Residential treatment services are being provided even though the county is not able to bill for these services yet. The community-based provider has not been able to become DMC certified, but submitted their application to the Provider Enrollment Division (PED). Napa was concerned with the long wait for this certification.

Napa has two PIPs that focus on access to services as well as retention, one focused on outpatient and the other focuses on recovery support services.

Access to services for youth treatment services is low compared to the statewide penetration rate. Napa has executed a contract with Aldea Children and Family services to provide expanded youth outpatient and intensive outpatient treatment.

Currently there is only one main clinic location in Napa for substance use disorder (SUD) services. Clients would like to see another outpatient location because it can take a long time on the bus to get to the Napa office campus. Napa reported that there is an additional location for outpatient services located in Calistoga which is Napa's northernmost city.

Timeliness

Napa expanded services this past year to meet all the requirements of the DMC-ODS continuum of care. They executed a contract with two Narcotic Treatment Programs (NTP) providers and with a Youth community-based provider. Because of the limitations

of their electronic health system, the data is tracked through Excel spreadsheets. Napa stores the Excel spreadsheet in a shared drive and results of the data collected are analyzed and reviewed in the Quality Improvement Committee (QIC).

Napa tracks timeliness requirements for intakes both internally and with contracted providers. However, not all of the timeliness measures meet DHCS standards. For example, the length of time from initial request to first kept face to face appointment for adults meets the 10-day standard only 42 percent of the time. The length of time from initial request to offered first face-to-face appointment for adults meets the 10-day standard 86 percent of the time. The standard for length of time from service request for urgent appointment to actual face to face is 48 hours and this is only met 45 percent of the time.

Residential treatment services are being provided, but Napa has not been able to bill for these services. Their contract provider has submitted an application for DMC certification to DHCS, but it is still in process. The contract with this residential treatment provider began April 2019 and residential discharge date began to be collected from July 2019 forward and is now reflected in the QIC third quarterly report. Napa does not have a contract for a youth residential program and is also coordinating with other counties in the northern California when this is needed to identify options. Since the closure of the program in Marin last year there is one program in Santa Clara county which will take Medi-Cal youth and only when there is an available bed. Santa Clara county has a dedicated bed model where a county has to purchase the bed for the entire year rather than a fee-for-service model.

Quality

Napa does have a Quality Management/Quality Improvement Work Plan for 2019 to 2020. Each quarter during this time period, Napa has produced an ADS and Contractors QIC report. This report includes the following data: access, timeliness, referral sources, outpatient services at Probation, level of care assignments, MAT referrals, cultural services and results of client satisfaction surveys. Napa reported that it takes three staff working together to compile the QIC reports.

Each quarter this past year, Napa has been able to add additional data to the QIC quarterly reports. This report includes data from the contract providers. Napa has a contract with two out of county NTP providers. Because of the small number of Napa county residents that are serviced by these providers, they are unable to obtain separate client data reports. Napa plans on conducting site visits to review both NTPs to find possible solutions to gather this data.

Napa does have two active PIPs. Both PIPs focus on access to services as well as retention, one focused on outpatient and the other focuses on recovery support services.

The quality of the outpatient care is enhanced by use of “Living in Balance” curriculum, an evidence-based practice, which has both group and individualize components and has clients choosing some elements based on their needs and desires. Also research show that length of stay in care enhances positive outcomes related to sustained recovery and abstinence so successful transitioning of clients from outpatient to recovery support services allows for more time for clients to adjust to being back in the community working and living with friends and family, exposed to potential stressors and triggers, and learning and implementing coping skills to not go back to drug or alcohol use. Testing the value of this service and refining its elements and strategies for engagement is an important part of improvement of the overall care system under DMC-ODS and the Waiver.

Napa has a lower than statewide average for initiation and engagement into DMC-ODS services. Adult clients who initiate services is lower than the statewide percentage (63.9 compared to 90.3). Adult clients who then engage in services is also below the statewide rate of 65 percent compared to 79.8 percent. Thus, the PIP topic is very appropriate for addressing a local issue.

Outcomes

Napa participated in the Treatment Perception Survey (TPS) in October 2019. A total of 5 outpatient treatment programs and one residential treatment program participated in the survey. Overall satisfaction with services was 79.7 percent.

The domain with the lowest percentage of 63.8 percent was convenience of location. Napa has one location for service that used to be located in downtown Napa. The current facility is located on a bus route on the outskirts of town. The group treatments are scheduled in alignment with the bus schedules. The low rating is consistent with the previous TPS survey results. Other low TPS results linked to the residential site which led to a series of interventions by staff to assist in improvements. It is the intent of the quality improvement (QI) staff to administer an additional TPS specific to the residential program to evaluate if they have improved.

Napa CalOMS data indicates a higher percentage of homeless, than the statewide average. Clients involved in post release supervision AB 109 were higher than the statewide average. The employment status was consistent with the statewide percentages.

Client/Family Impressions and Feedback

Both PIPs demonstrated encouraging outcomes in terms of engagement and retention and continuity of care from outpatient to recovery support services. The county collected Recovery Services data with clients who had been in recovery services for a minimum of 30 days to evaluate the impact. Clients felt more clean and sober housing was

needed to help avoid relapse after leaving residential. There is a high percentage of clients with homeless status in the Napa SUD program based on CalOMS data. These and other findings from the review will be discussed further with the county for possible follow-up PIP topics.

Clients reported that they like the new treatment modality of "Living in Balance." Napa staff spent several months reviewing their curriculum and researching other options. They previously used the Matrix Models and decided to retire that model and implemented Living in Balance. This is an evidence-based practice that incorporates biopsychosocial topics into addiction treatment. The result was more than 10 new groups were implemented in February 2020 which has been favorably received by the clients.

Napa continues to have a challenging housing issue. The clients reported that the homeless shelter is wet (one can be intoxicated and use the shelter), and it is easy to relapse because of that. Clients would like to have more assistance with finding housing such as a recovery residence or Sober Living Environment.

Recommendations

The report recommendations are included at the end of the full report.

Barriers to this Review

None

EXTERNAL QUALITY REVIEW COMPONENTS

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

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

This report presents the FY 2019-20 EQR findings of Napa's FY 2018-19 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 Measures¹

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

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

Performance Improvement Projects²

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

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

DMC-ODS Information System Capabilities³

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

Validation of State and County Client Satisfaction Surveys

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

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

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS

In this section, the status of last year's FY 2018-19 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 2018-19 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 2019-20 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. Napa needs to address the service continuum gaps so it can provide all of the services required under the Waiver. It should continue to take active steps to solicit qualified service providers and if necessary secure agreements with providers in the region. Likewise, initiating a contract with an NTP provider should be a priority for Napa. With new licensed providers, such as the incoming residential treatment provider, it should formalize its relationship and standards in both contract and policy language to meet Waiver standards and maximize new resources. Finally, as the health plan provider which provides substance abuse treatment for eligible beneficiaries Napa needs to take meaningful steps to move away from a traditional reimbursement model in order to meet its managed care obligations under the DMC-ODS Waiver.

Status: Met

DMC-ODS Activities

In 2019, Napa formalized fee-for-service agreements with the following providers:

1. Aldea Children and Family Services – Outpatient services for youth (DMC-ODS Certified Provider).
2. MedMark Treatment Centers – NTP/OTP services for adults and youth ages 18-20 (DMC-ODS Certified Provider, operating out of Solano County, within time and distance standards for Napa County beneficiaries).
3. Successful Alternatives for Addiction Counseling Services (SAACS) – NTP/OTP services for adults and youth ages 18-20 (DMC-ODS Certified Provider, operating out of Solano County, within time and distance standards for Napa County beneficiaries).

All contracts were included in the Significant Changes and Initiatives document's attachments.

Currently, Napa is providing all services required under the Waiver, with the exception of Youth Residential Treatment. To satisfy this requirement, Napa is exploring a partnership with neighboring counties to purchase a bed at Advent Group Ministries in Santa Clara. Advent runs a dedicated-bed model at a rate of \$450/day. Because there are minimal referrals at this level of care, Napa is researching ways to offset the substantial costs associated with this service.

All contracts incorporate Napa County Agreement No. 180182 (Napa's agreement with DHCS, 17-94203) ensuring that network providers are responsible for upholding the standards of our Intergovernmental Agreement.

Recommendation 2. Napa needs updated supports for its electronic interfaces, records and associated analysis. The access line and other service entry points should be supported by a telephonic software application which would give Napa the analytics necessary to address Waiver reporting requirements. Napa also needs to increase its understanding and internal analytic and report writing capabilities in order to maximize the data from its electronic health record (EHR). They should consider hiring a consultant familiar with its EHR. Finally, Napa needs to secure dedicated data analytics capacity for its DMC-ODS to in order to support the analytic and reporting needs of the organization.

Status: Partially Met

DMC-ODS Activities

In 2019, Napa County Alcohol and Drug Services (ADS) took active steps to streamline processes in our EHR, including the development of several new electronic forms/attestations to support DMC-ODS compliance, as well as our monthly/quarterly state reporting. Generating reliable demographic data from the EHR continues to pose challenges but has improved. The division was able to generate all necessary data for

the metrics reports submitted to BHC. Additionally, Napa County will likely be releasing a Request for Proposals (RFP) in 2020 for a new EHR contract, since the existing EHR is not conducive to meeting the agency's analytic needs.

With regards to a telephonic software, ADS has researched multiple vendors and will finalize a contract by 7/1/2020.

Recommendation 3. Napa should continue to address quality improvement aspects of its delivery system such as a review of its existing treatment curriculum. Such efforts need to be formalized in a work group and develop a time bound implementation plan once determinations are made. Napa should continue to work towards enhancing quality of care by meeting the PIP standard required by CMS of having two active and ongoing PIPs.

Status: Met

DMC-ODS Activities

In July 2019, seven ADS staff members, including two program supervisors, began meeting weekly for approximately three months to evaluate the program's curriculum and research new evidence-based practices. The group unanimously decided to retire ADS's use of the Matrix Model in the adult outpatient program and implement Living in Balance, an evidence-based practice that incorporates a wide-range of biopsychosocial topics into addiction treatment. The structure and schedule of the counseling groups were also reevaluated, leading to the roll out of more than ten new groups on 2/2/20 to supplement Living in Balance and provide necessary hours for clients enrolled in intensive outpatient treatment (IOT).

The group schedule, list/description of ancillary groups offered, and meeting agendas were included in the Significant Changes and Initiatives document's attachments.

Napa County has implemented two ongoing PIPs throughout the last year. The Clinical PIP was deemed 'active' and ADS continues its efforts to reduce the dropout rate in the first 30 days of treatment by 10 percent. The Non-Clinical PIP was classified as 'concept' in the Year 1 EQRO visit. Since then, ADS have its Recovery Services program and continues to strive toward 40 percent Recovery Services enrollment by ADS graduates. Dashboards including outcome measures have been submitted for both PIPs.

Recommendation 4. While the mental health Cultural Competency Committee recently invited ADS division representation, there are no specific initiatives or elements of the plan that pertain to substance abuse. As written, the cultural competency plan (CCP) needs a major revision to demonstrate meaningful inclusion of Napa DMC or they should be given allowance to author their own.

Status: Met

DMC-ODS Activities

ADS is committed to ensuring services are delivered in ways which recognize, are sensitive to, and respectful of individual, cultural, and linguistic differences. In June 2019, Mental Health and ADS established a joint Behavioral Health Cultural Competency Committee (BHCCC) in an effort to ensure that culturally competent services are consistently provided to consumers. ADS has two representatives that participate on the BHCCC. This committee provides guidance on culturally relevant practices and aims to reduce behavioral health disparities based on race, ethnicity, language, sexual orientation, gender expression, and other dimensions of diversity. As part of the plan and activities of the opioid coalition and MHSA joint cultural competence work, a number of activities with the native tribes council have also taken place which include SUD education and outreach.

Since forming this joint committee, significant revisions to the Cultural Competency Plan have been made and the document is far more inclusive of Alcohol and Drug Services. The full CCP was submitted to BHC for review in preparation for the upcoming site visit.

Recommendation 5. In order to broaden the impact of its efforts on non-methadone forms of MAT, link with new partners and add its expertise in the treatment of those with substance use disorders, the DMC should seek membership on the Napa Opioid Safety Coalition.

Status: Met

DMC-ODS Activities

Since the Year 1 EQRO Site Visit, a staff member from ADS, Jeremy Ostrander, has consistently attended the Napa Opioid Safety Coalition (NOSC), as well as tabling events organized by NOSC. At these events, he has represented Alcohol and Drug Services. Jeremy also collaborates closely with the treatment team at Clinic OLE (X-waivered MD, X-waivered PA, and Clinical Case Manager) where clients are referred for non-methadone MAT services.

Recommendation 6. Napa should continue its working relationship with probation in order to further facilitate transition of the courts from a mandated treatment model to one that utilizes medical necessity and the ASAM paradigm. This is essential to maintain good coordination with offices of the court as admission data indicates that more than 70 percent of incoming clients are criminal justice involved.

Status: Met

DMC-ODS Activities

One full time ADS Licensed Mental Health Counselor (LPHA) works four days per week at Probation's offices, conducting ASAMs with clients on probation, as well as those in-custody. This service enables clients to move directly from custody to treatment. It also expedites the intake process for clients on probation and reduces barriers such as transportation. The regular presence of ADS staff at Probation's office has helped to strengthen Napa's relationship with Probation so that staff can encourage that treatment referrals be based on medical necessity, rather than court mandates. Probation is responsive to ADS's clinical recommendations and collaborates willingly with ADS staff to ensure mutual clients are referred to the appropriate level of care.

In addition to the Mental Health Counselor, an Alcohol and Drug Counselor provides case management to clients participating in Drug Court; this staff member meets weekly with the Drug Court team, consisting of the judge, probation officer, and representatives from the public defender and district attorney's offices.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

Past Year's Initiatives and Accomplishments

1. Residential Contract

In October 2018, Napa County executed a contract with Center Point Inc. to provide Adult Residential and Withdrawal Management services (ASAM LOC 3.1, 3.2, 3.5) in Napa County. On April 1, 2019, Center Point opened its program in Napa County. Since then, there have been 456 admissions into Center Point's Residential and Withdrawal Management programs. ADS's Contract Supervisor, Tracy Ulitin, meets weekly with Center Point staff to ensure authorizations for residential treatment are happening in a timely manner. Due to a delay in the program's Drug MediCal application, Napa County has been unable to submit DMC claims for residential treatment or withdrawal management. However, the application was submitted on 8/16/19. Therefore, upon its approval, Napa will claim for services dating back to that date.

2. Youth Treatment Contract

In April 2019, Napa County executed a new contract with Aldea Children and Family Services to provide youth outpatient and intensive outpatient treatment. Napa County has contracted with Aldea for many years, but the new contract moved Aldea out of a cost-reimbursement model and into a fee-for-service model under DMC-ODS, as of 7/1/2019.

3. NTP/OTP Contract

In April 2019, Napa County executed a contract with two NTP/OTP providers: MedMark Treatment Centers (located in Fairfield) and Successful Alternatives for Addiction Counseling (located in Vallejo). These contract sites are also part of the Hub and Spoke grant program to expand non-methadone MAT access. After executing the contract, Napa County was informed that both sites had been serving Napa County clients since October 2018. Therefore, Napa County's Board of Supervisors approved a contract amendment which backdated the contract to October 1, 2018. This enabled Napa County to significantly increase its NTP claiming. As of January 2020, Napa County has submitted claims to the state through October 2019.

4. Division Organizational Changes to Support DMC-ODS

In 2019, ADS implemented several organizational changes to support its compliance with the DMC-ODS waiver. In April, a new Division Director was hired. Between April and July, ADS hired two additional LPHAs to expedite the intake/ASAM process and ensure clients are placed in the appropriate level of

care. In July, ADS added the position of Contracts Supervisor; this position ensures that ADS contractors receive thorough training in the DMC-ODS model and are operating with compliance. An additional bilingual LPHA position was created, though filling this has been challenging and the job remains open at this time. Lastly, an Extra Help Office Assistant was brought on to support Utilization Review.

5. Implementation of Concurrent Review

From April to August 2019, the Leadership team of Alcohol and Drug Services met for five hours a week with a consultant (previous HHSA Director, Randy Snowden) to review the DMC-ODS rules at all Levels of Care, establish formalized workflows, and implement a Concurrent Review system. This process concluded with extensive training for ADS direct service staff, as well as Napa County's contractors for residential and youth services. Since October 2019, the Concurrent Review system has been in full operation and highly effective at catching compliance issues early on, consequently preventing future disallowances.

6. Program Curriculum

In July 2019, seven ADS staff members, including two program supervisors, began meeting weekly for approximately three months to evaluate the program's curriculum and research new evidence-based practices. The group unanimously decided to retire ADS's use of the Matrix Model in the adult outpatient program and implement Living in Balance, an evidence-based practice that incorporates a wide-range of biopsychosocial topics into addiction treatment. The structure and schedule of the counseling groups were also reevaluated, leading to the roll out of more than ten new groups on 2/2/20 to supplement Living in Balance and provide necessary hours for clients enrolled in IOT.

7. Cultural Competency Plan

ADS is committed to ensuring services are delivered in ways which recognize, are sensitive to, and respectful of individual, cultural, and linguistic differences. In June 2019, Mental Health and ADS established a joint Behavioral Health Cultural Competency Committee (BHCCC) in an effort to provide consistent culturally competent services to the consumers. ADS has two representatives that participate on the BHCCC. This committee provides guidance on culturally relevant practices and aims to reduce behavioral health disparities based on race, ethnicity, language, sexual orientation, gender expression, and other dimensions of diversity.

The HHSA Strategic Plan includes a goal to reinforce culturally responsive approaches to service delivery, ensuring an accessible, welcoming, and supportive environment for the diverse community Napa County serves. This includes the development of an inclusive workforce model, as well as system-wide engagement, adoption and implementation of an HHSA Diversity Committee Strategic Plan. ADS has a representative who participates in the

HHSA Diversity Committee (separate from BHCCC) and is currently providing input on the Racial Equity Policy and Tool.

8. Napa Opioid Safety Coalition (NOSC)

Since the Year 1 EQRO Site Visit, a staff member from ADS, Jeremy Ostrander, has consistently attended the Napa Opioid Safety Coalition, as well as tabling events organized by NOSC. At these events, he has represented Alcohol and Drug Services. Jeremy also collaborates closely with the treatment team at Clinic OLE (X-waivered MD, X-waivered PA, and Clinical Case Manager) where ADS clients are referred for MAT services.

9. Probation/Jail Coordination

One full time ADS Mental Health Counselor works four days per week at Probation's offices, conducting ASAMs with clients on probation, as well as those in-custody. This service enables clients to move directly from custody to treatment (typically residential LOC 3.1). It also expedites the intake process for clients on probation and links them to treatment more quickly. In addition to the Mental Health Counselor, an Alcohol and Drug Counselor provides case management to clients participating in Drug Court; this staff member meets weekly with the Drug Court team, consisting of the judge, probation officer, and representatives from the public defender and district attorney's offices. Beginning in July 2019, data from services provided by ADS at Probation was included in our quarterly Quality Improvement Committee (QIC) reports.

10. Electronic ASAM

This year, Dr. David Mee-Lee made a licensing agreement available for use of ASAM criteria. This enabled Napa County to create an electronic version of the ASAM in its EHR, Cerner-Anasazi. Prior to this, all intake clinicians were conducting the ASAM in Microsoft Word and having it scanned into the medical record. Converting this to an electronic format has made the process quicker and more reliable and also minimizes the printing and transmission of protected health information (PHI).

11. Added Measures on Quality Improvement Committee Report

Each quarter, ADS compiles a report for the Quality Improvement Committee. This report reflects data related to utilization, timely access, and client feedback. Each quarter, ADS expanded this report to include additional data, including data from our contractors. During 2019, the following measures were added:

- Reason first appointment was NOT kept (added in Q1)
- Count of new clients whose preferred language is Spanish (added in Q1)
- Breakdown of MAT referrals, including number of days between intake and MAT referral, and outcome of referral (added in Q1)
- Level of Care Assignments / Reason for difference between assessed LOC and actual placement (added in Q2)
- Number of residential admissions (added in Q2)

- Number of assessments completed at probation offices and the jail, as well as reasons why probation/jail appointments were not kept (added in Q2)
- Data on grievances and appeals (added in Q2)
- Outcome of all Client Satisfaction Surveys (added in Q2)
- Average number of days between first appointment (intake/ASAM) and second appointment (treatment) (added in Q3)
- Feedback from Secret Shopper Calls from UCLA (added in Q3)
- Data from contractors (added in Q3) – details below
- Data from Center Point (contracted provider of 3.1, 3.2, 3.5) including:
 - o Number of clients who received follow up appointment within 7 days of discharge
 - o Number of readmissions within 30 days of discharge
 - o Number of clients with 3+ Withdrawal Management episodes per year
- Data from Aldea (contracted provider of YOUTH 1.0 and 2.1)
 - o Number of requests for services
 - o Timeliness of services
 - o Number of urgent referrals
 - o Types of service requests (probation, community, etc)
 - o Number of clients receiving services in Spanish
 - o Primary and preferred language of all new clients
 - o Data on notices of adverse benefit determination (NOABDs)
 - o Results of test calls
- Termination NOABDs issued (added in Q4)
- Average length of stay in residential, provided by Center Point (added in Q4)
- Number of residential completions and reasons for incompletes, provided by Center Point (added in Q4)

For more information about CalOMS and about the two measurement tools, see below:

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_Note_17-026_TPS_Instructions.pdf

3. ASAM Level of Care Data Collection System:

http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Note_17-035_ASAM_Data_Submission.pdf

Napa Goals for the Coming Year

1. Perinatal Residential Contract

Napa County is in the process of developing a contract with an out-of-county residential treatment center to provide both Perinatal and Gender-Responsive 3.1 Residential Treatment. This provider is DMC-ODS certified and contracts with

both Contra Costa County and Solano County. They are approximately 30 minutes from the city of Napa. The contract will be for four beds; in addition to serving all pregnant clients who assess for residential treatment, female clients will be given the option of attending treatment at this facility, rather than the in-county provider which is co-ed. This contract is expected to go to Napa County's Board of Supervisors in March 2020. (Of note, Napa County's current residential provider, Center Point, does accept pregnant clients; however, they do not provide the perinatal services required by DMC-ODS.)

2. Youth Residential Treatment Contract

During 2019, Napa County did not receive any referrals for youth requiring 3.1 or 3.5 residential treatment. However, under DMC-ODS, youth residential treatment is a required service. The only provider identified in Northern California (Advent Group Ministries in Santa Clara County) will only offer a dedicated-bed model at a rate beyond what Napa County can reasonably accommodate. Napa County is exploring partnerships with other counties to share a bed at Advent and reduce costs associated with an unused bed.

3. Call Center Software

Since the Year 1 Site Visit, the Senior Office Assistants who receive all incoming calls during working hours have implemented numerous changes to enhance the tracking of phone calls. However, Napa County was advised that it should use a Call Center Software so that the time, duration, and details of phone calls can be automated. Napa County is exploring options for this software and has consulted with several other counties regarding their software. Napa did explore use of one vendor by requesting a bid but costs were not feasible.

4. NTP Data

Napa's two NTP contractors are out of county and primarily serve clients from Solano Counties. Because Napa County clients make up a small portion of the total clients served in these two sites, the sites have been unable to dedicate resources to providing Napa County the data it seeks. In the coming months, Napa County will be conducting two site visits and reviewing the contractors' existing data collection processes. Napa will also provide the contractors with a set of basic measures to begin collecting.

PERFORMANCE MEASURES

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

The first six PMs 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 assessments, and outcomes. The additional six measures could be modified in subsequent years if better, more useful metrics are needed or identified.

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

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries;
- Number of days to first DMC-ODS service after client assessment and referral;
- Total costs per beneficiary served by each county DMC-ODS by ethnic group;
- Cultural competency of DMC-ODS services to beneficiaries;
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes);
- Coordination of Care with physical health and mental health (MH);
- Timely access to medication for NTP services;
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured;
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after residential treatment;
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics);
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs);

- Percentage of clients with three or more 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 complimentary data cell is suppressed to prevent calculation of initially suppressed data. Additionally, suppression is required of corresponding percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Year Two of Waiver Services

This is the second year that Napa has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 18-19), and from UCLA for TPS, ASAM, and CalOMS data from CY2018. 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 a claims lag for services in the data available at the time of the review. CalEQRO used the time period of CY 2018 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 2018-19

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

CY 2018 Table 1 shows Napa'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.

For Napa, the age group 18 to 64 makes up the majority of DMC-ODS clients served which is consistent with the prior year's findings. Adults ages 65 and over are proportionally underserved compared to the 18 to 64 age group, but on par with the penetration rates statewide.

DMC-ODS Beneficiaries Served in Fiscal Year 2018-19 Data from DHCS, October 2019

Table 1: Penetration Rates by Age, FY 2018-19

Table 1: Penetration Rates by Age, FY 2018-19					
	Napa			Small Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	4,293	*	n/a	0.20%	0.26%
Ages 18-64	15,700	312	1.99%	0.51%	1.12%
Ages 65+	3,397	*	n/a	0.31%	0.70%
TOTAL	23,389	339	1.45%	0.43%	0.93%

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

Table 2 below shows Napa'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. Napa's overall average approved claim are lower than claims statewide (\$1,568 compared to \$3,868). Average approved claims for all age groups are lower than the statewide average approved claims.

Table 2: Average Approved Claims by Age, FY 2018-19

Table 2: Average Approved Claims by Age, FY 2018-19			
	Napa		Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	\$770	\$385	\$1,750
Ages 18-64	\$475,920	\$1,525	\$3,898
Ages 65+	\$54,994	\$2,200	\$4,560
TOTAL	\$531,684	\$1,568	\$3,868

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. In Napa, clients who are White are accessing services more readily than African American, Asian/Pacific Islander and Native American. The next highest ethnicity accessing services are Hispanic/Latino. This is consistent with the demographics of the county.

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, FY 2018-19

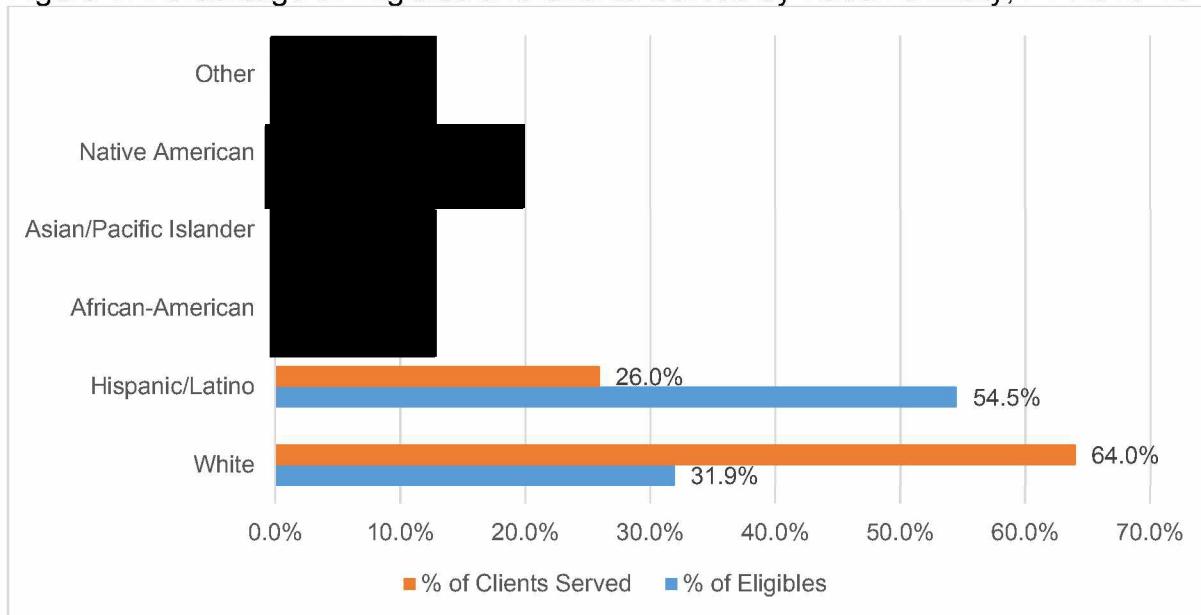


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. As discussed, White clients have a higher penetration rate than small counties and statewide.

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19

Table 3: Penetration Rates by Race/Ethnicity FY 2018-19					
	Napa			Small Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	7,473	217	2.90%	0.53%	1.76%
Latino/Hispanic	12,754	88	0.69%	0.39%	0.67%
African-American	411	*	n/a	0.31%	1.28%
Asian/Pacific Islander	1,413	*	n/a	0.07%	0.16%
Native American	53	*	n/a	0.14%	1.55%
Other	1,288	21	1.63%	0.42%	1.05%
TOTAL	23,389	339	1.45%	0.43%	0.93%

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

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

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19				
	Napa			Statewide
Eligibility Categories	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate
Disabled	2,721	56	2.06%	1.62%
Foster Care	80	*	n/a	1.72%
Other Child	1,963	*	n/a	0.28%
Family Adult	3,650	48	1.32%	0.95%
Other Adult	4,087	*	n/a	0.10%
MCHIP	2,629	-	-	0.20%
ACA	8,161	235	2.88%	1.46%

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

Table 5 below shows Napa's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Average approved claims for Napa are generally lower than statewide averages, reflected her by eligibility categories.

Table 5: Average Approved Claims by Eligibility Category, FY 2018-19

	Napa			Statewide
Eligibility Categories	Average # of Eligibles per Month	# of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	2,721	56	\$1,381	\$4,207
Foster Care	80	*	n/a	\$1,117
Other Child	1,963	*	n/a	\$1,690
Family Adult	3,650	48	\$1,324	\$3,255
Other Adult	4,087	*	n/a	\$4,269
MCHIP	2,629	-	-	\$1,810
ACA	8,161	235	\$1,633	\$3,867

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

Children 12 and under rarely need treatment for SUD. Foster Care, Other Child and

Maternal and Child Health Integrated Program (MCHIP) include children of all ages contributing to a low penetration rate.

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2018-19. The majority of the clients served were in outpatient treatment program (75.6%). Napa has a contract with a provider for residential treatment but is delayed in billing due to the provider working through DMC certification with Provider Enrollment Division.

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	28	7.0%	\$789
Residential Treatment	-	-	\$0
Residential Withdrawal Mgmt.	-	-	\$0
Ambulatory Withdrawal Mgmt.	-	-	\$0
Non-Methadone MAT	-	-	\$0
Recovery Support Services	-	-	\$0
Partial Hospitalization	-	-	\$0
Intensive Outpatient Tx.	70	17.4%	\$1,438
Outpatient Drug Free	304	75.6%	\$1,345
TOTAL	402	100%	\$1,568

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

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

Persons seeking methadone maintenance medication must first show a history of at least one year of opiate addiction and at least two unsuccessful attempts to quit using opioids through non-MAT approaches. They are likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they may soon resume opiate use and an addiction lifestyle that

can be life-threatening. For these reasons, NTPs regard the request to begin treatment with methadone as time sensitive.

Median number of days indicated below for Napa client beneficiaries indicate that are able to access care in a timely manner, on average within one day of diagnosis/assessment.

Table 7: Days to First Dose of Methadone by Age, FY 2018-19

Age Groups	Napa			Statewide		
	# of Clients	%	Median Days	# of Clients	%	Median Days
Ages 12-17	-	-	-	*	n/a	n/a
Ages 18-64	*	n/a	n/a	28,929	80.04%	<1
Ages 65+	*	n/a	n/a	*	n/a	n/a
TOTAL	28	100%	<1	36,144	100%	<1

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

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

Some people with opiate addictions 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.

Napa utilizes a FQHC to provide non-methadone MAT services. The FQHC has four clinics in the county and two clinics in a neighboring county. They are exploring some mobile outpatient care in far northern parts of the county which would assist with the one zip code where there is an access issue for MAT in the county.

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

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

Non-methadone MAT services are provided by the FQHC and the services are not billed through the county system.

Table 8: Three or more DMC-ODS Non-Methadone MAT Services by Age, FY 2018-19

Age Groups	Napa				Statewide			
	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	-	-	-	*	n/a	n/a	n/a
Ages 18-64	-	-	-	-	3,200	4.15%	1,335	1.73%
Ages 65+	-	-	-	-	*	n/a	n/a	n/a
TOTAL	-	-	-	-	3,462	3.81%	1,012	1.3%

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

Transitions in Care Post-Residential Treatment – FY 2018-19

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

Table 9 show two aspects of this expectation — (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

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

Napa has not been able to bill for any residential treatment services at the time of the review. Napa has a contract with Center Point and are providing residential treatment services. However, Center Point has not received DMC certification from the Provider Enrollment Division yet and will begin to bill once the application has been successfully processed.

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2018-19

Table 9: Timely Transitions in Care Following Residential Treatment FY 2018-19				
Napa (n= 1)			Statewide (n= 24,582)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	-	-	1140	5.7%
Within 14 Days	-	-	1,579	7.8%
Within 30 Days	-	-	1,987	9.9%
Any days (TOTAL)	-	-	2,895	14.4%

Access Line Quality and Timeliness

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

Table 10 shows Access Line critical indicators from January 2019 through December 2019. Napa has two FTEs solely dedicated to the DMC Access line during normal business hours. Napa has a contract with Bright Heart Health to answer after hour calls.

Table 10: Access Line Critical Indicators, January 2019-December 2019

Table 10: Napa Access Line Critical Indicators, January 2019 through December 2019	
Average Volume	67.5 calls per month
% Dropped Calls	0
Time to answer calls	2 rings
Monthly authorizations for residential treatment	9.5
% of calls referred to a treatment program for care, including residential authorizations	This is not currently tracked
Non-English capacity	2 FTE Access Line staff are bilingual (English/Spanish) and uses the Language Line if needed

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services in Napa. 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 \$14,015 in approved claims per year. The table lists the average approved claims costs for the year for Napa HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

Napa did not have any high cost beneficiaries because they have not been able to bill for residential treatment as was discussed previously.

Table 11a: High Cost Beneficiaries by Age, Napa, FY 2018-19

Table 11a: Napa High Cost Beneficiaries by Age FY 2018-19						
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages 12-17	*	-	n/a	n/a	n/a	0%
Ages 18-64	312	-	n/a	n/a	n/a	0%
Ages 65+	*	-	n/a	n/a	n/a	0%
TOTAL	339	0	n/a	n/a	n/a	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).

Table 11b: High Cost Beneficiaries by Age, Statewide, FY 2018-19

Table 11b: Statewide High Cost Beneficiaries, Statewide, FY 2018-19					
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims
Ages 12-17	4,028	30	0.7%	\$13,629	\$408,873
Ages 18-64	77,199	4,558	5.9%	\$15,585	\$71,034,634
Ages 65+	8,837	270	3.1%	\$15,569	\$4,203,684
TOTAL	90,064	4,858	5.4%	\$15,572	\$75,647,191

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.

Napa has not been able to bill for any residential treatment including WM.

Table 12: Withdrawal Management with No Other Treatment, FY 2018-19

Table 12: Withdrawal Management with No Other Treatment FY 2018-19				
	Napa		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	-	n/a	5,010	2.4%

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.

Data from Napa indicate a high level of congruence of level of care referrals to ASAM findings. Clinical judgement, client preference and level of care were not available were the main reasons indicated for a level of care that was different from the referral.

Table 13: Congruence of Level of Care Referrals with ASAM Findings

ASAM Level of Care (LOC) Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
Dates of Screenings: 05/01/18 – 12/18/19 (19 Months)						
If assessment-indicated LOC differed from referral, then reason for difference	#	%	#	%	#	%
Not Applicable - No Difference	-	-	1,078	67.8%	315	72.4%
Patient Preference	-	-	112	7.0%	29	6.6%
Level of Care Not Available	-	-	103	6.5%	[REDACTED]	[REDACTED]
Clinical Judgement	-	-	233	14.6%	68	15.6%
Geographic Accessibility	-	-	*	n/a	-	-
Family Responsibility	-	-	-	-	-	-
Legal Issues	-	-	35	2.2%	[REDACTED]	[REDACTED]
Lack of Insurance/Payment Source	-	-	*	n/a	-	-
Other	-	-	[REDACTED]	[REDACTED]	*	n/a

Actual Referral Missing	-	-	-	-	-	-
TOTAL	-	-	1,589	100.0%	435	100.0%

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 is what in this measure is defined as “initiating” treatment. Napa’s data indicates that the adult clients who initiate services is lower than the statewide average.

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. Napa’s data indicates that the adult clients who then engage in services is lower than the statewide average. This is the focus of one of their PIPs.

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2018-19

	Napa				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	327		*		88,582		4,136	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	209	63.9%	*	n/a	79,988	90.3%	3,288	79.5%
Clients who then engaged in DMC-ODS services	136	65.1%	*	n/a	63,828	79.8%	2,291	69.7%

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. Napa has only billed for outpatient treatment, intensive outpatient treatment and NTP services. The FQHC provides the MAT services and as previously discussed, Napa has not been able to bill for residential treatment services.

Table 15: Initial DMC-ODS Service Used by Clients, FY 2018-19

Table 15: Initial DMC-ODS Service Used by Clients, FY 2018-19				
DMC-ODS Service Modality	Napa		Statewide	
	#	%	#	%
Outpatient treatment	284	86.3%	30,542	32.9%
Intensive outpatient treatment	16	5.9%	6,527	7.0%
NTP/OTP	29	8.8%	35,986	38.8%
Non-methadone MAT	-	-	192	0.2%
Ambulatory Withdrawal	-	-	44	0.05%
Partial hospitalization	-	-	16	0.02%
Residential treatment	-	-	15,446	16.7%
Withdrawal management	-	-	3,965	4.3%
Other	-	-	-	-
TOTAL	329	100.0%	92,718	100.0%

Retention in Treatment

Table 16 is a measure of how long the system of care 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 seven days per week if they had at least one outpatient visit in a week.

The mean (average) length of stay for Napa clients was 80 days (median 31 days), compared to the statewide mean of 128 (median 84 days). 34% percent of clients had at least a 90-day length of stay; 15 percent had at least a 180-day stay, and; five percent had at least a 270-day length of stay. The length of stay for 90 days is higher than statewide and the clients with at least a 270-day stay is much lower than the statewide percentage.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2018-19

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2018-19				
	Napa		Statewide	
Clients with a discharge anchor event*	377		88,228	
Length of stay (LOS)** for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50 th percentile)	Mean (Average)	Median (50 th percentile)
	80	31	128	84
	#	%	#	%
Clients with at least a 90-day LOS	129	34.0%	41,633	47.0%
Clients with at least a 180-day LOS	55	15.0%	22,355	25.0%
Clients with at least a 270-day LOS	18	5.0%	13,277	15.0%

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential withdrawal management readmissions within 30 days of discharge. Napa has not been able to bill for residential WM treatment as previously discussed so there was no data to analyze.

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2018-19

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2018-19				
	Napa		Statewide	
Unduplicated clients of the DMC-ODS*	339		90,064	
	#	%	#	%
Total DMC-ODS clients who were admitted into residential withdrawal management (WM)	-	-	6,198	100.0%
Clients admitted into WM who were readmitted within 30 days of discharge	-	-	432	7.0%

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the Napa and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2018-19. Alcohol, other stimulant abuse and opioid use were the most prominent types of substance use disorders addressed by Napa's DMC-ODS providers.

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19

Diagnosis Codes	Napa		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	43.8%	\$1,784	15.8%	\$4,232
Cannabis Use	[REDACTED]	[REDACTED]	8.7%	\$1,953
Cocaine Abuse or Dependence	[REDACTED]	[REDACTED]	2.1%	\$4,593
Hallucinogen Dependence	-	-	0.2%	\$3,847
Inhalant Abuse	-	-	0.02%	\$3,119
Opioid	15.3%	\$965	46.9%	\$4,286
Other Stimulant Abuse	27.9%	\$1,822	24.4%	\$3,736
Other Psychoactive Substance	-	-	0.4%	\$5,521
Sedative, Hypnotic Abuse	-	-	0.5%	\$4,033
Other	[REDACTED]	[REDACTED]	0.9%	\$2,586
TOTAL	100%	\$1,568	100%	\$3,868

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

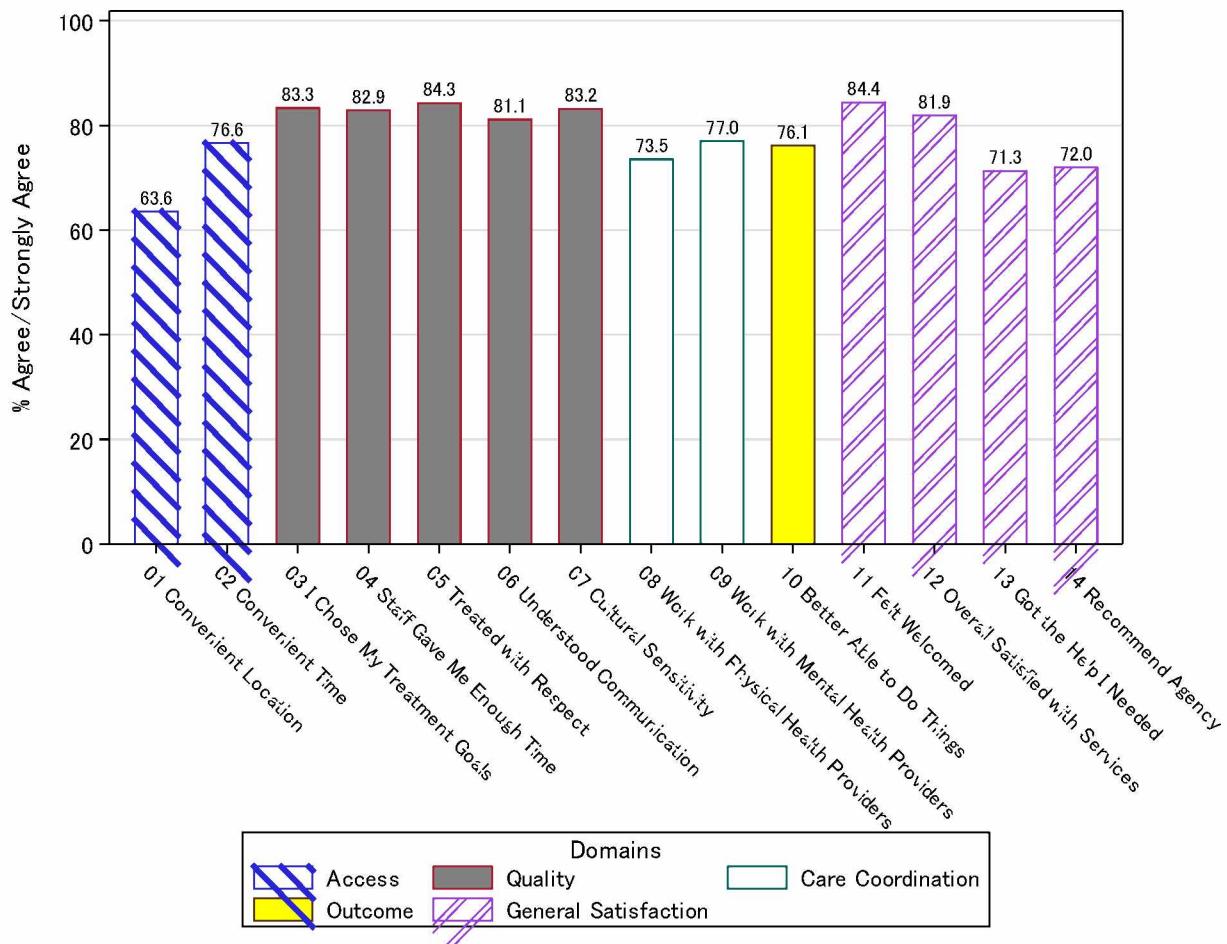
Client Perceptions of Their Treatment Experience

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

Napa clients who responded to the TPS were generally positive about their treatment experience. The domains that received the lowest ratings, comparatively were: Convenient Location, Got the Help I Needed and Recommend Agency.

The QI Committee did follow-up analysis of these findings and worked to do improvement tasks in the residential program which accounted for some of the lower ratings.

Figure 2: Percent of survey participants in agreement by survey questions and five domains, October 2019 (N = 109)



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 Napa will need to consider and with which agencies they will need to coordinate. Napa's percentage of homeless was higher than the statewide average. Clients involved in post release supervision AB 109 were higher than the statewide average. The employment status was consistent with the statewide percentages.

Table 19: CalOMS Admission Living Status, CY 2018

Admission Living Status	Napa		Statewide	
	#	%	#	%
Homeless	249	42.2%	24,020	26.2%
Dependent Living	103	17.5%	26,296	28.6%
Independent Living	238	40.3%	41,472	45.2%
TOTAL	590	100.0%	91,788	100.0%

Table 20: CalOMS Legal Status on Admission, CY 2018

Admission Legal Status	Napa		Statewide	
	#	%	#	%
No Criminal Justice Involvement	282	44.4%	54,930	59.8%
Under Parole Supervision by CDCR	*	n/a	2,288	2.5%
On Parole from any other jurisdiction	*	n/a	890	1.0%
Post release supervision - AB 109	259	45.6%	28,801	31.4%
Court Diversion CA Penal Code 1000	*	n/a	1,259	1.4%
Incarcerated	*	n/a	389	0.4%
Awaiting Trial	██████████	██████████	3,221	3.5%
TOTAL	590	100.0%	91,788	100.0%

Table 21: CalOMS Employment Status on Admission, CY 2018

Current Employment Status		Napa		Statewide	
		#	%	#	%
Employed Full Time - 35 hours or more		93	15.8%	12,134	13.2%
Employed Part Time - Less than 35 hours		42	7.1%	7,259	7.9%
Unemployed - Looking for work		137	23.2%	25,522	27.8%
Unemployed - not in the labor force and not seeking		318	53.9%	46,873	51.1%
TOTAL		590	100.0%	91,788	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. Napa's standard adult discharges and detox discharges were slightly higher than statewide in comparison with the administrative adult discharges and youth discharges being under statewide data.

Table 22: CalOMS Discharge Types, CY 2018

Discharge Types	Napa		Statewide	
	#	%	#	%
Standard Adult Discharges	413	50.4%	43,654	49.6%
Administrative Adult Discharges	224	27.5%	33,344	37.9%
Detox Discharges	*	n/a	8,470	9.6%
Youth Discharges	*	n/a	2,609	3.0%
TOTAL	820	100.0%	88,077	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 different types of reasons.

Napa's client who completed treatment is higher than the statewide percentage.

Table 23: CalOMS Discharge Status, Napa and Statewide, CY 2018

Discharge Status	Napa		Statewide	
	#	%	#	%
Completed Treatment - Referred	392	47.8%	20,190	22.9%
Completed Treatment - Not Referred	61	7.4%	6,070	6.9%
Left Before Completion with Satisfactory Progress - Standard Questions	86	10.5%	12,220	13.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	101	12.3%	7,259	8.2%
<i>Subtotal</i>	57	6.9%	16,253	18.4%
Left Before Completion with Unsatisfactory Progress - Standard Questions	102	12.4%	24,781	28.1%
Left Before Completion with Unsatisfactory Progress - Administrative	*	n/a	96	0.1%
Death	*	n/a	1,208	1.4%
Incarceration	820	100.0%	88,077	100.0%
<i>Subtotal</i>	392	47.8%	20,190	22.9%
TOTAL	61	7.4%	6,070	6.9%

Performance Measures Findings—Impact and Implications

Access to Care PM Issues

- Access to services for youth treatment services is low compared to statewide penetration rate.
- Overall the penetration rate for Napa is higher than the statewide penetration rate.
- Residential treatment services are being provided but have not been billed so measures cannot be determined in terms of quality.
- Napa clients are able to access a range of MAT services through the FQHC and through the NTPs.

Timeliness of Services PM Issues

- Napa clients are able to receive NTP services in less than a day.

Quality of Care PM Issues

- Napa has a lower than statewide average for initiation and engagement into DMC-ODS services.
- Residential treatment services are being provided through a contract with a community-based provider. Because of the difficulty with obtaining DMC certification, Napa has not been able to bill for these services. There is no data to analyze to evaluate the effectiveness of these services.
- Retention in care statistics are generally lower than statewide in this first baseline year of this measure, but this is the focus of a PIP for retention, so this measure is a focus for improvement.

Client Outcomes PM Issues

- Client satisfaction was low on convenient location compared to the other domains (63.6 compared to a high of 84.4).
- Napa used the TPS to evaluate high and low performance areas and did follow up interventions with the residential provider to make improvements and enhance outcomes for clients and their experience of care.

INFORMATION SYSTEMS REVIEW

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

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

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

ISCA Table 1: Distribution of Services, by Type of Provider

ISCA Table 1: Distribution of Services, by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	72%
Contract providers	28%
Total	100%

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

The budget determination process for information system operations is:

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

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

- Yes
- No
- In Pilot phase

Summary of Technology and Data Analytical Staffing

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

ISCA Table 2: Summary of Technology Staff Changes

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

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

ISCA Table 3: Summary of Data and Analytical Staff Changes

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

The following should be noted regarding the above information:

- Technology support include a Senior Systems Analyst and a Systems Analyst.
- Analytic support is shared by the application support team as well as various leadership staff. Napa estimates the total staff time to be equivalent to two FTEs.
- The MHP has had no change in technology or analytic staffing in the past year.

Current Operations

DMC-ODS continues to utilize the Cerner Community Behavioral Health (CCBH) system for practice management and electronic health record (EHR) functionality in an application service provider (ASP) model with Kings View as their provider. CCBH promotion 230 has been installed. They continue to consider whether this is the best system for Napa especially with the new Millennium limitations they perceive relative to their needs.

ISCA Table 4 lists the primary systems and applications the DMC-ODS county uses to conduct business and manage operations. These systems support data collection and

storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third-party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

ISCA Table 4; Primary EHR Systems/Applications

ISCA Table 4: Primary EHR Systems/Applications				
System/ Application	Function	Vendor/Supplier	Years Used	Operated By
Cerner Community Behavioral Health (CCBH)	Electronic Health Record and Billing System	Cerner Corporation	11	MHP/HHSA

Priorities for the Coming Year

- Prior to implementation, work collaboratively with Cerner Corporation to resolve questions regarding the ability of the Millennium software to meet the analytic and data collection needs.
- Complete implementation and testing of CalOMS functionality in Cerner Millennium backend, if implementation of this product continues.
- Complete implementation and testing of Drug Medi-Cal and other insurance plans in Cerner Millennium backend, if implementation continues.
- Complete Upgrade to Windows 10 for county workstations and laptops.

Major Changes since Prior Year

- Completed the implementation of an electronic ASAM assessment and reassessment in CCBH.
- Clinical staff were provided documentation refresher training for progress notes and treatment planning related to SUD requirements.
- The design and implementation of an internal services utilization/timeliness tracking system in Excel was completed.
- Implementation of new residential treatment facility and medication assisted treatment program coding in CCBH was completed to allow for billing of the NTP sites, residential billing is still waiting for PED approval.
- While the planning phase for Cerner Millennium began in April 2019, it was placed on hold in February 2020 while DMC-ODS questioned

whether the product could meet their data collection and analytic needs. Discussions with Cerner Corporation on this issue is ongoing with the hope that the product can be enhanced to meet their requirements. There are concerns that they would need a data warehouse to overcome some of the limitations they see in the proposed system, but funds for such a system are not available at this time.

Other Significant Issues

- Excel is utilized for timeliness to service tracking and many other functions which the computer system from Cerner cannot provide.
- While Napa plans to install call center software, the product to be implemented has not yet been identified.

Plans for Information Systems Change

While DMC-ODS had an implementation in progress, this project was put on hold in February 2020 due to questions regarding whether the Cerner Millennium product could meet data collection and analytic needs. Discussions with Cerner Corporation to determine the feasibility of enhancing Millennium to meet their requirements are currently occurring.

Current Electronic Health Record Status

ISCA Table 5: EHR Functionality

ISCA Table 5: EHR Functionality		Rating			
Function	System/ Application	Present	Partially Present	Not Present	Not Rated
Alerts	CCBH	X			
Assessments	CCBH	X			
Care Coordination				X	
Document imaging/storage	CCBH	X			
Electronic signature— client	CCBH	X			
Laboratory results (eLab)				X	
Level of Care/Level of Service		X			
Outcomes	CCBH	X			
Prescriptions (eRx)	CCBH	X			
Progress notes	CCBH	X			
Referral Management				X	
Treatment plans	CCBH	X			

ISCA Table 5: EHR Functionality					
		Rating			
Function	System/ Application	Present	Partially Present	Not Present	Not Rated
Summary Totals for EHR Functionality:		8	0	4	0

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

- There has been no change in EHR functionality in the past year.

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

Paper Electronic Combination

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

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings

	Yes	No	%
ASAM Criteria is being used for assessment for clients in all DMC Programs.	x		
ASAM Criteria is being used to improve care.	x		
CalOMS being administered on admission, discharge and annual updates.	x		
CalOMS being used to improve care. Track discharge status. Outcomes.	x		
Percent of treatment discharges that are administrative discharges.	NA	NA	27.5%
TPS being administered in all Medi-Cal Programs.	x		

Highlights of use of outcome tools above or challenges:

- CalOMS data is utilized as part of the Quality Management plan, including tracking outcomes such as housing and vocational status.
- The TPS is administered to clients in outpatient services.
- Screeners and assessors collect data as required and enter it into the ASAM LOC Referral Data spreadsheet.

Drug Medi-Cal Claims Processing

- DMC-ODS has yet to submit claims for residential withdrawal management.

Special Issues Related to Contract Agencies

- Contract agencies staff currently do not have access to CCBH system.
- Agencies submit paper documents by secure email to DMC-ODS who then manually enter client data into CCBH.

Overview and Key Findings

Access to Care

- While there are plans to install call center software, the product to be implemented has not yet been identified.

Timeliness of Services

- Excel is utilized to manually track timeliness indicators.

Quality of Care

- An electronic ASAM assessment and reassessment form/screen is now available in CCBH.
- Clinical staff were provided documentation refresher training for progress notes and treatment planning.
- The TPS is administered and reports from UCLA are received which provide results for the overall DMC-ODS and by treatment program.

Client Outcomes

- CalOMS data entry is done per requirements and once Napa has access the reports, the data will be used to monitor outcomes.

NETWORK ADEQUACY

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

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

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Napa, the time and distance requirements are 45 minutes or 75 miles for outpatient services and 45 minutes or 75 miles for NTPs. The two types of care that are measured for compliance with these requirements are outpatient treatment services and narcotic treatment programs. These services are separately measured for time and distance in relation to two age groups—youth and adults.

CalEQRO reviews the provider files request in Information Notice 18-011, maps of clients in services, and distances to the closest providers by type and population served. If there is no provider within the time or distance standard, the county DMC-ODS plan must submit a request for an alternate access standard (AAS) for that area with details of how many individuals are impacted, and access to any alternative providers who might become Medi-Cal certified for DMC-ODS. They must also submit a plan of correction or improvement to assist clients to access care which may include actions such as: 1) making available mobile services, transportation supports, and/or telehealth services, 2) making possible the taking home of doses of MAT where appropriate, and 3) establishing new sites with new providers to resolve the time and distance standards where feasible.

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

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

CalEQRO reviewed separately and with Napa County staff all documents and maps submitted to DHCS. CalEQRO also reviewed the special form created by CalEQRO for alternative access standard zip codes, timely access, and efforts to resolve these access issues. The DHCS requirement for Napa is for services to be within either 45 miles or 75 minutes from the clients' residence. Maps show the areas covered by the time and distance standards.

Napa has a three county run outpatient sites spread over the county, one contract children's provider, two NTP/OTP sites, one residential treatment and WM site in county under Center Point and provides outpatient MAT through a partnership with an FQHC for non-methadone medications. The NTP/OTP sites also provide non-methadone medications and are part of the Hub and spoke grant program. Napa County DMC-ODS also has a robust recovery services program housed with the outpatient services to allow for smooth transitions from one level of care to another.

There was one zip code area outside of the driving time standard with an approved alternative access standard in Napa County in the area north of Pope Valley. It was for OTP/NTP services since the closest NTP is MedMark in Fairfield, CA which is one hour and 24 minutes' drive time and 52 miles from this zip code. Upon additional review, the area north of Pope Valley, known as Aetna Springs has a distance of 44 miles and a drive time of approximately 70 minutes.

There are no closer NTP/OTPs in any of the other surrounding counties. This impacts 188 Medi-Cal eligibles in this area out of a total 625 population. Much of this area is wilderness. Telehealth is not a viable option for NTP/OTP services. Of the 188 Medi-Cal eligible, zero are current Alcohol and Drug clients. Much of the area is wilderness.

The AAS requested by Napa county DMC-ODS was for 90 minutes instead of the standard of 75 minutes for travel to the NTP.

Plan of Correction to Meet NA Standards

For access to non-methadone MAT, clients can go to a clinic in the north of the county near Calistoga which could allow for prescribing and management of buprenorphine, suboxone, Vivitrol, naloxone, and other FDA medications. The FQHC provider has six clinic sites. Four in Napa and two in Solano and a central clinic is sharing space with the county behavioral health and public health programs in the same campus to coordinate care for safety net populations.

CalEQRO will follow up on this new outreach to north county in the follow review.

In addition, Napa County monitors transportation needs of members to support access to care through free bus passes, coordination of treatment with the bus schedules, and in partnership with the Partnership Health Plan.

DHCS provided a timely response to the Napa County network adequacy application in April 2019 as required within the 90-day timeline.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Napa PIPs Identified for Validation

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

Clinical PIP—Enhancing Engagement and Retention in Treatment

Date PIP Began: 8/1/2018 **Status of PIP:** Active and ongoing

Brief Description of the problems the PIP is designed to address:

The goal of this PIP is to enhance engagement and retention in treatment in the first 30 days (thereby reducing dropouts). This was identified as a problem using data and is well documented in research as a critical first step in treatment of substance use disorders, where the client is often in denial or ambivalent about treatment. The research also documents the benefits of sustained engagement and retention in care and the benefits to the clients in improved outcomes, symptom relief, functioning, and sustain abstinence especially the longer the client is engaged in care. Therefore, Napa county DMC-ODS services identified a set of interventions to enhance the engagement and retention process in the first 30 days and reduce these dropouts by at least 10% from baseline rates.

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

PIP Study Question:

Napa presented its study question for the clinical PIP as follows:

Will developing an early therapeutic alliance with consumers by providing the initial support of reminder appointment calls, one-week engagement contacts, and a minimum of four scheduled appointments in the first 30 days decrease drop-out rates in clients' first 30 days of treatment by ten percent.

Indicators:

Napa listed the following PIP indicator:

- Percentage of enrolled clients who drop out (discontinue) treatment in the first 30 days of treatment (measured quarterly).

Interventions:

Napa cited the following interventions:

1. Clients will receive follow-up call from counselor within 5 days of intake/assessment to encourage participation;
2. Clients will be given a gift card after they participate in treatment for 30 days;
3. Clients will be given reminder calls the day before any appointments during the first 30 days and adjustments made if needed;
4. Clients will be given a wallet size appointment card with all of their appointments during the first 30 days of services with four appointments being goal for participation.

Results/Impact upon Clients:

Napa cited the following client outcomes compared to baseline of 23 percent dropout rate:

- For the last three quarters (May, August, and November 2019) the dropout rate improved by 11, 14, and 10 percent over baseline, and measurement is continuing.
- Clients reported satisfaction with program activities linked to Living in Balance which is an evidence-based practice curriculum used by the outpatient program.

Technical Assistance Provided: BHC provided technical assistance by telephone on 2/26/2020 related to the organization of data and information clarifying the goals and process of the PIP from the first DMC-ODS review through to the second DMC-ODS review.

PIP Score: 90%

Non-Clinical PIP- Increasing care transitions to recovery services and reducing SUD relapse experiences.

PIP Title: Increasing continuity of care in transitions from outpatient to recovery services to reduce recidivism/SUD relapse.

Date PIP Began: 11/1/2018

Status of PIP: Active and ongoing

Brief Description of the problems the PIP is designed to address:

The goal of this PIP is to increase enrollment and engagement in Recovery Services by individuals who have successfully completed outpatient treatment, in order to reduce recidivism/SUD relapse in the six months immediately following completion. The strategy is to develop and promote ADS's Recovery Services program in order to maximize client enrollment and participation to enhance skills and supports sustaining their SUD recovery.

PIP Question:

Napa presented its study question for the clinical PIP as follows:

Will participation in Recovery Services decrease the likelihood that clients will relapse and recidivate during the first six months post completion of outpatient treatment?

Indicators:

Napa listed the following PIP indicators:

- Participation in recovery services for 30 days or more;
- Recidivism rates (re-entry into trt at residential or WM or arrest for intoxication) during the six months post successful completion of outpatient treatment

Interventions:

Napa cited the following interventions:

Counseling services of the PIP are focused on supporting a participant's individual goals during Recovery Services. The interventions are aimed at increasing program engagement post-completion of outpatient. Recovery Services are voluntary and offered to all clients during Discharge Planning from outpatient. The following is a procedural description of the Recovery Services intervention programming:

1. Recovery Services participants receive at least one Counseling session per month. Sessions can be by telephone, individual face-to-face, Recovery Group, or Recovery Alumni Peer Group.
2. Recovery Services participants are encouraged and assisted to find a community-based social support recovery group (12-step meeting) that supports their recovery outside of ADS. The SSR groups most commonly utilized by program participants at this time are Alcoholics Anonymous, Narcotics Anonymous, and Celebrate Recovery. ADS Recovery Services participants can choose any group/s that have recovery from substance use disorders as a topic.
3. Recovery Services participants are given the option to continue working with the primary counselor assigned to them during treatment to foster and build on the existing therapeutic alliance.
4. Recovery Services participants set goals in their Recovery Plan with their primary counselor. Counselors assist these participants, through counseling and case management, to address any obstacles that arise such as accessibility of meetings, transportation, childcare and interpersonal challenges.
5. Program leadership continually meets with ADS staff & QIC to discuss strategies to increase participation in Recovery Services.
6. Incentive gift cards are offered at completion of 30 days in Recovery Services.
7. All clients can receive a ticket for a hot breakfast and lunch any time they attend a service at ADS (located in building adjacent to ADS) and bus passes as needed for transportation.
8. Recovery Services Alumni Peer Group is available; this includes participation incentives and supports recovering clients in participation in sober activities, such as pizza dinners and birthday celebrations and pro-social activities which are drug free to develop a community support network.
9. Recovery Services flyer is posted and disbursed monthly to all Outpatient beneficiaries.
10. Many community re-entry activities are the focus of recovery family connections, vocational and educational needs, housing, benefits, connections to the faith community and health supports.

Results/Impact upon Clients:

Napa cited the following client outcomes:

- Since beginning the PIP, the average clients now participating in recovery services after outpatient is 45 percent and the most recent quarter is 62 percent and the trend is increasing participation;
- There is a 2 percent improvement over baseline related to recidivism in the six months post completion from outpatient.
- ADS collected Recovery Service data with clients who enrolled in Recovery services a minimum of 30 days. Additional analysis may be done for those who have participated longer and more regularly than those with just 30 days to examine this theory that this would reduce recidivism even further.

Technical Assistance Provided: Similar to the clinical PIP, BHC provided technical assistance by telephone on 2/26/2020 related to indicators and interventions and on the design and documentation issues.

PIP Score: 94%

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

PIP Table 1: PIP Validation Review

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

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

PIP Table 2: PIP Validation Review Summary

PIP Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-clinical PIP
Number Met	20	21
Number Partially Met	5	4
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating Clinical: $((M^2)+(PM))/(AP^2)$ Non-clinical: $((M^2)+(PM))/(AP^2)$	90%	94%

PIP Findings—Impact and Implications

Overview

Napa PIPs worked on two important clinical issues for SUD services, engagement and retention in early phases of treatment and the impact of recovery services on avoiding relapse and recidivism after completing outpatient treatment. Few counties have robustly expanded their recovery services and even fewer have measured their impact and consequently this is a positive and groundbreaking start to look at a new and important clinical service.

Napa did a good job including client input with surveys and the structure of their committee. Since this was their first set of SUD PIPs it took some time to get used to organizing the information into the PIP format, but staff were eager to learn and very organized and good about collecting details of their work.

Since recovery services is very individualized it is not always easy to say which interventions are making the most difference with the outcomes, but it is this individualization which makes the service attractive to clients in their process of community adjustment and stabilization.

The PIPs for engagement and retention can be expanded to other levels of care such as MAT and residential as well since these also take effort to help clients fully integrate into the program and optimize the benefits of these treatments.

Access to Care Issues related to PIPs

Both PIPs focus on access to services as well as retention, one focused on outpatient and the other focuses on recovery support services.

Timeliness of Services Related to PIPs

The outpatient PIP does have a timeliness element in that it focuses on providing four services within the first 30 days of treatment which has some similarities to the Washington Circle research and measures on engagement.

Quality of Care Related to PIPs

The quality of the outpatient care is enhanced by use of Living in Balance curriculum, an evidence-based practice, which has both group and individualize components and has clients choosing some elements based on their needs and desires. Also research show that length of stay in care enhances positive outcomes related to sustained recovery and abstinence so successful transitioning of clients from outpatient to recovery support services allows for more time for clients to adjust to being back in the community working and living with friends and family, exposed to potential stressors and triggers, and learning and implementing coping skills to not go back to drug or alcohol use. Testing the value of this service and refining its elements and strategies for engagement is an important part of improvement of the overall care system under DMC-ODS and the Waiver.

Client Outcomes Related to PIPs

Both PIPs demonstrated encouraging outcomes in terms of engagement and retention and continuity of care from outpatient to recovery support services. The issue of successful avoidance of relapse needs more assessment and the intensity and length of time in recovery services may need to be much longer than 30 days and possibly coupled with clean and sober housing to impact the issue of relapse in a substantial way. There is more here to be examined and tested, and especially when one considers the high percentage of clients with homeless status in the Napa SUD program. These and other findings from the review will be discussed further with the county for possible follow-up PIP topics.

CLIENT FOCUS GROUPS

CalEQRO conducted two 90-minute client and family member focus groups during the Napa DMC-ODS site review. As part of the pre-site planning process, CalEQRO requested these two focus groups with eight to ten participants each, the details of which can be found in each section below.

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

Focus Group One: Adult SUD Outpatient

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 first focus group occurred on March 4, 2020 with ADS clients all of whom had initiated services within the past year with Napa County. [REDACTED] participants were interviewed, [REDACTED] of whom were between the ages of 25 and 59, and [REDACTED] 60 or older. [REDACTED] males and [REDACTED] females were present, [REDACTED] were Caucasian and [REDACTED] Latino. All spoke English and an interpreter was not utilized.

Number of participants: [REDACTED]

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.7	3-5
2. I got my assessment appointment at a time and date I wanted.	4.3	2-5

Question	Average	Range
3. It did not take long to begin treatment soon after my first appointment.	4.9	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.9	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.0	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.7	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	5.0	5
8. Because of the services I am receiving, I am better able to do things that I want.	4.9	4-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	5.0	5

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

- The highlight of the discussion was the programming. “Living in Balance” and “Seeking Safety” were specifically identified as beneficial to acquiring recovery skills and knowledge.
- Stakeholders had positive comments regarding their counselors and felt the caring, sincere and pertinent discussions contributed to their recovery.

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

- Finding affordable housing in an abstinent environment was the need the group desired assistance from staff for transitioning from Residential to Outpatient treatment.
- Cannot go to the wet shelter and expect to be ok.

Recommendations for improving care included the following:

- The lower satisfaction rating related to “access in the desired amount of time” was underscored by the recommendation that during walk-in days the capacity needs to be more than two intake appointments, and more staff are needed to accommodate this entry into SUD services. Beneficiaries waiting in line early in the morning also fostered a sense of competition among the group to obtain one of the limited intake slots. It is not right to have to fight to get into treatment.
- Require beneficiaries to attend weekly AA/NA meetings participation while still in treatment to make the transition easier and help them find sponsors, improve social connections for support.

Interpreter used for focus group 1: No

Focus Group Two: Napa Adult Residential Treatment

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

The second focus group was held March 5, 2020 at Center Point Residential Facility. [REDACTED] were in attendance, [REDACTED] males and [REDACTED] females. All were in the 25-59 age group, and [REDACTED] were Caucasian, [REDACTED] were Latina, and [REDACTED] [REDACTED] both African American and Native American. [REDACTED] had initiated services within the past year while [REDACTED] had been in SUD services before this treatment episode. All participants spoke English, and no interpreter was needed.

Number of participants: [REDACTED]

Participants were first facilitated through a group process to rate each of nine items on a survey, and discussion was encouraged. The facilitator asked each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients were told there were no wrong answers, and that their feelings were important. The group facilitators explained that the information sharing was regarded as confidential and reflected the participating group members' own experiences and feelings about the program. The facilitators further explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.2	2-5
2. I got my assessment appointment at a time and date I wanted.	4.1	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.3	1-5
4. I feel comfortable calling my program for help with an urgent problem.	3.9	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.8	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	3.7	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.1	3-5

Question	Average	Range
8. Because of the services I am receiving, I am better able to do things that I want.	4.1	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.3	3-5

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

- Admission is generally, easier if referred through Probation or the hospital, and much slower if it is a self-referral.
- Appreciation for the counselors on the staff was significant.
- Services in this county is better than many others. Staff and counselors remember you and care about you and how you are doing, make you feel like you matter, and you can make it.

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

- Request for access to vocational and housing help earlier in treatment, need more Sober Living Environments (SLEs) and coaching on how to transition smoothly. The homeless shelter is wet, and it is easy to relapse if utilize the homeless shelter.
- Program is good but would like to see more connection to healthy folks in the community. Need help with housing, jobs, sponsors, and social groups is desired.

Recommendations for improving care included the following:

- Better preparation for transition as part of process completing the program such as helping with finding sober living/transitional housing and connecting to 12-step program connections.
- More structure and communication among staff to provide continuity of policy and procedures for all residents.

Interpreter used for focus group two: No

Client Focus Group Findings and Experience of Care

Overview

There were two focus groups conducted during the on-site review of Napa that included adult outpatient clients and adult residential treatment clients with a total of 19 participants. Most feedback was positive with some very specific recommendations on the outpatient drop-in admission program and also on the discharge planning process for the residential program which were very constructive.

Access Feedback from Client Focus Groups

- Client's reported that there was easier access to services if you come from the hospital or Probation.
- Clients reported that there is a delay in transferring Medi-Cal benefits when coming from another county.
- Clients would like to see another outpatient location because it can take a long time to get to the Napa office.
- Clients want more access to drop in appointment hours, so clients are not turned away or "fighting" for limited appointments.

Timeliness of Services Feedback from Client Focus Groups

- Clients recommend that Napa has more walk-in capacity.
Self referral for residential treatment if it is clinically appropriate should not take longer than a referral from Probation.

Quality of Care Issues from Client Focus Groups

- Clients would like more information regarding resources earlier on in treatment to help with planning for the future especially in residential.
- Clients would like more assistance with transitions of care earlier in the residential treatment process and connections with healthy people and community earlier in the treatment environment.
- Clients in residential treatment would like more structure and more ancillary groups such as AA or NA connected to their residential program to let them get to know people early before they leave or help with sponsors.

Client Outcomes Feedback from Client Focus Groups

- Clients like the new treatment modality of "Living in Balance".
- Clients would like to have more assistance with finding housing such as a Sober Living Environment.
- Clients feel the Napa staff and counselors care about them and have good services once you get in.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasize 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		Quality Rating
	Component	Quality Rating
1A	Service Access are Reflective of Cultural Competence Principles and Practices	Met
	Napa has a Cultural Competence Plan and a CCP committee which includes SUD focus and connections to key community resources and activities for outreach and engagement.	
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	Met
	Data is reported to the Quality Improvement Committee and is reported and reviewed on a quarterly basis.	
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	Met
	Community-based providers participate in relevant committee meetings on a regular basis.	

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 of Care Components

KC Table 2: Timeliness of Care Components		
	Component	Quality Rating
2A	Tracks and Trends Access Data from Initial Contact to First Appointment Napa tracks data utilizing an Excel spreadsheet that is saved on a shared drive. This is an important requirement which is met but takes a lot of work with the current data system limitations. It is also prone to problems especially with staff turnover in county or contract programs.	Met
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment Performance measures shows prompts access to first medication administration after assessment (within one day).	Met
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment: Not tracked by the NTP or the FQHC clinic, but the NTP stated they need to taper client off of opioid street drugs to begin Suboxone or buprenorphine.	Not Met
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions Napa has a definition for urgent conditions but is not meeting the established standards for providing the services. Napa reported that two issues have been identified which are documentation and notifying the supervisor.	Partially Met
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment This is an area of improvement which should begin in the next year.	Not Met
2F	Tracks and Trends Data on Follow-up and Re-Admission to Residential Withdrawal Management Napa tracks re-admission within 30 days of discharge from residential and withdrawal management.	Partially Met
2G	Tracks Data and Trends No Shows Napa reports this data in the QIC quarterly report.	Met

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	Met
	Napa has a current QM/QI Plan, quarterly reports and QI committee. The senior leadership and new staff are involved and committed to client care and outcomes as reflected in goals and activities and especially evident in improvements over the last year.	
3B	Data is used to inform management and guide decisions	Met
	Data is reviewed and analyzed at the QIC meetings. However, data is collected via an Excel Spreadsheet. IT infrastructure is very fragile and a more system approach is recommended. Management is aware of this and considering options.	
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	Met
	QIC minutes reflect stakeholder input and involvement into system planning and implementation.	
3D	Evidence of an ASAM continuum of care	Met
	Napa did expand the continuum of care last year to include all required services. This was a very positive achievement over last year.	
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	Met
	Napa has two contracts for NTP services with providers who are part of the Hub and Spoke project and also provide access to non-methadone medications as part of their programs. They also coordinate extensively with the FQHC clinics in the region including the one at the Napa county campus which is a rural health clinic and has a number of sites with community-based services and provides MAT with counseling being provided by the DMC-ODS staff. The evidence of coordination in the residential program was the testimony of the residents and the descriptions of the services from the clinic and the counselors. The primary area of challenge with access was a far northern zip code of the county which is rural and sparsely populated. This area has residents who need to travel to Solano county for NTP services. The FQHC clinic on the Napa county campus was planning to send a provider to a nearby site to this area to begin prescribing non-methadone MAT for those who wanted an alternative.	
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	Met
	Training was evident in the QI training materials and discussions with staff at various programs who were using these skills as part of treatment planning and assessment.	

KC Table 3: Quality of Care Components		
	Component	Quality Rating
3G	Measures clinical and/or functional outcomes of clients served	Met
	CalOMS and TPS are used to track clinical improvements and outcomes to enhance quality of care by evaluating discharge status codes for improvement and ratings in the TPS by program site. The TPS found that the residential program had low scores and interventions and engagement of program leadership and staff were enhanced by Napa staff, and now the program will be re-administrating the TPS to track improvements based on the interventions and changes in the program.	
3H	Utilizes information from client perception of care surveys to improve care	Met
	As stated above, the TPS was used to identify areas needing improvements, motivated changes and plans of corrections, and now was being used to re-test the performance of the program.	

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Overall the penetration rate for Napa is higher than the statewide penetration rate. As newly added services expand this trend should continue.
- Residential treatment services are being provided even though the county is not able to bill for these services yet as the community-based provider has not been able to become DMC certified.
- Napa clients are able to access non-methadone MAT services through the FQHC network partners as well as two NTPs who are part of Hub and Spoke network.
- Both PIPs focus on access to services as well as retention, one focused on outpatient and the other focuses on recovery support services.

Opportunities:

- Access to services for youth treatment services is low compared to statewide penetration rate.
- While there are plans to install call center software, the product to be implemented has not yet been identified.
- Clients reported that there is a delay in transferring Medi-Cal benefits when coming from another county, and this impacts access and smooth transitions in care. Napa ADS does not control the time it takes to transfer Medi-Cal from other counties and does serve clients in its programs while waiting, but other programs do not necessarily take other county Medi-Cal. This has been reported as a statewide problem in reviews.
- Clients would like to see another outpatient location because it can take a long time on the bus to get to the Napa office, or options for mobile services like mental health.
- Client's reported that there was easier access to services if you come from the hospital or Probation.

Timeliness of DMC-ODS Services

Strengths:

- Napa is able to track timeliness measures and data is provided in the QIC reports. Napa does this manually and uses Excel spreadsheets to track their data.
- Napa clients are able to receive NTP services in less than a day.
- The outpatient PIP does have a timeliness element in that it focuses on providing four services within the first 30 days of treatment which has some similarities to the Washington Circle research and measures on engagement as well as retention in care.

Opportunities:

- Clients recommend that Napa has more walk-in capacity for access/drop-in hours. Currently Napa only offers walk-in appointments one day a week and only two clients are provided an intake and assessment. This was a source of stress and anxiety for clients who needed services. Napa had to reduce the number of walk-in appointments when a LPHA resigned but plans on increasing walk-ins once they hire a replacement.
- Only 47.7 percent of the youth clients met the ten-day DHCS standard for length of time from initial request to first offered routine appointment. Napa has executed a contract with a community-based provider to provide outpatient and intensive outpatient treatment to youth.

Quality of Care in DMC-ODS

Strengths:

- An electronic ASAM assessment and reassessment form/screen is now available in Cerner.
- Clinical staff were provided documentation refresher training for progress notes and treatment planning.
- The TPS is administered and reports from UCLA are received which provide results for the overall DMC-ODS and by treatment program.
- The quality of the outpatient care is enhanced by use of "Living in Balance" curriculum, an evidence-based practice, which has both group and individualize components and has clients choosing some elements based on their needs and desires. Also research show that length of stay in care enhances positive outcomes related to sustained recovery and abstinence so

successful transitioning of clients from outpatient to recovery support services allows for more time for clients to adjust to being back in the community working and living with friends and family, exposed to potential stressors and triggers, and learning and implementing coping skills to not go back to drug or alcohol use. Testing the value of this service and refining its elements and strategies for engagement is an important part of improvement of the overall care system under DMC-ODS and the Waiver.

Opportunities:

- Napa has a lower than statewide average for initiation and engagement into DMC-ODS services.
- Residential treatment services are being provided through a contract with a community-based provider. Because of the difficulty with obtaining DMC certification, Napa has not been able to bill for these services. There is no data to analyze to evaluate the effectiveness of these services. Napa needs help with the PED process to begin billing and doing analysis of these services.
- Napa reported that it takes three staff to compile the QIC reports and the system of managed care IT EHR infrastructure is very fragile for all the responsibility of a full managed care plan. Just using excel spreadsheets is not a viable long-term solution.

Client Outcomes for DMC-ODS

Strengths:

- CalOMS data entry is done per requirements and once Napa has access to the reports, the data will be used to monitor outcomes. Data is completed with training and oversight.
- Clients reported that they like the new treatment modality of “Living in Balance.”
- Napa is using TPS results to improve care through quality improvement efforts.

Opportunities:

- Client satisfaction was low on convenient location compared to the other domains (63.6 percent compared to a high of 84.4 percent).
- Clients would like to have more assistance with finding housing such as a Sober Living Environment.

- Clients need access to recovery housing to sustain positive outcomes from treatment in outpatient and residential if they do not have stable housing in the community.
- Both PIPs demonstrated encouraging outcomes in terms of engagement and retention and continuity of care from outpatient to recovery support services. The issue of successful avoidance of relapse needs more assessment and the intensity and length of time in recovery services may need to be much longer than 30 days and possibly coupled with clean and sober housing to reduce the issue of relapse in a more substantial way. ADS collected Recovery Service data with clients who enrolled in Recovery services for a minimum of 30 days.
- So, there is more here to be examined and tested, and especially when one considers the high percentage of clients with homeless status in the Napa SUD program. These and other findings from the review will be discussed further with the county for possible follow-up PIP topics

Recommendations for DMC-ODS for FY 2019-20

1. Access Call Center software is needed to track volume, disposition, dropped calls, wait times, and other key metrics, etc.
2. Napa only offers one walk-in time weekly with only two intake and assessment slots. More walk-in appointments are needed as there were complaints from the clients on long wait lines and having to return multiple times to obtain one of the appointments.
3. Napa has only one location for services. Clients complained that this is a hardship for many of them since the bus ride is too long especially for outlining zip code areas. The Waiver allows for mobile services as well as other site options. These should be considered to meet individual client needs.
4. Napa has an affordable housing shortage and clients do not like staying at the homeless shelter because it is wet and can trigger a relapse. Napa should collaborate with community partners to expand recovery residence beds in order to enhance the housing options. Clients are in need of options when transitioning from a residential treatment stay or who are assessed as needing intensive outpatient services.
5. Begin the discharge planning process earlier in the residential treatment program with more community engagement in vocational, housing, social supports and aftercare options.
6. Examine the low rates for client engagement and retention and develop strategies for improvement.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: County Highlights - None at this time

Attachment E: Continuum of Care Form

Attachment F: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A—On-site Review Agenda

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

Table A1—CalEQRO Review Sessions - Napa 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, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Medication-assisted treatments (MATs)
Executive Directors/COO/Administrators group interview – contracted
Clinical line staff group interview – county and contracted
Recovery support services group interview including staff with lived experience – county and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family
Site visits such as residential treatment (youth, perinatal, or general adult), WM, access center, MAT induction center, and/or innovative program
Exit interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Karen Baylor, Lead Quality Reviewer
Rama Khalsa, Second Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Luann Baldwin, Client/Family Member Consultant

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

Sites for Napa's DMC-ODS Review

DMC-ODS Sites

Alcohol and Drug Services
2751 Napa Valley Corporate Drive
Napa, CA 94558

Contract Provider Sites

Center Point Residential Center
2100 Napa Vallejo Highway
Napa, CA 94558

Table B1 - Participants Representing Napa

Last Name	First Name	Position	Agency
Adhearn	Kenny	CEO	Aldea
Aril Lafaya	Letoya	Compliance Officer	Health and Human Service Agency
Boatswain	Annette	Physician Assistant	OLE Health
Bodin	Gabrielle	Treatment Center Director	MedMark
Bongiovi	Jamie	Director, Behavioral Health	OLE Health
Burnett	Lisa	Asst Compliance	Health and Human Services Agency
Caston	Jerome	Vista	Napa County Public Health
Elkin	Emily	Compliance Coordinator	Center Point, Inc.
Figoni	Rose	CFO	Health and Human Service Agency
Flores	Brenda	Social Worker	Napa County Child Welfare Services
Harry	Carolina	Assistant Manager	Health and Human Service Agency, OPS
Hart	Joel	Alcohol and Drug Counselor III	Alcohol and Drug Services
Hering	Marc	Vice President	Center Point, Inc.
Hershman	Candice	LPHA	Health and Human Service Agency
Iadapola	Nicole	LPHA	Health and Human Service Agency
Joel	Hart	Alcohol and Drug Counselor	Health and Human Service Agency
Koufos	Mitchell	Treatment Supervisor	Health and Human Service Agency
Lally	Raj	Treatment Center Director	MedMark
Leo	Valladarel	Alcohol and Drug Counselor	Health and Human Service Agency
Lipman	Laurette	Program Director	Aldea
McElroy	Karen	Staff System Analyst	Health and Human Service Agency

Table B1 - Participants Representing Napa

Last Name	First Name	Position	Agency
Menges	Jennifer	MH Quality Coordinator	Health and Human Service Agency
Murphy	Lisa	Senior System Analyst	Health and Human Service Agency
Nicholas	Josefina	Alcohol and Drug Counselor	Alcohol and Drug Services
O'Bryne	Jennifer	Alcohol and Drug Counselor III	Alcohol and Drug Services
Ostrander	Jeremy	Alcohol and Drug Counselor	Alcohol and Drug Services
Pimentel	Ivette	Senior OA	Health and Human Service Agency
Powers	Kevin	UR Coordinator	Health and Human Service Agency
Riva	Roberta	Alcohol and Drug Counselor	Health and Human Service Agency
Rotdo	Vanessa	Program Director	Center Point, Inc
Saenz	Maribel	Probation Officer	Napa County Probation
Salvatore	Teresa	Assistant Deputy Director	Alcohol and Drug Services, HHSA
Snowden	Susanne	Utilization Review Coordinator	Alcohol and Drug Services, HHSA
Souza-Pense	Noelle	Supervising Mental Health Counselor	Alcohol and Drug Services, HHSA
Stark	Lindsey	Deputy Director	Health and Human Service Agency
Storment	Lisa	Assistant Manager, Quality Management	Health and Human Service Agency
Stringer	Angelica	Senior OA	Health and Human Service Agency
Upson	Tobi	Supervising Staff Service Analyst	Health and Human Service Agency
Ulitin	Tracy	Supervising Staff Service Analyst	Health and Human Service Agency
Vargas	Jesica	Intern	Napa County Probation
Valladanes	Leonardo	Alcohol and Drug Counselor	Health and Human Service Agency
Vallejo	Courtney	Asst. MH Director	Health and Human Services Agency

Table B1 - Participants Representing Napa

Last Name	First Name	Position	Agency
Yasumoto	Jennifer	Director	Health and Human Service Agency
Zamora	Erin	Compliance Supervisor	Aldea

Attachment C—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
DMC-ODS: Napa FY 19-20	<input checked="" type="checkbox"/> Clinical PIP <input type="checkbox"/> Non-Clinical PIP
PIP Title: Reducing SUD Client Dropout Rate & increasing engagement and retention in treatment and improving outcomes	
Start Date (08/01/18): Completion Date (08/01/20): Projected Study Period (#of Months):24 Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Date(s) of On-Site Review: 03/03-4/20 Name of Reviewer: Karen Baylor MFT	Status of PIP (Only Active and ongoing, and completed PIPs are rated): Rated <input checked="" type="checkbox"/> Active and ongoing (baseline established and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR) Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only. <input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of this PIP is to enhance engagement and retention in treatment in the first 30 days (thereby reducing dropouts). This was identified as a problem using data and is well documented in research as a critical first step in treatment of substance use disorders, where the client is often in denial or ambivalent about treatment. The research also documents the benefits of sustained engagement and retention in care and	

the benefits to the clients in improved outcomes, symptom relief, functioning, and sustain abstinence especially the longer the client is engaged in care. Therefore, Napa county DMC-ODS services identified a set of interventions to enhance the engagement and retention process in the first 30 days and reduce these drop-outs by at least 10 percent from baseline rates.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	There was a cross disciplinary team and a client survey was used targeting those who had left the program to gather information on why they had dropped out of treatment. Many due to intense cravings felt the desire to use again and did not feel they could or should still be in treatment. There were some other results as well.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Yes, the data was showing an alarming number of individuals not returning after the referral to treatment and their first face to face visit.
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input checked="" type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions	<i>Non-Clinical:</i> <input type="checkbox"/> Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	This process of initial engagement of SUD clients in treatment is a critical first step in the treatment process with a disease that fosters denial and ambivalence about the need for treatment based on a variety of factors, plus the intensity of the cravings based on brain chemistry changes makes commitment to treatment and abstinence or even reduced use difficult physiologically and psychologically.

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input checked="" type="checkbox"/> Age Range <input checked="" type="checkbox"/> Race/Ethnicity <input checked="" type="checkbox"/> Gender <input checked="" type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Age was all adults in outpatient or intensive outpatient levels of care based on ASAM screenings regardless of race, sex, language,
	Totals 4	4 Met 0 Partially Met 0 Not Met 0 UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? <i>Include study question as stated in narrative:</i> Will developing an early therapeutic alliance with consumers by providing the initial support of reminder appointment calls, one week engagement contacts, and a minimum of four scheduled appointments in the first 30 days decrease drop-out rates in clients' first 30 days of treatment by 10 percent?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
	Totals 1	1 Met 0 Partially Met 0 Not Met 0 UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input checked="" type="checkbox"/> Age Range <input checked="" type="checkbox"/> Race/Ethnicity <input checked="" type="checkbox"/> Gender <input checked="" type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	All Napa SUD Adults who were assessed using ASAM for outpatient and intensive outpatient including all ethnic groups, sex, languages,

<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i></p> <p><input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification</p> <p><input type="checkbox"/> Other: <Text if checked></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Outpatient utilization data and intervention activity data were used
Totals 2		2 Met 0 Partially Met 0 Not Met 0 UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <ol style="list-style-type: none"> 1. Percentage of clients who drop out in their first 30 days of treatment comparing different periods after interventions to baseline. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused.</p> <p><input type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Processes of care with strong associations with improved outcomes
Totals 0		0 Met 1 Partially Met 0 Not Met 0 UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	No sampling of clients used
5.2 Were valid sampling techniques that protected against bias employed? <i>Specify the type of sampling or census used:</i> <Text>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals 3		0 Met 0 Partially Met 0 Not Met 3 NA 0 UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data was collected on both intervention activities and on utilization of outpatient services.
6.2 Did the study design clearly specify the sources of data? <i>Sources of data:</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met	

<input type="checkbox"/> Member <input checked="" type="checkbox"/> Claims <input type="checkbox"/> Provider <input type="checkbox"/> Other: Phone call logs for reminders, medical records for one on one engagement supports by primary counselor first week of treatment services, medical record for the 4 visits scheduled and attended in first 30 days, or drop out of care, gift cards for those completing 4 visits in 30 days	<input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	It clearly stated the source of each type of information but not specifically who was doing it or their qualifications.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input checked="" type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other: Phone log for reminders, Claims for visits	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Medical records documentation (visit note present or not) and phone logs were consistently used and provided accurate data over the time period studied. Claims linked to visit notes.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP included a data analysis plan but no contingency plan.

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <hr/> <hr/>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine							
<p>Name: Teresa Salvatore, LCSW, CADC Title: Asst Alcohol and Drug Administrator Role: supervision of staff implementing pip and data collection</p> <p><i>Other team members:</i> Names: no listed</p>								
Totals 6	3	Met	3	Partially Met	0	Not Met	0	UTD
STEP 7: Assess Improvement Strategies								
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> See body of the report 11 Primary barriers were staff leaves and insuring consistency for vacations etc.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	See details in body of report						
Totals 1	1	Met	0	Partially Met	0	Not Met	0	UTD
STEP 8: Review Data Analysis and Interpretation of Study Results								
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	Yes, the percent of client engaged and retained in treatment improved and participation in the program and its activities increased due to the PIP						

<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Tables and documentation on interventions attached provided detailed needed to assess the PIP and do analysis</p>
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____ quarterly _____</p> <p>Indicate the statistical analysis used: _____ pre and post percentages _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____ 10 _____ % _____ Unable to determine</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP demonstrated sustain improvement in client engagement due to the set of interventions, and though it is difficult to determine which interventions impacted the client improvement the post, the overall impact is positive and will continue to be evaluated</p>

<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> Limited to outpatient clients based on ASAM assessments, requires high levels of staff commitment to creating the therapeutic alliance to be successful, linking clients to all services needed within OP including MAT if needed</p> <p><i>Conclusions regarding the success of the interpretation:</i> PIP is still being evaluated and one of the factors influencing dropouts was drug testing and probation reactions to relapse events. Staff were going to engage Probation on this in a harm reduction approach to not re-arrest</p> <p><i>Recommendations for follow-up:</i> Continue interventions with enhanced work with Probation and Probation clients.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals 4	4	Met 0 Partially Met 0 Not Met 0 UTD
STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Same interval was repeated using the same data and method of data collection. Same client profile and program and same tools.</p>

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there:</p> <p>Statistical significance:</p> <p>Clinical significance:</p>		<input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>There was documented improvement based on interventions and program and client satisfaction appeared to be enhanced by additional engagement activities including the acknowledgment activities including the gift cards</p>					
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p>		<input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input checked="" type="checkbox"/> High	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>While there could be other possible causes impacting behavior external to the treatment experience, therapeutic alliance is knowledge to have a major impact on care retention and outcomes and the time and effort of primary counselors in these types of activities was increased by the types of interventions.</p>					
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p>		<input type="checkbox"/> Weak <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Strong	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine						
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine						
Totals 5		4	Met	1	Partially Met	0	Not Met	0	UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
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Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

The PIP showed to positive impact of enhanced activities linked to therapeutic alliance in the primary counseling relationship in SUD treatment in retention in care.

The model has applicability to more programs than just the outpatient programs and is continuing to be evaluated with additional efforts linked to Probation, drug testing, and also a possible new client survey which could create new insights into client experience and improvements.

Recommendations:

Continue PIP as discussed and document efforts until concluded. Work with EQRO on new PIP concepts as appropriate when this is concluded.

Check one:

- High confidence in reported Plan PIP results
- Low confidence in reported Plan PIP results
- Confidence in reported Plan PIP results
- Reported Plan PIP results not credible
- Confidence in PIP results cannot be determined at this time

PIP SCORE: $((m^2)+pm)/AP = \text{score}$ $20 \times 2 \text{ plus } 5 = 45/50 = 90\%$

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

NON-CLINICAL PIP

DMC-ODS: Napa	<input type="checkbox"/> Clinical PIP <input checked="" type="checkbox"/> Non-Clinical PIP
PIP Title: Increasing continuity of care in transitions from outpatient to recovery services to reduce recidivism/SUD relapse	
Start Date (MM/DD/YY): 11/1/2018 Completion Date (MM/DD/YY): 11/1/2020 Projected Study Period (#of Months): Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Date(s) of On-Site Review (MM/DD/YY): 02/03-4/20 Name of Reviewer: Karen Baylor	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated Active and Ongoing
	<input checked="" type="checkbox"/> Active and ongoing (baseline established and interventions started)
	<input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
	<input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP
Brief Description of PIP (including goal and what PIP is attempting to accomplish):	
<p>The goal of this PIP is to increase enrollment and engagement in Recovery Services by individuals who have successfully completed outpatient treatment, in order to reduce recidivism/SUD relapse in the 6 months immediately following completion. The strategy is to develop and promote ADS's Recovery Services program in order to maximize client enrollment and participation to enhance skills and supports sustaining their SUD recovery.</p>	
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY	
STEP 1: Review the Selected Study Topic(s)	

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	There was a multi-functional team including a direct consumer invested in this issue.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Problem of lack of engagement post outpatient completion was leading to relapse and re-admissions/recidivism and it was important to work to engage clients in recovery services to help them maintain the success they had achieved in outpatient.
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions	<i>Non-Clinical:</i> <input checked="" type="checkbox"/> Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Transitions in care and length of engagement in care are associated in the research with sustained abstinence and recovery. The goal of this PIP to redesign the system post outpatient to increase transitions into recovery support services is positive for clients in many respects related to their long term SUD condition and ability to manage it.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input checked="" type="checkbox"/> Age Range <input checked="" type="checkbox"/> Race/Ethnicity <input checked="" type="checkbox"/> Gender <input checked="" type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	All adult outpatient clients successfully finishing outpatient will be asked to consider enrollment in recovery services regardless of race, gender, language, etc.
Totals 4	4	Met 0 Partially Met 0 Not Met 0 UTD

STEP 2: Review the Study Question(s)					
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i></p> <p>Will participation in ADS Recovery Services decrease the likelihood that clients will relapse and recidivate during the first six months post completion of outpatient treatment?</p>		<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Ideally would add a quantitative amount to the study question as well since the baseline is known and goal for improvement is identified.</p>		
Totals 1			0	Met	1 Partially Met
STEP 3: Review the Identified Study Population					
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i></p> <p><input checked="" type="checkbox"/> Age Range <input checked="" type="checkbox"/> Race/Ethnicity <input checked="" type="checkbox"/> Gender <input checked="" type="checkbox"/> Language <input type="checkbox"/> Other</p>		<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>All adult outpatient clients successfully completing the program regardless of race, gender, language, etc.</p>		
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i></p> <p><input checked="" type="checkbox"/> Utilization data <input checked="" type="checkbox"/> Referral <input checked="" type="checkbox"/> Self-identification <input type="checkbox"/> Other: <Text if checked></p>		<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Since recovery services is a voluntary service, motivational interviewing and encouragement will be critical to have clients self-identify to go into this next level of care. Interventions are intended to support clients taking this action and staying in recovery services.</p>		
Totals 0			0	Met	0 Partially Met
Totals 0			0	Met	0 Not Met
Totals 0			0	Met	0 UTD

STEP 4: Review Selected Study Indicators			
4.1 Did the study use objective, clearly defined, measurable indicators? <i>List indicators:</i> 1. Will participation in ADS Recovery Services decrease the likelihood that clients will relapse and recidivate during the first six months post completion of outpatient treatment?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Both indicators are easily measurable with claims and with client medical record activities. Napa also used calls to clients to maintain contact throughout recovery services and outpatient treatment. Recidivism is defined as return at a higher level of care than outpatient within the 6 month after successfully completing outpatient such as residential or residential WM or incarceration for drug use.	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused. <input checked="" type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Both health and functional status are impacted by measures identified	
Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Totals 2		2 Met 0 Partially Met 0 Not Met 0 UTD	
STEP 5: Review Sampling Methods			
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	NONE USED	

5.2 Were valid sampling techniques that protected against bias employed? <i>Specify the type of sampling or census used:</i> <Text>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? ____ N of enrollees in sampling frame ____ N of sample ____ N of participants (i.e. – return rate)	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals 0		0 Met 0 Partially Met 0 Not Met 0 UTD

STEP 6: Review Data Collection Procedures

6.1 Did the study design clearly specify the data to be collected?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Recovery services claims, also documented in medical record visits. And admission data, and for recidivism claims for residential or WM and Probation/Detention notifications of arrests for drug use. Calls to clients were made to maintain contact throughout care
6.2 Did the study design clearly specify the sources of data? <i>Sources of data:</i> <input type="checkbox"/> Member <input checked="" type="checkbox"/> Claims <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: Medical record activities for recovery services and also residential and WM and also surveys at 3 and 6	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	

months post from outpatient. Client survey was also used to gather data on the problem.		
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	What was being collected was identified but how and who was not as clear except in the area of surveys. Tracking active participation in services using claims or medical record was not really identified though it should be in standard reports. Regular calls to clients were also part of the intervention and data gathering process.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input checked="" type="checkbox"/> Survey <input checked="" type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input checked="" type="checkbox"/> Other: claims	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	All tools were very structured
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	There was a plan, but no contingencies for untoward results.

<p>.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name: Teresa Salvatore Title: Asst Alcohol & Drug Administrator Role: Program supervisor</p> <p><i>Other team members:</i></p> <p>Names: none specified to collect data</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine					
Totals 6	3 Met	3 Partially Met	0	Not Met	0	UTD
STEP 7: Assess Improvement Strategies						
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p>There were no specific barriers identified.</p> <p><i>Describe Interventions:</i></p> <p>Counseling services are targeted at supporting a participant's goals during Recovery Services. The interventions are aimed at increasing program engagement post-completion. Recovery Services are voluntary and offered to all clients during Discharge Planning. The following is a procedural description of ADS Recovery Services:</p> <ol style="list-style-type: none"> 11. Recovery Services participants receive at least one Counseling session per month. Sessions can be by telephone, individual face-to-face, Recovery Group, or Recovery Alumni Peer Group. 12. Recovery Services participants are encouraged to find a community-based social support recovery group (12-step meeting) that supports their recovery outside of ADS. The SSR groups most commonly utilized by program participants at this time are Alcoholics Anonymous, Narcotics Anonymous, and Celebrate Recovery. ADS Recovery 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine					

<p>Services participants can choose any group/s that have recovery from substance use disorders as a topic.</p> <p>13. Recovery Services participants are given the option to continue working with the primary counselor assigned to them during treatment.</p> <p>14. Recovery Services participants set goals in their Recovery Plan with their primary counselor. Counselors assist these participants, through counseling and case management, to address any obstacles that arise such as accessibility of meetings, transportation, and interpersonal challenges.</p> <p>15. Program leadership continually meets with ADS staff & QIC to discuss strategies to increase participation in Recovery Services.</p> <p>16. Incentive gift cards are offered at completion of 30 days in Recovery Services.</p> <p>17. All clients can receive a ticket for a hot breakfast and lunch any time they attend a service at ADS (located in building adjacent to ADS).</p> <p>18. Recovery Services Alumni Peer Group is being developed; this will include participation incentives and support recovering clients in participation in sober activities, such as pizza dinners and birthday celebrations.</p> <p>19. Recovery Services flyer is posted and disbursed monthly to all Outpatient beneficiaries.</p>		
<i>ext></i>	Totals 1	1 Met 0 Partially Met 0 Not Met 0 NA 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	Analysis did track to the plan. It was not possible to see this fully without having all the attachments visible with the PIP narrative.

<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>It was hard to follow all the data for the 3 and 6 month surveys plus the recidivism without the narrative and staff discussion, but it was a solid effort and they really did do a great job increasing engagement in this important service and having reduced relapses for clients who stayed solidly engaged in the care safety net.</p>
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: <u>quarterly</u></p> <p>Indicate the statistical analysis used: <u>comparisons across the quarters</u></p> <p>Indicate the statistical significance level or confidence level if available/known: <u>%</u> Unable to determine</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>There were repeat measurements with significant results, no known factors threatening validity internally or externally.</p>

<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> None identified</p> <p><i>Conclusions regarding the success of the interpretation:</i> The PIP was determined to be successful but is continuing to refine data and interventions of the recovery program itself</p> <p><i>Recommendations for follow-up:</i> Document key elements of a successful recovery services program so others can learn from your success and critical tasks for engagement and retention in care</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals 4		3 Met 1 Partially Met 0 Not Met 0 NA 0 UTD
STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask:</i> <i>At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	Yes to all questions at left.
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	

<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input checked="" type="checkbox"/> High</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Strong</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p> <p>Yes and measurements are continuing</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals 5		5 Met 0 Partially Met 0 Not Met 0 NA 0 UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions: The set of interventions with surveys, engagement, and the robust recovery services had an impact on relapse and recidivism.

Recommendations:

Document thoroughly the key elements of success such as the co-location of outpatient and recovery and ease of access, the special outreach efforts before during and after outpatient to lay the foundation for recovery services, and the special curriculum to keep clients feeling their needs were being met with time spent in recovery support and other insights from the program experience and research.

Check one:

- High confidence in reported Plan PIP results Low confidence in reported Plan PIP results
- Confidence in reported Plan PIP results Reported Plan PIP results not credible
- Confidence in PIP results cannot be determined at this time

Score ((M*2)plusPM)/AP=score 21 * 2= 42 plus 5 =47/50 =94%

Attachment D—County Highlights

None at this time.

Attachment E—Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: **Napa County** Review date(s): **March 4-5, 2020**

Person completing form: **Mitchell Koufos, LMFT**

Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted: 28%

County role for access and coordination of care for persons with SUD requiring social work/linkage/peer supports to coordinate care and ancillary services.

Describe county role and functions linked to access processes and coordination of care:

See ADS DMC-ODS Documentation Manual V2 attached;

See 2019 Referrals for Treatment – by Referral Source;

Referrals to Tx - Client Gateway to ODS attached;

See Post ODS Documentation Procedures attached;

See Continuity of Care Policy and Procedure document attached.

Napa County Alcohol and Drug Services (ADS) Division provides a continuum of services including prevention, early intervention, youth treatment, outpatient treatment, intensive outpatient treatment, case management, residential withdrawal management, residential treatment, and recovery services. Napa County ADS is a direct provider of adult outpatient treatment (including intensive outpatient, case management, and recovery services).

Additional substance use disorder treatment services are provided through contracts with community-based organizations. Napa County ADS provides integrated care and coordinates services for all its clients to:

1. Ensure each client has an ongoing source of care appropriate to their needs
2. Ensure seamless transitions between levels of care (i.e. withdrawal management, residential, outpatient) without a disruption of service or gaps in treatment
3. Ensure recovery services are offered immediately after discharge with the goal of sustained engagement and long-term retention in SUD treatment

Role of Primary Counselor (PC)

The Primary Counselor (PC) assigned to a client is either a Certified Drug & Alcohol Counselor or a Licensed Clinician (LPHA) and is responsible for supporting the coordination and continuity of care. A client is made aware of their PC and the range of SUD services at their initial treatment planning appointment. In Napa County, the PC also provides case management services and obtains Releases of Information from the client to allow the exchange of information and facilitate collaboration with both primary care and mental health. Examples of specific care coordination activities include: assessing client progress and goals, monitoring and follow-up of client needs, helping with transitions of care and linking to community resources.

Role of the Licensed Practitioner of the Healing Arts (LPHA)

For every client receiving DMC-ODS Services, a Licensed Practitioner of the Healing Arts (LPHA) is

required to:

1. Establish medical necessity
2. Determine substance use diagnosis
3. Ensure appropriate LOC is assigned

LPHA's use the ASAM Placement Criteria to determine the appropriate level of care (LOC) for the client. When an outside agency or individual recommends residential treatment, Napa County will assess the client to determine if residential service is the appropriate level of care and if the client meets medical necessity.

Role of the Medical Director

The support of a qualified Medical Director within a Drug Medi-Cal program is not only a requirement but also supports integration of substance use disorder services into the greater healthcare system. The Medical Director for Napa County Alcohol & Drug Services is available to the Division on a regularly scheduled basis. In addition to assisting/supporting professional staff with challenging cases (i.e. case conferences, SUD, co-occurring conditions, medication assisted treatment) the Medical Director has the following responsibilities for outpatient clients:

1. Establishing, reviewing and maintaining medical policies and standards
2. Ensuring the quality of medical services provided to all clients
3. Ensuring provider's physicians and LPHA's are adequately trained to perform diagnosis of substance use disorders for beneficiaries and determining the medical necessity of treatment for beneficiaries

Case Management- Describe if it's done by DMC-ODS via centralized teams or integrated into DMC certified programs or both:

Monthly estimated billed hours of case management: **35 hours billed per month**

Comments:

Napa County integrates DMC-ODS Case Management Services in its outpatient/IOT programs and provides those services to Level 1.0 and 2.1 clients who meet medical necessity. Napa County's residential contractor is in the process of integrating DMC-ODS Case Management Services and working to provide those services to clients in Levels 3.1 and 3.5. Of note, Napa's residential contractor is awaiting DMC certification, so case management claims in Levels 3.1 and 3.5 have not yet been submitted.

Napa County Case Management services provide advocacy, linkages to physical health, mental health, housing, transportation, vocational, educational, and transition services for reintegration into the community. This involves outreach services to beneficiaries lacking engagement in treatment and/or requiring additional support to succeed in completing treatment. Case Management services incorporates evidence-based techniques such as Motivational Interviewing and the Stages of Change, to support the goals of each beneficiary as identified through the initial ASAM and ongoing assessment process and treatment planning. In the past, Napa County case management services solely focused on clients in forensic settings, such as Drug Court. Under DMC-ODS, case management has been expanded to increase the potential for engagement in all treatment programs. All services are consistent with confidentiality requirements identified in 42 CFR, Part 2, California Law and the Health Insurance Portability and Accountability Act (HIPPA).

Recovery Services – Support services for clients in remission from SUD having completed treatment services but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing, relapse prevention, peer support.

Pick 1 or more as applicable and explain below:

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

Total Legal entities offering recovery services: 2

Total number of legal entities billing DMC-ODS: 2

Choices: 1, 2, and 3

Comments:

Outpatient Treatment:

Recovery Services support the recovery and wellness process following a primary treatment episode. It is intended that providers will assess the treatment needs in the recovery environment during the transfer/transition planning process. Recovery services are utilized when the client is triggered, has relapsed, or simply as a preventative measure to prevent relapse. Recovery services emphasize the client's central role in managing their health and teaches them to use effective self-management support strategies.

The offer of Recovery Services is indicated on a client's Discharge Plan (attached). If a client accepts Recovery Services, the Primary Counselor must follow the steps outlined in the Recovery Services Workflow (attached). Based upon the recently completed ASAM update (conducted prior to discharge), a new Recovery Plan that addresses the client's needs across all ASAM Dimensions will be completed. The Recovery Plan may be completed by a Certified Counselor but must be approved by an LPHA.

Attachments: DMC-ODS OP Tx - Recovery Services Workflow; ADS Discharge Plan; DMC-ODS Residential Tx – Recovery Support

Level 1 WM and 2 WM: Outpatient Withdrawal Management – Withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).

Number of Sites: 0

Total number of legal entities billing DMC-ODS: 0

Estimated billed hours per month: Enter hours.

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

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

Choice(s): N/A

Comments:

Withdrawal Management – Level 1-WM and 2-WM are not currently available in Napa County.

OLE Health is a Federally Qualified Health Center (FQHC) on the HHSA campus co-located with the Public Health Clinic and WIC (Women, Infants, Children) Nutrition Program and the building adjacent to Alcohol and Drug Services (ADS) Outpatient Access and Treatment program. ADS refers potential clients and clients in need of physical health services to OLE Health for physical exams, medical clearance, and to establish a primary healthcare home.

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

Number of sites: 1

Total number of legal entities billing DMC-ODS: 1

Number of beds: 10

Estimated billed hours per month: 107 bed days billed per month

Pick 1 or more as applicable and explain below:

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

Choice(s): 3

Comments:

Napa County contracts with Center Point, Inc. (CPI) to provide DMC-ODS Withdrawal Management and Residential Treatment services (Levels 3.1, 3.2, 3.5). Center Point Inc. opened its doors on 4/1/2019. Since that time, there have been 370 episodes of 3.2 WM.

Attachments:

Centerpoint Contract

Centerpoint Amendment

Center Point Workflow – WM

DMC-ODS WM - Referral for Detoxification

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

Total legal entities in county: 0

In county NTP: Sites 0 Slots: 0

Out of county NTP: Sites 2 Slots: 45

Total estimated billed hours per month: 63, including dosing and counseling

Are all NTPs billing for non-methadone required medications? Yes No

Comments:

Currently, there are no NTP programs or methadone clinics in Napa County. In April 2019, Napa County executed a contract with Med Mark Treatment Center for Med Mark to provide NTP services to Napa County Residents. Med Mark Treatment Center is a national treatment provider with two locations in Solano County which is geographically adjacent to Napa County. One facility is located in Fairfield, approximately 19 miles from the town of Napa and the Vallejo facility is approximately 13 miles away. There is direct bus route access to the Vallejo facility. MedMark Treatment Center is a DMC certified facility that provides comprehensive treatment services for opiate addictions through methadone maintenance and medically supervised methadone withdrawal and detoxification. The treatment team at MedMark is comprised of a Medical Director, Program Director, Clinical Supervisor, nurses and certified counselors. Services are provided in accordance with the beneficiaries' individualized need. The center is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Beneficiaries with an identified need for an NTP are referred to the regional site. Med Mark Treatment Center has been serving Napa County ADS beneficiaries for the purposes of opioid, narcotic treatment for 13 years.

Attachments: Medmark Contract; Medmark Contract Amendment

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

Total legal entities: 0 Number of sites: 0

Total estimated billed hours per month: 0

Comments:

Medication Assisted Treatment Includes the ordering, prescribing, administering and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber. MAT consists of buprenorphine, naloxone and disulfiram.

Napa County does not provide MAT through DMC-ODS. All clients in need of MAT are referred to OLE Health County Campus Clinic, an FQHC in a building adjacent to ADS. An X-waivered physician and X-waived PA oversee the ordering, prescribing, administering and monitoring of all medications for ADS clients requiring MAT services. Medically necessary services are provided in accordance with an individualized treatment plan determined by the licensed physician or licensed prescriber.

In ADS, the AOD counselor identifies the need for MAT services during the initial treatment planning session. If the client chooses to engage in this modality of treatment, the Counselor completes an interagency referral form for OLE Health, attaches an ROI and a copy of the ASAM assessment and sends the referral packet via interoffice mail to OLE Health. After the referral is completed, the AOD counselor completes the *MAT Referral* form in the EHR for tracking and data collection purposes.

Napa County Medication Assisted Treatment (MAT) Processes, as written in the Medical Policies and Procedures by the Medical Director of ADS Outpatient Treatment:

During assessment, the following clients should be evaluated for MAT and a discussion should be held with the client about their interest.

1. All clients with opioid use disorder, for treatment with buprenorphine
2. Clients with alcohol use disorder that are high risk (multiple failed treatments, multiple ER visits, high risk, etc.)

Referral process:

At the time that a need for MAT Treatment is identified, the referral form is created and sent to OLE Health for MAT. Referral form must be accompanied by a Release of Information. Medical necessity for MAT will be determined by provider; counselors should make clear that the patient is being referred for evaluation but may or may not be good candidates for MAT.

For patients currently on buprenorphine, coordination of care between medical clinic (in this case either OLE Health County Campus, Bright Heart Health or other provider) and ADS treatment team is essential.

Currently, a standing meeting between OLE County Campus MAT coordinator and designated ADS counselor occur bi-weekly to review new and challenging cases.

Annual Training on MAT:

Presentations to ADS treatment staff and/or providers on any new developments in medical treatment will, at minimum, be conducted at an annual training by the medical director.

Attachments:

DMC-ODS Medication Practices document;
Coordination of Care with Physical Health & MAT attachment;
MAT Training Sign-in Sheet 8-21-19 attachment.

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

Total legal entities: 2 Total sites: 2

Total number of legal entities billing DMC-ODS: 2

Average estimated billed hours per month: 555 hours billed per month

Comments:

Napa County ADS Adult Outpatient Treatment services include assessments, treatment planning, substance abuse treatment including individual and group counseling, collateral services, psycho-education, crisis intervention, discharge planning, recovery services, and reintegration into the community. Case Management services are provided per individual needs and included in the individual's treatment plan. DMC-ODS Outpatient services consist of up to nine (9) hours per week of evidence-based services for adults, provided directly at Napa County ADS.

Adolescent Youth Treatment services are provided by a local CBO, Aldea Children and Family Services and consist of up to six (6) hours per week of individual and group counseling, collateral services, and case management.

Attachment: Aldea contract

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

Estimated billed hours per month: 137

Total legal entities: 2 Total sites for all legal entities: 2

Total number of legal entities billing DMC-ODS: 2

Average estimated billed hours per month: 137 hours billed per month

Comments:

Napa County ADS provides Level 2.1 IOT services to adult beneficiaries who meet medical necessity. Services are provided for a minimum of nine (9) hours, maximum nineteen (19) per week for adult perinatal and non-perinatal beneficiaries. These services include assessments, treatment planning, substance abuse treatment including individual and group counseling, collateral services, psycho-education, crisis intervention, and discharge planning, including step-downs into 1.0 ODF. Case Management services are provided per individual needs and included in the individual's treatment plan.

Adolescent Youth Treatment services are provided by a local CBO, Aldea Children and Family Services and consist of a minimum of six (6) hours, maximum of nineteen (19) hours per week of individual and group counseling, collateral services, and case management.

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

Total sites for all legal entities: 0

Total number of legal entities billing DMC-ODS: 0

Total number of programs: 0

Average client capacity per day: 0

Average estimated billed treatment days per month: 0 0

Comments:

N/A

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

Total sites for all legal entities: 1

Total number of legal entities billing DMC-ODS: 1

Number of program sites: 1

Total bed capacity: 25 beds flexed between 3.1 and 3.5

Average estimated billed bed days per month: 652 bed days billed per month

Comments:

Napa County contracts with Center Point, Inc. (CPI) to provide DMC-ODS Withdrawal Management and Residential Treatment services (Levels 3.1, 3.2, 3.5). Center Point Inc. opened its doors on 4/1/2019. Since that time, there have been 86 residential admissions authorized by Napa County.

Attachments:

DMC-ODS Residential Tx – Level 3.1 and 3.5

Center Point WorkFlow – Residential.

Level 3.3: Clinically Managed, Population Specific, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.

Total sites for all legal entities: 0

Number of program sites: 0

Total number of legal entities billing DMC-ODS: 0

Total bed capacity: 0

Average estimated billed bed days per month: 0

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

Comments:

Currently, Napa County does not offer 3.3 under its ODS. Napa County will amend its contract with CPI to include 3.3 by December 2020. Napa County does offer co-occurring services in 1.0 and 2.1.

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

Total sites for all legal entities: 1

Number of program sites: 1

Total number of legal entities billing DMC-ODS: 1

Total bed capacity: 25 beds flexed between 3.1 and 3.5

Average estimated billed bed days per month: 44 bed days billed per month

Comments:

Napa County contracts with Center Point, Inc. (CPI) to provide DMC-ODS Withdrawal Management and Residential Treatment services (Levels 3.1, 3.2, 3.5). Center Point Inc. opened its doors on 4/1/2019. Since that time, there have been 86 residential admissions authorized by Napa County.

Attachments:

DMC-ODS Residential Tx – Level 3.1 and 3.5
Center Point WorkFlow – Residential.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) Yes No

Number of program sites: 0

Total number of legal entities billing DMC-ODS: 0

Number of legal entities: 0

Total bed Capacity: 0

Average estimated billed bed days per month: 0

Comments:

Napa County does not currently have Level 3.7 inpatient facilities. A client in need of a higher level of care than the Withdrawal Management and Residential facility in Napa (3.1, 3.2, 3.5) is directed to the Emergency Room of the local hospital to be medically cleared. If sufficiently stabilized, the client is reassessed and stepped down into the appropriate level of care.

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting. (Billing Health Plan/FFS can you access services? Yes No

Access)

Number of program sites: 0

Total number of legal entities billing DMC-ODS: 0

Number of legal entities: 0

Total bed capacity: 0

Average estimated billed bed days per month: 0

Comments:

Napa County does not currently have Level 4.0 inpatient facilities. A client in need of a higher level of care than the Withdrawal Management and Residential facility in Napa (3.1, 3.2, 3.5) is directed to the Emergency Room of the local hospital to be medically cleared. If sufficiently stabilized, the client is reassessed and stepped down into the appropriate level of care.

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

Total sites for all legal entities: 0

Number of program sites: 0

Total bed capacity: 0

Comments:

While Napa County ADS does not have any formal sites through the DMC-ODS waiver that offer Recovery Residences, all treatment programs utilize Case Management services to attempt to link client's to housing support programs. Within Napa County, there is a Homeless and Housing Services Division, an outreach position dedicated toward identifying and making contact with homeless people with mental health and substance abuse challenges, and a consistent collaboration with Abode Services.

Attachments:

MH ADS Outreach Worker Attachment
Abode Napa – Services Presentation

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

Napa's contracted Residential provider (3.1, 3.2, 3.5) submitted their DMC application via PAVE on 8/16/2019. At this time, the application is under review. Therefore, we are continuing to authorize residential admissions and operating under the assumption that Napa will be able to submit claims back to the date their application was received by DHCS-PED.

Napa County is currently exploring a contract with a telehealth provider to improve access to clients who lack transportation or cannot attend treatment in person for any reason. Napa County is also interested in contracting with one additional ODF site to ensure all clients are served within 10 days of initial contact.

Attachment F—Acronym List Drug Medi-Cal EQRO Reviews

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

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

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