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

SAN FRANCISCO DMC-ODS REPORT

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INTRODUCTION TO THE SAN FRANCISCO DMC-ODS REPORT

Beneficiaries Served in Fiscal Year (FY) 2018-19: 4,002
San Francisco Threshold Languages: Chinese, Russian, Spanish, and Vietnamese
San Francisco Size: 884,363 (U.S. Census Bureau estimate July 1, 2017)
San Francisco Region: Bay Area
San Francisco Location: on the Pacific Coast with the San Francisco Bay and Alameda County to the east, Marin County to the north, and San Mateo to the South
San Francisco Seat: none (City and County are the same)
San Francisco Onsite Review Process Barriers: see Site Review Special Characteristics

Site Review Special Characteristics

This review took place during the COVID-19 pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, CalEQRO worked with San Francisco to design an alternative to the usual in-person onsite review format. All sessions were conducted through video conferencing. At San Francisco's request, four of the sessions were scheduled for briefer lengths of time and much of the information was collected beforehand through questions emailed by CalEQRO to San Francisco.

Background

In July 2017 San Francisco officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) for Medi-Cal recipients as part of California's 1115 DMC Waiver. San Francisco was the seventh county to launch statewide. San Francisco's Substance Use Disorders Services (SUDS) is part of the Behavioral Health Services (BHS) Division in the San Francisco Department of Public Health (SFDPH). In this report, "San Francisco" (SF) shall be used to identify the San Francisco DMC-ODS program unless otherwise indicated. CalEQRO reviews are retrospective; this review is of San Francisco's third year of DMC-ODS implementation during FY2019-20.

How Beneficiaries Access Care

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

evaluate this element of quality, it is important first to know how this DMC-ODS has chosen to organize its access system to bring beneficiaries into the treatment system via screenings, assessment, and engagement.

San Francisco developed its access system for persons seeking treatment for substance use disorders (SUDs) primarily through a county-operated walk-in clinic or calls directly to a community-based treatment provider for an appointment. The walk-in clinic, known as the Treatment Access Program, or TAP, is usually able to provide same-day assessments but also schedules appointments upon request. Whether through the clinic or through a community-based treatment provider, clients receive an assessment based upon American Society of Addiction Medicine (ASAM) criteria. According to the findings, they are then referred to a treatment provider at an appropriate level of care for treatment.

San Francisco BHS operates an Access Call Center 24/7 that primarily screens callers with mental health-related requests. San Francisco estimates that their Access Call Center provides brief substance use screenings and referrals to two percent of callers and provides substance use-related information without a screening or referral to another five percent of callers. When a caller requests substance use treatment, call center staff usually refer them to TAP for a more focused screening.

TAP staff use an intake screening form to first determine whether to conduct the full assessment at TAP or refer to a provider for the assessment. TAP staff have access to the Avatar electronic health record (EHR) database to look up a new client's mental health and substance use history if in the system. They also have access to FindTreatmentSF, a real-time electronic database of bed census availability at residential treatment and withdrawal management sites. After deciding upon an appropriate referral, TAP staff contact that provider to present the case and assist the client in making an appointment. San Francisco is considering adopting the practice of three-way calling to streamline this process.

Continuum of Care Overview

The Special Terms and Conditions (STCs) require an implementation plan with phased build-out levels of care based on the ASAM continuum, expanding over time the treatment options for clients based on their individual needs. Each year the CalEQRO reviews the current services and capacity as well as plans for changes by levels of care or capacity, including consideration of locations, special needs, age groups, etc.

San Francisco provides a full continuum of care at all of the levels required by the STCs. They meet the Network Adequacy time and distance standards for outpatient treatment and narcotic treatment programs (NTPs), and they are continuing to build capacity in many of their services.

San Francisco provides 50 residential withdrawal management (WM) beds across two facilities, one of which specializes in medication-monitored withdrawal from alcohol and/or benzodiazepines. They also provide non-DMC-certified inpatient WM when needed for

those admitted for other conditions. The emergency departments of three hospitals participate in the E.D. Bridge program to conduct WM, provide initial MAT inductions and addiction counseling, and refer to stepdown addiction treatment services.

San Francisco reports 197 DMC residential treatment program beds and 54 non-DMC residential treatment program beds with services at ASAM levels 3.5, 3.3, and 3.1. The predominant level is 3.5, and the initial authorization is usually for 90 days during the COVID pandemic, with an optional extension for 30 days based on medical necessity. Four of San Francisco's eight residential treatment facilities obtained DMC certification during the past year, and San Francisco is providing technical assistance to them on implementation of ASAM criteria, chart documentation, and billing.

San Francisco currently provides 197 recovery residence beds. There were plans and funding for further expansion. However, with the sudden onset of the COVID pandemic, substantial funding and human resources were needed to address other medical, housing, and social service needs related to the pandemic. Further expansion of recovery beds was put on temporary hold.

San Francisco provides a full range of outpatient services, including intensive outpatient treatment (IOT), outpatient treatment, and recovery support services. Their IOT services are underutilized, with providers finding it challenging to engage clients for the minimum number of hours required for IOT. The less intensive outpatient treatment programs are highly utilized. Recovery support services are available but not yet fully implemented.

SF supports and encourages the delivery of MAT and seems to have effectively overcome the stigma attached to MAT approaches. There are seven NTPs, which in combination provide most of the DMC-ODS treatment in San Francisco. They primarily provide methadone as the addiction medicine of choice, although they also provide non-methadone addiction medicines when clients request them. The University of San Francisco (UCSF) provides a DMC-certified, office-based induction buprenorphine clinic (OBIC) for many clients at the county's central pharmacy site and refers them after induction to Federally Qualified Health Centers (FQHCs) for maintenance dosing. Some residential treatment programs, such as HR360, provide non-methadone MAT, although it is through their primary care clinic, which does not bill through the DMC-ODS. Delivery of non-methadone MAT is more widespread through physical health care services. The street medicine team within SFDH's Street Medicine and Shelter Health Program delivers buprenorphine to 100-200 clients per month in hotels, residential programs, and on the street. Nearly two-thirds of SF's physicians are X-waivered and able to deliver buprenorphine through primary care clinics and a range of non-profit organizations. San Francisco CURES data (including non-Medi-Cal) indicated 2784 clients received buprenorphine prescriptions in 2019 (a 6.4 percent increase over the previous year).

Case Management/Care Coordination Model

Case management (CM) and coordination of care, in a managed care model based on the ASAM continuum of care, is a critical service. DMC-ODS programs have approached

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

The City and County of San Francisco provides extensive CM services, although most are not DMC-certified. During the COVID pandemic, with many shelters closed, the county established several Navigation Centers that provide CM services, especially for those who are homeless. The services include connectivity to county-supported housing, including Project Room Key which converted over a thousand hotel rooms into temporary housing. The Navigation Centers also provide referrals to a wide range of county services, including harm reduction and more traditional approaches to treatment of SUDs. The San Francisco Aids Foundation is particularly active in providing harm reduction approaches to helping persons with SUDs who are housed in Project Room Key and other supported housing.

In San Francisco’s model for DMC-certified CM, the service is provided by the programs providing the treatment to those same clients. San Francisco estimates their average monthly billing rates for these services are 310 units, which are low for like-size counties. Some of the residential WM and treatment programs contracted for a rate that includes CM in the bed-day rate, making it difficult to track units of service separately and partially explaining the low billing numbers for CM. In addition, some providers prefer not to document and bill separately for these services, even when they are contractually unbundled, reflecting a pre-Waiver practice. Where billing for CM services through DMC-ODS is appropriate, San Francisco should work with its providers to do so in order to capture revenue that can later be used for the funding of more services.

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

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

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

Validation of Performance Measures[1]

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

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

Performance Improvement Projects[2]

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

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

DMC-ODS Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which San Francisco meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of San Francisco 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 to the specific Substance Use Disorder (SUD) program that administered the survey so that quality activities can follow the survey results for services at that site. CalEQRO reviews the

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

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

UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

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

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

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

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

PRIOR YEAR REVIEW FINDINGS

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

Status of Prior Year Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

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

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

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

Prior Year Key Recommendations

Recommendation #1: Transition the Treatment Access Program (TAP) brief ASAM screening pilot to full implementation resulting in brief screens being completed by TAP except in specific cases when a full assessment is necessary to determine level of care. They should enter the screening findings and referral choices into the ASAM Criteria Level of Care (LOC) Referral Data as required by Department of Health Care Services (DHCS).

Status: Met

- After last year's EQRO Review the TAP fully implemented a shorter intake screening form. Full LOC Recommendation Forms are only completed at the request of the program admitting the client, except in specific cases when a full assessment is necessary to determine LOC.

- Since the implementation of the brief screening tool, San Francisco reports that clinic flow is faster. Clients inquiring about treatment are screened on the same day and referred out. Full SUD LOC forms are required at the admitting program within 72 hours of admission into the appropriate level of care.

Recommendation #2: The San Francisco Continuum of Care has been established and is billing at all levels of required services; however, there is additional capacity needed in outpatient treatment, residential step down (RSD) beds, and recovery support services. San Francisco is planning for additional services at these levels of care but should take steps to determine how much is still needed, apply to the Board of Supervisors for expenditure approval, and begin growing capacity.

Status: Met

- In FY 2019-20, BHS-SUD added three outpatient programs to the DMC-ODS network, in particular two located in the Bayview, oriented to serve Black/African American clients.
- Additionally, the Plan increased Residential Step-Down bed capacity by 72. The funding for these beds was provided by the Educational Revenue Augmentation Fund (ERAF) and County General Funds.
- In December 2019, DPH launched an online bed tracker, FindTreatmentSF.org, that allows the public, providers, and potential clients to see where substance use treatment beds are available daily. Early data from the bed tracker reflects vacancy rates ranging from five percent to as much as 40 percent across different types of treatment beds. In response to increased bed vacancy rates Dr. David Pating began planning a Value Stream process with stakeholders and program staff scheduled for May 2020. The value streaming process was intended to reach across the entire system and include the Treatment Access Program (TAP), withdrawal management, and residential programs, assessing values, flows, and barriers. The process was intended to build a framework for “right sizing residential”, allow the plan to determine how much RSD/OP and residential is still needed, and make necessary adjustments to San Francisco’s current system. The May 2020 value stream mapping meeting was unable to occur due to COVID-19 and remains on hold.
- San Francisco City’s Mayor announced the intent to add 1,000 behavioral health beds. High level planners said that approximately 300 of those beds were intended for residential step-down beds. The need to actualize this plan was substantiated by the consistently full census reported on the vacancy tracker for RSD. San Francisco clarified there was no longer a clear commitment to the plan since onset of COVID-19. Creation of Shelter-in-Place (SIP) hotel housing took precedence as existing, congregate shelters were forced to close.

Recommendation #3: The API community is substantial in San Francisco but its penetration rate for DMC-ODS services is markedly low. San Francisco should establish a specific initiative to outreach and engage this population through focus groups and

other strategies, building on the existing efforts in place to serve this population. Efforts should establish new strategies that will result in an increase of services provided to this population.

Status: Partially Met

- An SFDPH team conducted a needs assessment and noted the shortfall in penetration rate was small compared to national, state, and other local benchmarks. They noted the lower SUD utilization by Asians was partly explained by lower community SUD prevalence rates, lower acuity, better housing status and resident location, and the higher mean age of Asians in high-density neighborhoods. The assessment also noted a lack of Asian-language capacity in San Francisco's SUD residential treatment programs, and limited AAPI-competent outpatient SUD services.
- To improve outreach to AAPI with SUD, the team designed a pilot in conjunction with Chinatown North Beach Mental Health Clinic (CTNB) to increase SUD identification and treatment. This pilot included:
    - Conjoint development of a culturally sensitive "approach" to address SUD among Asians.
    - Identification of an appropriate SUD screening tool to replace their outdated SUD checklist.
    - Implementation of real-time Chinese-language telehealth assessment by DPH Treatment Access Program (TAP).
    - Outcome measures were to include acceptance of any SUD referral, service, or medication.
- At the time of the COVID-19 emergency declaration in February 2020,
    - An implementation team consisting of a physician, nurse practitioner and pharmacist was assembled.
    - This team completed preliminary interviews with CTNB physicians and staff.
    - Two 1-hour clinic "SUD screening" discussions had been scheduled,
    - An alternative culturally appropriate assessment tool had not been selected
    - Installation of tele-health equipment was pending.
- Five months into COVID-19, San Francisco regards it as unlikely that the planned pilot of interventions can move forward. Citywide, the supply and demand for SUD services has been disrupted by "sheltering in place" referrals to housing (in lieu of SUD treatment) and closure of most of the outpatient SUD services. At CTNB, face-to-face services were suspended, and the clinic is limited to providing only essential care. Only the persistent lack of AAPI language capacity in residential treatment remains consistent. However, San Francisco expressed concern that this lack will be even more challenging to resolve during COVID-19. San Francisco worked on a three-way telehealth solution, but their plans were interrupted by COVID-19 pandemic.

Recommendation #4: San Francisco is facing severe staffing shortages that are impacting programs and the implementation of the DMC ODS. During the review it was reported that 20 percent of the overall staff positions in BHS are vacant, and 33 percent of the positions at the ACCESS and TAP units are vacant. It is recommended the County find ways to significantly reduce the length of time it currently takes to hire behavioral health.

Status: Partially Met

- DPH Human Resource (HR) Department has a new director, who has focused on streamlining the hiring process. However, even 'COVID hires' still are challenged by slow civil service procedures and requirements. BHS cooperated in HR requests to prioritize positions, and HR committed to processing the 'priority' hires first. Quite a number of SUD positions are in this group. However, this problem continues to plague BHS and SUD.

Recommendation #5: As Avatar Information System (IS) staffing resources were reduced in the last year, critical new reports and software modifications became delayed in the DMC-ODS implementation. New IS Avatar dedicated staff need to be hired and are critical in working with Netsmart to develop and install new data fields in Avatar to support documentation, process flow and billing. This is necessary for San Francisco to effectively implement year three of their DMC- ODS and comply with data and reporting requirements necessary for program oversight, quality of care and revenue.

Status: Partially Met

- San Francisco explained they advocated strongly to maintain their current level of support. They have three positions that are moving through the HR process. However, the process encountered some delays due to the need to deploy staff in response to COVID-19 and pending budget cuts.
- San Francisco took other steps to address this recommendation. They restructured responsibilities in order to free up resources who can be more dedicated to report development. They provided training and technical assistance to existing staff in order to improve their report writing skills. They enlisted Netsmart consultants to develop dashboards and reports for residential authorization flow.

Recommendation #6: Staffing shortages are also a significant contract provider issue as a result of staff leaving for higher paying jobs and as a reaction to the stress of the increased documentation requirements of the DMC-ODS. In addition, the staffing requirements for the DMC ODS were at times underestimated by providers in their initial negotiation. San Francisco should review contractor staffing levels and rates to implement year three of DMC-ODS successfully.

Status: Partially Met

- On July 1, 2019, the City's Minimum Compensation Ordinance (MCO) changed to increase the minimum compensation paid by nonprofit organizations to workers on City contracts to $16.50 per hour. This new wage rate is $0.91 per hour higher than San Francisco's minimum wage. The Mayor and Board of Supervisors recognized the burden this increase may place on nonprofit suppliers and provided $5.8 million in FY 2019-20 and in FY20-21 to help offset the cost of the MCO wage increase.

  While these increases were welcomed, the spread of funding across all nonprofit contractors throughout the County reduced the extent of the impact on substance use contractors. Accordingly, BHS/SUD submitted their FY2020-21 budget proposal with funding for higher contracting partner line staff salaries.

Recommendation #7: The redesign of TAP for authorizations appears to have improved efficiencies positively. However, the reauthorization process needs to complete a similar LEAN-like process involving contract provider leadership to improve, streamline and clarify this process.

Status: Met

- Dr. David Pating worked with HealthRIGHT360's clinical staff to develop a mechanism and flow to ensure reassessments were done in a timely manner, reflect genuine medical necessity, and establish a need for ongoing treatment. It was piloted over a period of time in Nov/Dec for efficacy and fully implemented in January 2020. The Reauthorization Guidelines were revised for clarity between clinicians and authorizers and to reduce the number of "bounce-backs."
- During the COVID-19 pandemic, San Francisco reduced the need for 30-day reauthorizations and began approving SUD residential treatment stays for 90 days during Shelter in Place, which has minimized paperwork and red tape during their emergency response to the pandemic.

Recommendation #8: The ACCESS Call Center does not have the capacity to track all the required timeliness data elements required by the DMC-ODS Waiver using their existing Avatar software. Currently, the Access Call Center (TAP) is using an Access Database to collect data. BHS has plans to move the call intake process into Avatar this fiscal year. San Francisco needs to assure that Avatar will provide the data tracking support for compliance with timeliness requirements of the DMC-ODS Waiver.

Status: Partially Met

- San Francisco created an Avatar-based access call log for tracking a simple screening and individual risk assessment. The new form can collate when the call happened, the duration of the call, and which clinician is answering the call. However, it does not have the capabilities to record dropped calls automatically.

- San Francisco describes their current call center software as dated, deficient and needing replacement. They lack many of the basic functions integral to call center software, such as caller wait time and caller abandonment rates. Without these functions, a call center is unable to gauge call volumes, call backlogs, and staffing needs at varying times of day and days of the week. San Francisco is considering a solicitation process for potential vendors to replace their current software. Alternatively, they are also considering adopting the call center software currently in use at one of their hospitals (La Honda).

Recommendation #9: The San Francisco Pharmacy that supports multiple MAT programs for high risk populations successfully redesigned its non-structural space in order to increase efficiencies in the last year. San Francisco should follow the previously made CalEQRO recommendations for structural space redesign to better meet the increased demand that this program is experiencing to treat a very high-need population.

Status: Partially Met

- Since the last DMC-ODS update, the Behavioral Health Services (BHS) pharmacy has continued to refine and improve non-structural work processes using LEAN methodologies to meet the increasing demand for medication for opioid use disorder (OUD) for San Franciscans.
- In the past year, newly passed legislation called Mental Health SF (MHSF) required expansion of hours of the pharmacy in order to serve high-risk populations. To meet these requirements and the higher demand, phased construction plans were drawn up and costed out. Preliminary meetings for a new LEAN workshop were completed. The goal was to align a remodeled space for pharmacy, Treatment Access Program, and Behavioral Health Access Program with the new vision of MHSF. This included shared discussion with stakeholders across the BHS and within the physical location of 1380 Howard St. Structural changes were being considered with the goal of 'one-cell flow' in mind, and included elements such as a new space for client triaging, increasing window capacity for private counseling of multiple clients at a time, capacity for tele-medicine visits, adding a lab to the 1st floor space, and easier access to the physical pharmacy during off hours. Budget requests for new technology such as medication packagers were submitted, as well as staffing models for expanded hours.
- Not unexpectedly, as resources were re-allocated during the COVID-19 public health emergency, MHSF and the pharmacy space remodel were deprioritized. As the effects of the pandemic on high-risk clients needing medication for OUD are being fully understood the need to re-examine the structural space remain. While significant budgetary restrictions are likely, San Francisco anticipates the trajectory of increased demand to continue. Furthermore, the space remodeling will likely need to additionally address the reality of social distancing and other new regulatory requirements that emerge from the COVID-19 pandemic.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

1. Staffing Changes:

- Chona Peralta retired as BHS Compliance Officer in September of 2019 after 32 years of civil service. Garrett Chatfield is serving as acting BHS Compliance Officer for the Office of Compliance and Privacy Affairs.

- Irene Sung, MD retired as Acting BHS Director after 22 years of service in the Department of Public Health. Marlo Simmons, MPH is currently serving as Acting Director of the San Francisco Health Network BHS, effective February 17, 2020.

- Elissa Velez, SUD Program Coordinator, transitioned out of SUD Services to Quality Management in March 2020. The SUD Program Coordinator position remains vacant.

2. Mental Health SF:

- It is a strategic goal of the recently established Mental Health SF to improve San Francisco's approach to mental health and substance use treatment for at-risk people experiencing homelessness, creating low-barrier access to welcoming, high quality behavioral health care that matches their needs.

- In March 2019, Mayor London Breed appointed Dr. Anton Nigusse Bland as the Director of Mental Health Reform for a two-year assignment. Dr. Nigusse Bland has been vital in the development and strategic design of Mental Health SF.

- Recent data indicates the County has 18,000 homeless adults, 4000 of whom have mental health or substance disorders. Of the 4000, 95 percent have alcohol use disorder, 41 percent used urgent and emergent psychiatric services last year, and 35 percent are Black/African American.

- Prior to COVID-19, Mental Health SF legislation was moving along briskly, with various proposed changes to BHS and a strong emphasis on designing a system of care grounded in evidence-based practices that reduces harm and increases recovery for individuals experiencing homelessness. However, progress was interrupted by the pandemic. The most recent product of Mental Health SF has been the posting of the combined BHS and Mental Health SF Director position, along with a new organizational chart.

- Updates on Mental Health Reform were shared with Whole Person Care stakeholders on February 21, 2020. Details can be found at: https://www.sfdph.org/dph/files/wpcfiles/presentations/SF_Mental_Health_Reform.pdf

3. COVID-19:

- San Francisco was the first city to declare a state of emergency in response to the coronavirus outbreak. On February 23rd, Mayor London Breed announced a local state of emergency which would allow the City to mobilize city resources, accelerate emergency planning, streamline staffing, coordinate agencies across the city, and allow for future reimbursement by the state and federal governments.

- Prior to COVID, San Francisco had committed to various initiatives to improve mental health and substance use, including Mayor Breed's top priority project initiated from the methamphetamine task force recommendations report, the creation of low threshold sobering centers for methamphetamine use. Although the program was slated to start this Spring, the project was completely frozen by the pandemic, with no commitment from the Mayor's office to fund it after COVID.

- COVID response has led to decisions about which SUD services are considered "essential," and how to safely work in the new reality. Two essential services required the most attention: congregate/residential settings, and Opioid Treatment Programs. These changes have involved all SUD staff. Training on risk mitigation, health orders, and tele-treatment have been key areas of focus and program technical assistance.

- SIP orders have caused an increase in drug and alcohol use and an increase in overdose deaths. Individuals who were once homeless are now able to access SIP hotel rooms allowing for increased risk when using alone. COVID-19 and its responses have changed the experience of people who use drugs and of people experiencing homelessness. Challenges to working with new systems such as SIP sites, containment centers, and alternate care sites with regard to SUD needs have led to new relationships, and new care and harm reduction designs.

- The City of San Francisco's rapid responses to mitigate and contain the virus were particularly burdensome on the Civil Service Behavioral Health Clinics and the Drug Court Treatment Center. Many of the programs were required to deploy clinical staff as Disaster Service Workers (DSW) to provide support in Isolation and Quarantine (I&Q) and SIP sites.

- With competing demands and a new focus, many SUD initiatives are on hold and it is unclear as to what will continue as a priority and what will be let go due to budget reductions.

Past Year's Initiatives and Accomplishments and Current Initiatives

1. Implementing Methamphetamine Task Force Recommendations:

San Francisco experienced an increase in methamphetamine use, including increased emergency room visits and deaths. Following are some San Francisco-specific statistics related to the increase in methamphetamine use:

A. Since 2008, the overdose death rate involving methamphetamine in the City tripled from 1.8 to 11.5 persons per 100,000 San Franciscans (representing a 638 percent increase in methamphetamine overdose mortality). Users in San Francisco are most likely to be male, white, aged 26 and older, and consume the drug through smoking.

B. Nearly half (47 percent) of people who use psychiatric emergency services (PES) have methamphetamine involvement.

C. Nine out of ten people potentially eligible for SB 1405 have methamphetamine in their system.

D. Methamphetamine is also the most commonly present substance in homeless deaths (47 percent).

In February 2019, Mayor London Breed and Supervisor Rafael Mandelman called for the creation of a Methamphetamine Task Force, coordinated by the Department of Public Health, to develop recommendations on harm reduction strategies to:

A. Decrease risks for people under the influence of methamphetamine, especially for individuals experiencing homelessness and likely to use psychiatric emergency services;

B. Identify best practices for treatment and service options for people who use methamphetamine; and

C. Reduce the negative medical and social impacts of methamphetamine use on San Franciscans.

Two recommendations that have been a focus for BHS over the past year are:

A. Create a trauma-informed sobering site with integrated harm reduction services for individuals who are under the influence of methamphetamine.

   1) In November 2019, the San Francisco Department of Public Health identified HealthRIGHT 360 as the lead community-based organization (CBO) to partner with on the planning of San Francisco's first drug sobering site, Project 180.

This program is intended to be a 15-bed pilot project where clients may stay an average of eight to ten hours. The facility is able to serve 15 individuals at a time but over the course of a 24-hour period, can serve up to three times that many.

2) DPH worked collaboratively with HealthRIGHT 360 to design a facility and program to serve individuals with street drug use issues, particularly methamphetamines, who are pre-contemplative about entering into treatment or are not fully engaging with care.
3) The Program would prioritize a subset of substance using, homeless clients residing in the Tenderloin neighborhood and encourage their participation and willingness to engage in ongoing recovery and wellness programs to maximize the individuals' functional capacity and reduce their dependency on street drug use that results in urgent and emergent services.
4) By March 2020, “Project 180” leadership had developed a model of care factoring in services, staffing, bed capacity, length of stay, budget, location, referrals, and client flow. Vendors had been procured, contracts signed, and many staff already hired. The target date for opening doors to the public was mid-April 2020.
5) The Drug Sobering Center Proposal: “Project 180” was presented by BHS Deputy Medical Director Dr. Judith Martin, and Kathleen Silk, Director of Behavioral Health at HealthRIGHT 360, to the San Francisco Health Commission on March 3rd, 2020. It can be found at: https://www.sfdph.org/dph/hc/HCAgen/HCAgen2020/March%203/Drug%20Sobering%20Center-Health%20Commission%2003.20%20Final%20Combined.rev1.pdf. Findings from this effort will inform near-term future investments to save lives and promote safety in the Tenderloin and throughout the city. The Department of Public Health will evaluate the pilot program and refine the model for replication in other locations in San Francisco.
6) San Francisco describe the process as an interesting challenge in learning how to work on a Mayor’s initiative, with political visibility and community and press involvement. It engaged a substantial amount of the SUD team’s time, as well as the assisting agency, HealthRIGHT 360.
7) Due to COVID-19’s impact on the City and County of San Francisco, Project 180 was put on hold indefinitely.

B. Expand the use of proven intervention and treatment approaches for stimulant use disorder, including contingency management and medication support.

1) Contingency management is a type of behavioral therapy that uses motivational incentives such as vouchers or small cash rewards to encourage patients to engage in treatment and maintain abstinence (e.g., vouchers for negative urine drug tests). This behavior modification intervention reinforces desired behaviors through incentives and has shown some success in treating people with methamphetamine addiction. Contingency Management can be applied in a

wide range of treatment contexts for enhancing retention in treatment and decreasing drug use.

2) The San Francisco AIDS Foundation's Stonewall Project provided low-threshold CM as a behavioral therapy for many years through its Positive Reinforcement Opportunity Project (PROP). The program historically provided culturally appropriate services to support gay, bi, trans men, other men who have sex with men, and trans women interested in addressing their use of meth or cocaine; however, they recently expanded PROP services in March 2019 to anyone affected by stimulant use, coining the program expansion "PROP for All". Expanded services are intended to be largely beneficial to residents and community members of the 6th Street corridor and the Tenderloin.
3) To continue addressing the growing methamphetamine problem with proven intervention and treatment approaches, BHS-SUD requested additional funding to support PROP 4 All and increase outpatient treatment slots for the Stonewall Project.
4) Additionally, addiction clinicians at Zuckerberg San Francisco General Hospital have carried out two projects on Contingency Management for: 1) prenatal visits at the Family Health Center (primary care clinic), and 2) hospitalized people with congestive heart failure due to stimulant addictions.
5) In response to the San Francisco Methamphetamine Task Force recommendations, San Francisco legislators in Sacramento introduced a bill addressing the misapplication of Title 22 regulations against kickbacks and requiring that Contingency Management be included in EBPs for SUD treatments.
6) Full Methamphetamine Task Force Recommendations can be found at: https://www.sfdph.org/dph/files/MethTaskForce/Meth%20Task%20Force%20Final%20Report_FULL.pdf

2. Residential Bed Availability Initiatives:

In response to a rise in fentanyl and methamphetamine related overdoses and growing complaints of open drug use, the city invested in innovative tools like FindTreatmentSF.org to publicize, monitor, and ensure that treatment services are helping the city's most vulnerable residents. FindTreatmentSF.org is the San Francisco Department of Public Health's online inventory of substance use treatment beds. The site went live in December 2019, showcasing the provider network's withdrawal management (55), residential (251), and residential step-down (197) capacity and real time available bed numbers.

This centralized, online resource reveals how many of the City's short-term behavioral health treatment beds are available on a daily basis, essentially enabling San Francisco to make the best use of the substance use and mental health treatment resources they already offer and to make data-driven decisions about where they need to adjust their services. San Francisco explained that this tool became a recent catalyst for a variety of initiatives, including examining where vacancies exist, where there are extended wait times for beds, where program support is needed, and where

targeted investment will allow the entire system to function better for the patients under its care.

A. Residential Step-Down (RSD) Bed Expansion

An early assessment of the DMC-ODS network need for Residential Step-Down (RSD) was close to 300 beds. The San Francisco DMC-ODS Plan was able to build up residential services alongside residential step-down services, resulting in thoughtful care coordination within and between agencies and continuity during the reclassification of beds. Three residential treatment providers transitioned treatment beds into RSD beds, but San Francisco believes many more RSD beds are needed to support the continuum of care.

Expanding RSD was noted as a 2018-2019 SUD EQRO recommendation. Since then, San Francisco increased residential step-down beds at HealthRIGHT 360 by 72 units, using ERAF and County General Funds.

Additionally, HealthRIGHT 360 observed an increased need for residential step-down services specifically for women with children. The agency had begun planning a remodel of their Female Offender Treatment and Employment Program (FOTEP) facility to support a family RSD program. The HR360 women and families RSD expansion will yield 25 new beds. Due to the budget impacts of COVID-19, this initiative is on hold.

B. Rightsizing Residential Treatment Services

San Francisco has 4000 homeless individuals with MH/SUD disorders who have been prioritized under Mental Health SF (2019) to be sheltered through enhanced access to MH/SUD treatment. High bed vacancy, long waits and many admissions lost “in process” possibly indicated poor access by homeless clients requesting SUD Residential Treatment. Collectively these may have contributed to substantial SUD RT beds sitting idle for many weeks. In response, a LEAN “Value Stream” mapping process was scheduled to analyze the referral and admission process to our largest Residential Treatment provider. At the time of the COVID-19 emergency in February, this process was scheduled for April and subsequently cancelled.

Additional countermeasures remain active, including enhanced referrals from Mental to SUD Residential treatment, the provision of technical assistance to Residential Treatment program providers, and a plan to convert excess Residential Treatment beds to Residential Step-down beds.

C. Residential Formal Improvement Project Technical Assistance Plans

Since the commencement of the San Francisco Drug Medi-Cal Organized Delivery System (DMC-ODS) in 2017, BHS slowly expanded its network of DMC-ODS

providers. Using a phased- in approach, the County started with 14 ODS programs and progressively works to prepare new programs each year. On January 1st, 2019, the BHS-SUD care team initiated the transition of three State Plan residential programs (Latino Commission, Epiphany Center, and Friendship House) into residential 3.1 DMC-ODS providers. During the rollout period, the Plan observed network adequacy challenges related to program intake and authorization processes. Identified challenges include:

- Program staffing, retention, and training.
- Clients not receiving residential treatment services within 14 day of first request for services.
- Reducing the number of days to intake.
- Reducing bed vacancy rates.
- Increasing program use of the Timely Access Log.

In January and February of 2020, Erik Dubon, DMC-ODS Project Manager, held a number of meetings with program staff to develop a Technical Assistance plan for each of the three programs. In March 2020 San Francisco announced a state of emergency in response to COVID-19, and as a result, some of the action items in the TA plans have been put on hold.

3. Expansion of Outpatient Services

During FY 2019-2020, the Plan prepared four new outpatient programs for operation under the DMC-ODS Continuum of Care. Three of the programs are intended to bill Drug Medi-Cal, while the other is connected to an FQHC but will document and be monitored in accordance with the San Francisco DMC-ODS Intergovernmental Agreement.

Outpatient service expansion efforts included 2 programs in the Bayview-Hunters Point, Southeast sector of San Francisco. The Bayview, a historically predominantly black neighborhood, continues to include the highest percentage of Black/African Americans among San Francisco neighborhoods. Despite recent investments and structural improvements, the area remains disconnected and marginalized, with very few services and treatment options. Bayview Hunters Point Foundation has been providing methadone to people with OUD in the Bayview since the 1970’s. However, over the last year the program expanded services to include outpatient services for people with other primary substance use.

Additionally, HealthRIGHT 360 transitioned its African American Healing Center into a DMC-ODS outpatient program with the capacity to serve 30 clients.

4. Low-Threshold Telemedicine for Opioid Use Disorder

San Francisco entered into a contract with Bright Heart Health for tele-assessments and medication prescribing. Individuals meet with licensed medical staff via video

conferencing for support with OUD. These new services will be used to extend hours and enhance addiction treatment for OUD at existing low-threshold sites, such as syringe access, street medicine, and BHS pharmacy/access center and jail release linkages.

In addition, San Francisco is providing tele-behavioral health services as needed for alternative medical and containment sites during the COVID-19 emergency. They estimate it could help an additional 250 people per year beyond the 4,000 or so currently receiving addiction treatment medications in the city.

PERFORMANCE MEASURES

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

1. CalOMS Treatment Data Collection Guide: http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf
2. TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf
3. ASAM LOC Referral Data Collection System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

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

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

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries.
- Number of days to first DMC-ODS service after client assessment and referral.
- Total costs per beneficiary served by each county DMC-ODS by ethnic group.
- Cultural competency of DMC-ODS services to beneficiaries.
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes).
- Coordination of care with physical health and mental health (MH).
- Timely access to medication for Narcotics Treatment Program (NTP) services.

- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured.
- Timely coordinated transitions of clients between levels of care, focused upon transitions to other services after residential treatment.
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics).
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs).
- Percentage of clients with three or more Withdrawal Management (WM) episodes and no other treatment to improve engagement.

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

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

HIPAA Guidelines for Suppression Disclosure:

Values are suppressed on PM reports to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (* or blank cell), and where necessary a 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 3 of Waiver Services

This is the third year that San Francisco has been implementing DMC-ODS services. Because the review for San Francisco occurred in August 2020, the FY2019-20 claims were not yet fully available for analysis and discussion. Thus, while the majority of this report focuses on changes and initiatives that occurred in FY2019-20, the performance measure reporting relied on FY2018-19 data. Performance measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 2018-19), and from UCLA for TPS, ASAM, and CalOMS data. 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

Table 1 shows San Francisco'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.

San Francisco served 4,002 unique clients in FY 2018-19, the majority of whom were between the ages of 18 and 64 (79.3 percent). The penetration rate for this age group was over twice that of other large counties and statewide. San Francisco served a very small number of youth ages 12-17, which is partly attributable to having the lowest proportion of youth in their population of any major city in the nation. The penetration rate for those youth, however, was less than half of the statewide average, indicating that the low proportion of the total population they represent is not the full explanation.

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

San Francisco				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	14,740	19	0.13%	0.29%	0.27%
Ages 18-64	118,787	3,174	2.67%	1.24%	1.12%
Ages 65+	45,737	809	1.77%	0.78%	0.69%
TOTAL	**179,264**	**4,002**	**2.23%**	**1.03%**	**0.93%**

Table 2 below shows San Francisco's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. San Francisco's overall average approved claim is $5,480, higher than the statewide average of $3,921. Older adults 65 and over had the highest average approved claims of $5,938.

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

San Francisco			Statewide
Age Groups	**Total Approved Claims**	**Average Approved Claims**	**Average Approved Claims**
Ages 12-17	$19,830	$1,044	$1,834
Ages 18-64	$17,105,887	$5,389	$3,951
Ages 65+	$4,804,166	$5,938	$4,643
TOTAL	**$21,929,883**	**$5,480**	**$3,921**

The race/ethnicity results in Figure 1, below, 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.

One of the recommendations of the EQRO last year was to address the disproportionality of Asian Pacific Islanders served who are Medi-Cal eligible; they comprise 38.2 percent of the Medi-Cal eligibles, but only 2.4 percent of those treated for SUDs. San Francisco completed a needs assessment and reported two take-aways: 1) due to lower SUD prevalence in this population in San Francisco, the apparent underutilization is not as extreme as it might appear; and 2) there are some language capacity limitations that create challenges for serving monolingual Asian/Pacific Islander clients.

The majority of clients served in San Francisco were White (37.9 percent), even though this demographic group comprised only 12.5 percent of eligibles.

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

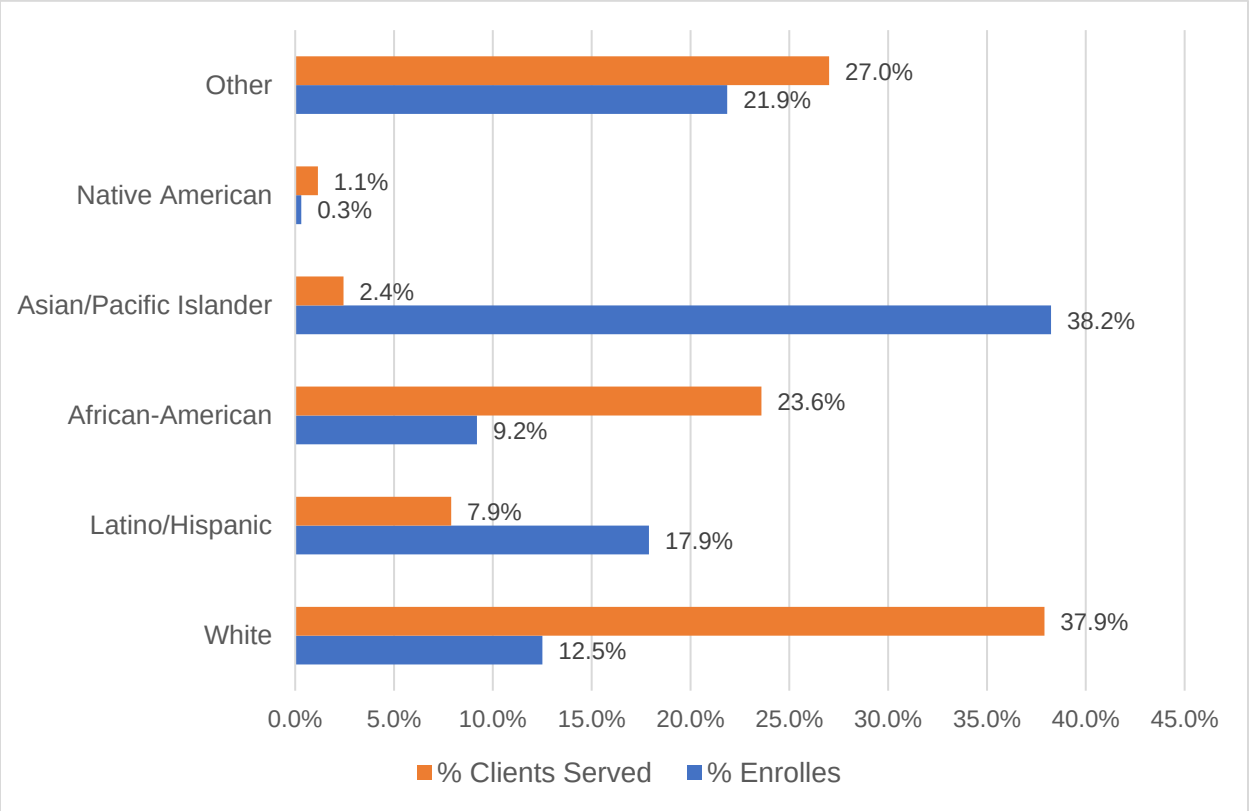


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide. The penetration rate for White clients is 6.77 percent, highlighting again that this demographic group is more likely to engage in services. With the exception of Asian/Pacific Islanders, all other race/ethnicity groups in San Francisco had higher penetration rates compared to statewide.

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

San Francisco				Large Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	22,414	1,517	6.77%	2.14%	1.77%
Latino/Hispanic	32,084	316	0.98%	0.73%	0.66%
African American	16,486	944	5.73%	1.36%	1.27%
Asian/Pacific Islander	68,550	98	0.14%	0.17%	0.16%
Native American	555	46	8.29%	2.53%	1.62%
Other	39,177	1,081	2.76%	1.08%	1.05%
TOTAL	**179,266**	**4,002**	**2.23%**	**1.03%**	**0.93%**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it.

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

Clients in San Francisco are largely eligible for services through ACA (48.2 percent) or disability status (42.3 percent). The penetration rate for clients who are eligible through a disability was 6.68 percent, which is over four times the statewide rate of 1.63 percent.

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

San Francisco				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	26,115	1,744	6.68%	1.63%
Foster Care	667	3	0.45%	1.77%
Other Child	8,324	11	0.13%	0.29%
Family Adult	20,486	233	1.14%	0.95%
Other Adult	44,920	139	0.31%	0.10%
MCHIP	6,533	5	0.08%	0.20%
ACA	71,396	1,988	2.78%	1.46%

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

Table 5 below shows San Francisco'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 adult categories are higher than statewide.

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

San Francisco				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	26,115	1,744	$5,604	$4,259
Foster Care	667	3	$1,376	$1,157
Other Child	8,324	11	$1,170	$1,770
Family Adult	20,486	233	$5,885	$3,321
Other Adult	44,920	139	$5,797	$4,344
MCHIP	6,533	5	$342	$1,884
ACA	71,396	1,988	$5,010	$3,911

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

Table 6 shows the percentage of clients served and the average approved claims by service categories in FY 2018-19. The majority of DMC-ODS clients in San Francisco are served in NTPs (61.5%). Residential treatment is the next most common service category, serving 14.9% of the total clients served. The lower number of clients served with non-methadone MAT does not reflect the substantial prescribing of non-methadone addiction medications outside the DMC-ODS in FQHCs and hospital emergency departments.

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	2,856	61.5%	$3,478
Residential Treatment	692	14.9%	$8,765
Res. Withdrawal Mgmt.	242	5.2%	$1,406
Ambulatory Withdrawal Mgmt.	1	0.0%	$0
Non-Methadone MAT	208	4.5%	$362
Recovery Support Services	14	0.3%	$1,046
Partial Hospitalization	0	0.0%	$0
Intensive Outpatient Tx.	58	1.2%	$2,801
Outpatient Services	574	12.4%	$898
TOTAL	**4,645**	**100%**	**$4,721**

The totals for penetration rates and average number of eligibles per month are not direct sums of the averages above it. The averages are calculated independently.
Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

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

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

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

The median time from initial, qualifying request to first dose of methadone in San Francisco is one day. This is comparable to the statewide average and is well within the DHCS standard of three days.

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

San Francisco				Statewide		
Age Groups	Clients	%	Median Days	Clients	%	Median Days
Ages 12-17	0	0.00%	n/a	8	0.02%	<1
Ages 18-64	2,106	74.63%	<1	29,072	80.27%	<1
Ages 65+	716	25.37%	<1	7,139	19.71%	<1
TOTAL	**2,822**	**100.00%**	<1	**36,219**	**100.0%**	<1

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

Services for Non-Methadone MATs 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.

San Francisco County stands out in California for its wide acceptance of MAT and its use within physical health care settings. Numerous X-waivered providers, estimated at nearly two thirds of San Francisco's physicians, are able to deliver buprenorphine through primary care clinics and a range of non-profit organizations. San Francisco CURES data (including non-Medi-Cal) indicated 2784 clients received buprenorphine prescriptions in 2019 (a 6.4 percent increase over the previous year).

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

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

As mentioned above in the narrative for Table 6, San Francisco serves through the DMC-ODS a relatively low number of clients with non-methadone MAT compared to the numbers served receiving methadone. However, those who do receive at least one service have high engagement in non-methadone MAT, as evidenced by the numbers who continue to receive three or more services (172 of 208, or 82.7% of clients).

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

San Francisco					Statewide			
Age Groups	**At Least 1 Service**	**% At Least 1 Service**	**3 or More Services**	**% 3 or More Services**	**At Least 1 Service**	**% At Least 1 Service**	**3 or More Services**	**% 3 or More Services**
Ages 12-17	0	0.00%	0	0.00%	3	0.07%	1	0.02%
Ages 18-64	179	5.64%	146	4.60%	3,251	4.20%	1,360	1.76%
Ages 65+	29	3.58%	26	3.21%	259	2.97%	82	0.94%
TOTAL	**208**	**5.20%**	**172**	**4.30%**	3,545	**3.86%**	1,461	**1.59%**

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

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

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

The DHCS standard for timely transitions in care is seven days, which San Francisco met six percent of the time. Overall, 10.8 percent of clients had a DMC-ODS follow-up service post-residential treatment. These percentages are lower than the statewide average and are consistent with other statistics, indicating that San Francisco has higher utilization rates for residential treatment than statewide and somewhat lower rates of outpatient treatment utilization than statewide.

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

San Francisco (n= 714)			Statewide (n= 25,123)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	43	6.0%	2,067	8.2%
Within 14 Days	51	7.1%	2,787	11.1%
Within 30 Days	56	7.8%	3,447	13.7%
Any days (TOTAL)	**77**	**10.8%**	**4,677**	**18.6%**

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 8/1/2019 through 7/31/2020.

Due to lack of software, San Francisco is unable to track many of the critical indicators used to monitor Access Line performance. While it is the case that the majority of clients do not initiate DMC-ODS services through the Access Call Center, it is important to have the technology to track time to answer calls and percentage of calls referred to a treatment program for care.

Table 10: Access Line Critical Indicators, 8/1/2019 to 7/31/2020

San Francisco	
Average Volume	762 calls per month
% Dropped Calls	Not able to track
Time to answer calls	Not able to track
Monthly authorizations for residential treatment	82.3
% of calls referred to a treatment program for care, including residential authorizations	Not able to track
Non-English capacity	1) Bilingual staff on-site: Spanish, Tagalog, Chinese/Cantonese, Chinese/Mandarin, Vietnamese, and Korean. 2) Over-the-phone interpretation services provided by Language Line Solutions when other languages are 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 San Francisco. 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 $10,589 in approved claims per year. The table lists the average approved claims costs for the year for San Francisco HCBs compared with the statewide average. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services 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 CM to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

In San Francisco, 8.5 percent of clients served met the threshold to be considered high-cost beneficiaries. Their claims comprised 26.2 percent of total claims for FY 2018-19.

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

San Francisco						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	19	0	0.0%	$0	$0	0.0%
Ages 18-64	3,174	297	9.4%	$17,042	$5,061,480	29.6%
Ages 65+	809	45	5.6%	$15,376	$691,901	14.4%
TOTAL	**4,002**	**342**	**8.5%**	**$16,823**	**$5,753,381**	**26.2%**

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

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

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 CM.

San Francisco served 241 clients in WM, and only 2.07 percent of them had three or more WM episodes with no other treatment.

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

San Francisco			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	241	2.07%	5,170	2.38%

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

Use of ASAM Criteria for Level of Care Referrals

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

In San Francisco, for both initial and follow-up assessments, the congruence rate between indicating LOC and referred LOC is high (96.4 percent and 95.8 percent). When there is a lack of congruence, the most common reason is patient preference. The columns for initial screening indicate zeroes because the call center does not conduct ASAM criteria-based screenings when making referrals to assessment centers, and the assessment centers do not conduct screenings because they provide full ASAM criteria-based assessments. CalEQRO has encouraged San Francisco to increase its screenings through the call center and use ASAM criteria in their screening and referral processes.

Table 13: Congruence of Level of Care Referrals with ASAM Findings, FY 2018-19

San Francisco ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
FY 2018-19	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	0	0.0%	2,739	96.4%	1,779	95.8%
Patient Preference	0	0.0%	76	2.7%	46	2.5%
Level of Care Not Available	0	0.0%	1	0.04%	0	0.0%
Clinical Judgement	0	0.0%	8	0.3%	17	0.9%
Geographic Accessibility	0	0.0%	0	0.0%	0	0.0%
Family Responsibility	0	0.0%	2	0.7%	0	0.0%
Legal Issues	0	0.0%	1	0.04%	0	0.0%
Lack of Insurance/Payment Source	0	0.0%	3	0.11%	1	0.05%
Other	0	0.0%	11	0.4%	14	0.7%
Actual Referral Missing	0	0.0%	0	0.0%	0	0.0%
TOTAL	**0**	**0.0%**	**2,841**	**100.0%**	**1,857**	**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. For adults in San Francisco, 95.28 percent initiated treatment after their initial visit, higher than the statewide percentage of 88.4 percent.

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. Engagement rates were also higher in San Francisco than statewide (87.69 percent compared to 79.9 percent statewide.)

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

	San Francisco				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	3,922		21		90,926		4,303	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	3,737	95.28%	11	52.38%	80,346	88.4%	3,397	78.9%
Clients who then engaged in DMC-ODS services	3,277	87.69%	10	90.91%	64,232	79.9%	2,386	70.2%

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. The majority of clients in San Francisco access DMC-ODS services through the NTPs (71.47 percent). Residential and outpatient treatment services are the next most common "doors" for clients.

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

San Francisco			Statewide	
DMC-ODS Service Modality	#	%	#	%
Outpatient treatment	415	10.52%	30,508	32.04%
Intensive outpatient treatment	26	0.66%	6,526	6.85%
NTP/OTP	2,818	71.47%	37,789	39.7%
Non-methadone MAT	15	0.38%	191	0.20%
Ambulatory Withdrawal	1	0.03%	43	0.05%
Partial hospitalization	0	0.00%	16	0.02%
Residential treatment	514	13.04%	15,754	16.5%
Withdrawal management	153	3.88%	4,057	4.3%
Recovery Support Services	1	0.03%	345	0.36%
TOTAL	**3,943**	**100.00%**	**68,436**	**100.0%**

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

Retention in Treatment

Table 16 is a measure of how long the system of care is able to retain clients in its DMC-ODS services and counts the cumulative time that clients were involved in all 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 discharges during the measurement year (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. Those clients discharged during the first three months of CY 2018 with a length of stay of at least 270 days will not show as such and the overall totals for that length of stay may therefore be somewhat undercounted. Clients in outpatient programs are counted as having a seven-day length of stay in a given week if they had at least one outpatient visit in that week.

The mean length of stay for San Francisco clients was 184 days (median was 106 days), compared to the statewide mean of 128 (median of 83 days). 51.9% percent of clients had at least a 90-day length of stay; 33.1% percent had at least a 180-day stay; and 24.3% percent had at least a 270-day length of stay.

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

San Francisco			Statewide	
Clients with a discharge anchor event	2,716		86,896	
Length of stay (LOS) for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	184	106	128	83
	#	%	#	%
Clients with at least a 90-day LOS	4,546	51.90%	40,481	46.6%
Clients with at least a 180-day LOS	2,900	33.10%	22,302	25.7%
Clients with at least a 270-day LOS	2,128	24.30%	13,194	15.2%

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential withdrawal management readmissions within 30 days of discharge. Of 276 clients admitted to residential WM in San Francisco, 6.9 percent were readmitted within 30 days of discharge compared to the 7.0 percent statewide average for all DMC-ODS counties.

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

San Francisco			Statewide	
Unduplicated clients of the DMC-ODS	4,002		91,853	
	#	%	#	%
Total DMC-ODS clients who were admitted into residential withdrawal management (WM)	276	6.90%	6,392	7.0%
Clients admitted into WM who were readmitted within 30 days of discharge	24	8.70%	446	7.0%

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the San Francisco and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2018-19. Given the high numbers of clients served in the NTPs, it follows that OUDs are the most common diagnosis codes for DMC-ODS clients in San Francisco (76.2 percent). Other Stimulant Abuse and Alcohol Use Disorders are also common (9.9 percent and 9.0 percent, respectively).

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

Diagnosis Codes	San Francisco		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	9.0%	$7,271	15.7%	$4,370
Cannabis Use	1.4%	$6,377	8.7%	$2,029
Cocaine Abuse or Dependence	3.1%	$8,929	2.1%	$4,719
Hallucinogen Dependence	0.1%	$1,084	0.2%	$3,651
Inhalant Abuse	0.0%	$5,086	0.0%	$3,733
Opioid	76.2%	$6,541	47.0%	$4,307
Other Stimulant Abuse	9.9%	$9,286	24.4%	$3,868
Other Psychoactive Substance	0.1%	$5,407	0.4%	$3,757
Sedative, Hypnotic Abuse	0.2%	$1,290	0.5%	$4,291
Other	0.2%	$7,271	0.9%	$2,627
Total	**100.0%**	**$5,480**	**100.0%**	**$4,001**

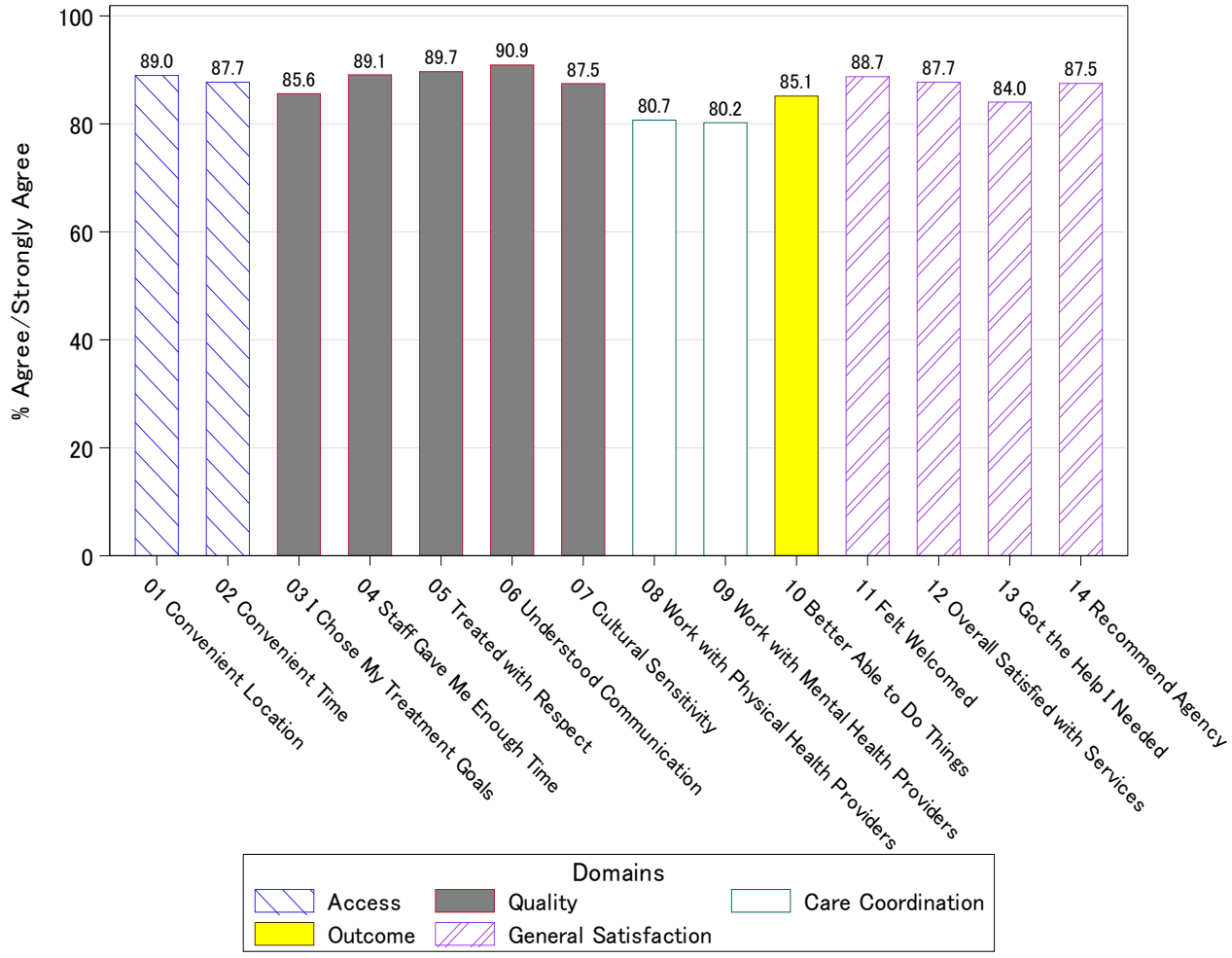
Client Perceptions of Their Treatment Experience

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.

San Francisco adult clients report high levels of satisfaction across the TPS domains. The Care Coordination domain is rated lowest, similar to other counties, but is still high.

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



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

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

Tables 19-21 depict client status at admission compared to statewide regarding three important situations: living status, criminal justice involvement, and employment status. These data provide important indicators of what additional services San Francisco will need to consider and with which agencies they will need to coordinate. San Francisco has more clients compared to statewide who are homeless (58.6 percent compared to 27.5 percent). Correspondingly, fewer clients in San Francisco live independently (32.7 percent compared to 46.4 percent statewide).

Table 19: CalOMS Living Status at Admission, FY 2018-19

Admission Living Status	San Francisco		Statewide	
	#	%	#	%
Homeless	2,466	58.6%	34,316	27.5%
Dependent Living	364	8.7%	32,097	26.0%
Independent Living	1,375	32.7%	57,048	46.4%
TOTAL	**4,205**	**100.0%**	**124,581**	**100.0%**

Clients in San Francisco are less likely to have criminal justice involvement compared to statewide (88.3 percent compared to 62.4 percent).

Table 20: CalOMS Legal Status at Admission, FY 2018-19

Admission Legal Status	San Francisco		Statewide	
	#	%	#	%
No Criminal Justice Involvement	3,715	88.3%	77,761	62.4%
Under Parole Supervision by CDCR	97	2.3%	2,232	1.8%
On Parole from any other jurisdiction	27	0.6%	1,597	1.3%
Post release supervision - AB 109	225	5.3%	34,542	27.7%
Court Diversion CA Penal Code 1000	77	1.8%	2,188	1.8%
Incarcerated	31	0.7%	720	0.6%
Awaiting Trial	33	0.8%	5,509	4.4%
TOTAL	**4,205**	**100.0%**	**124,581**	**100.0%**

Consistent with the high numbers of client who are disabled, San Francisco has a higher number of clients who are unemployed and not seeking work compared to statewide (82.6 percent compared to 49.8 percent).

Table 21: CalOMS Employment Status at Admission, FY 2018-19

Current Employment Status	San Francisco		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	185	4.4%	15,683	12.6%
Employed Part Time - Less than 35 hours	190	4.5%	9,910	8.0%
Unemployed - Looking for work	356	8.5%	36,869	29.6%
Unemployed - not in the labor force and not seeking	3,474	82.6%	62,119	49.8%
TOTAL	**4,205**	**100.0%**	**124,581**	**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. The administrative discharge rate for San Francisco clients is low at 7.9 percent. The majority of clients are in the Standard Adult Discharges category (65.9 percent).

Table 22: CalOMS Types of Discharges, FY 2018-19

Discharge Types	San Francisco		Statewide	
	#	%	#	%
Standard Adult Discharges	2,714	65.9%	58,885	43.8%
Administrative Adult Discharges	325	7.9%	62,542	46.6%
Detox Discharges	1,038	25.2%	9,882	7.3%
Youth Discharges	41	1.0%	3,011	2.2%
TOTAL	**4,118**	**100.0%**	**134,320**	**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.

Significantly more clients in San Francisco have positive discharge ratings compared to statewide (65.4 percent compared to 45.8 percent).

Table 23: CalOMS Discharge Status Ratings, FY 2018-19

Discharge Status	San Francisco		Statewide	
	#	%	#	%
Completed Treatment - Referred	810	19.7%	25,720	19.3%
Completed Treatment - Not Referred	165	4.0%	8,374	6.3%
Left Before Completion with Satisfactory Progress - Standard Questions	1,596	38.8%	17,486	13.1%
Left Before Completion with Satisfactory Progress – Administrative Questions	121	2.9%	9,419	7.1%
Subtotal	*2,692*	*65.40%*	*60,999*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	1,222	29.7%	19,485	14.6%
Left Before Completion with Unsatisfactory Progress - Administrative	162	3.9%	50,941	38.2%
Death	8	0.2%	207	0.2%
Incarceration	34	0.8%	1,633	1.2%
Subtotal	*1,426*	*34.60%*	*72,266*	*54.2%*
TOTAL	**4,118**	**100.0%**	**133,265**	**100.0%**

Performance Measures Findings: Impact and Implications

Access to Care

- San Francisco is reaching its adult population of eligibles with a penetration rate that is double the statewide rate.
- In response to last year's recommendation, San Francisco explored the underrepresentation of Asian/Pacific Islander clients and found as a partial explanatory factor that the SUD prevalence rate is substantially lower in this population. However, the penetration rate is still lower than the statewide average and warrants attention. San Francisco noted language gaps in the SUD counseling workforce that must be addressed to be able to effectively serve monolingual API clients.

- Youth remain underserved in San Francisco for FY 2018-19. While noted that the under 18 population in San Francisco has decreased over the last decade, the penetration rate for this age group is lower in San Francisco than statewide.
- San Francisco provides treatment to its beneficiaries with documented physical and mental health disabilities at four times the average statewide. Somewhat related, San Francisco's SUD clients have a substantially higher rate of homelessness than the statewide average (88.3 percent vs. 62.4 percent) and unemployment (65.4 percent vs. 45.8 percent).
- The Access Call Center does not have the software to track critical indicators that can help monitor performance and indicate opportunities for improvement.
- Adult clients rated their access to treatment positively in the TPS.

Timeliness of Services

- San Francisco has timely dosing for NTP clients who request a first dose of methadone (less than a day).
- Only 10.8 percent of clients are receiving a DMC-ODS service post-discharge from residential treatment within any days, compared to 18.6 percent statewide.

Quality of Care

- San Francisco clients have higher rates of initiation, engagement, and retention in treatment than the statewide average. Their engagement rates for clients receiving non-methadone MATs are nearly three times the statewide average.
- For initial assessment and follow-up assessments, congruence of indicated LOC and referred LOC is high. San Francisco has yet to conduct initial screenings and referrals using ASAM criteria.
- San Francisco certified additional residential and WM beds, expanding the continuum of DMC-ODS services.
- San Francisco County stands out in California for its wide acceptance of MAT. Within the DMC-ODS, the primary settings for MAT are the NTPs, which predominantly provide methadone, although notably an Office-Based Opioid Induction Clinic provides buprenorphine to many clients. The county of San Francisco also provides non-methadone MATs through its physical health care settings, including FQHCs, three hospitals, and the Street Medicine and Shelter Health Program. CURES data (including non-Medi-Cal) indicated that 2784 clients received buprenorphine prescriptions in 2019 (a 6.4 percent increase over the previous year).
- Adult clients rated their treatment as positive across the domains of Quality, General Satisfaction and Care Coordination in the TPS. They rated the Care Coordination domain slightly lower, but still high.

Client Outcomes

- Adult clients rated their outcomes positively (“better able to do things”) in the TPS.
- CalOMS administrative discharge rate is significantly lower than statewide (7.9 percent compared to 46.6 percent). This indicates that county staff are continuing to excel at training and supervising contract provider staff on administering the CalOMS summary forms at intake and discharge. It also indicates that CalOMS data results are likely to be accurate and useful representations of client progress in treatment.
- Results of CalOMS discharge data indicate substantially higher provider ratings of positive client progress in treatment than statewide (65.4 percent vs. 45.8 percent). San Francisco went further in most of the treatment programs, conducting pre-post studies of how well clients were able to maintain abstinence or reduce substance use while in treatment. The data indicate that approximately 75 percent of clients who participated in some form of treatment for at least 60 days were able to maintain abstinence or reduce their substance use while in treatment.

INFORMATION SYSTEMS REVIEW

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

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

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

ISCA Table 1 shows the percentage of DMC-ODS budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous two-year period, as well as the corresponding similar-size DMC-ODS and statewide averages.

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

Entity	FY 2020-21	FY 2019-20	FY 2018-19
San Francisco	0.99%	1.01%	0.71%
Large	N/A	3.09%	4.32%
Statewide	N/A	2.4%	3.16%

The budget determination process for information system operations is:

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

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

ISCA Table 2: Business Operations

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

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

ISCA Table 3: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	0.12%
Contract providers	99.98%
Total	**100%**

Summary of Technology and Data Analytical Staffing

Table 4 below displays the DMC-ODS self-reported IT staff changes by full-time equivalents (FTE) that occurred since the previous CalEQRO review.

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	2.0	0	1	0.5
2019-20	2.5	0	0.5	0
2018-19	3.0	0	0	0

Table 5 displays the DMC-ODS self-reported data analytical staff changes by FTEs that occurred since the previous CalEQRO review.

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	1.4	0	0	0
2019-20	1.4	0	0	0
2018-19	1.0	0	0	0

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

- The number of technology staff has increased by only 0.5 FTE since 2018-19. The number of data analytic staff has increased by only 0.4 FTE.

- The ongoing Epic EHR implementation continues to impact BHS IT staff; specifically, senior staff members with significant Avatar subject matter expertise are being pulled to support the Epic implementation. This diverts the already stretched IT staff elsewhere, making it challenging to address IT issues and make progress on key priorities.

- COVID-19 resulted in additional challenges for staff. While IT staff have not been diverted to other departments to support the County with COVID-19 issues, quality management staff have been deployed for months at a time, with very little notice, to other departments. It is understandable that the County must develop nimble solutions to staff and supervise key activities related to responding to COVID-19; however, it is noted that the combination of the Epic implementation with the

unanticipated demands that COVID-19 has placed on San Francisco has stretched the IS and QM teams responsible for critical DMC-ODS functions quite thin.

- In addition, the supplemental Netsmart support contract ended July 1st, 2020 resulting in further loss of staffing support for Avatar. However, some portions of the supplemental contract were consolidated into the main Netsmart contract.

Summary of User Support and EHR Training

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

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	20	74	94
Clinical Healthcare Professional	13	30	43
Clinical Peer Specialist	2	4	6
Quality Improvement	2	286	288
Total	37	394	431

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

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

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

Telehealth Services Delivered by County

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

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 7: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	15
Number of county-operated telehealth sites	n/a
Number of contract providers' telehealth sites	15

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

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

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

- San Francisco's DMC-ODS continuum is largely delivered by contract providers (over 99 percent of services). After the Shelter-in-Place order, San Francisco had to work quickly to help get providers up to date on billing telehealth services, getting started with telehealth and using Zoom as a clinical tool, and continuously updating information about all aspects of San Francisco Public Health and BHS responses to COVID-19 on a central website.

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

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 8: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Outpatient	15

Current DMC-ODS Operations

San Francisco hosts its Avatar system (currently using version 2017). Most software maintenance/upgrades are performed by BHS and County IT staff. Avatar Helpdesk phone support is available Monday through Friday from 9:00AM to 4:00PM.

Avatar classroom training sessions are conducted in the DPH administration site. Offerings include full-day Clinical/Admission classes and half-day Refresher/Specialized classes on progress notes, CalOMS, and reports. ASAM training is provided online and in person. After the Shelter-in-Placer order, all trainings have been delivered online.

With COVID-19, San Francisco had to quickly adapt to staff working remotely. DPH IT had to purchase additional equipment and upgraded Zoom to HIPAA-compliant licenses, expanded access to the existing Webex platform, provided additional training, and expanded Microsoft Teams.

For the Epic implementation, some behavioral health programs are already charting in Epic and using service upload to enter services into Avatar. The plan for DMC-ODS implementation continues to be evaluated as the behavioral health side makes the transition.

ISCA Table 9 lists the primary systems and applications the DMC-ODS uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Drug Medi-Cal and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

ISCA Table 9: Primary EHR Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar	Avatar/Practice Management	Netsmart Technologies	10	County
Avatar	Avatar/Clinical Workstation	Netsmart Technologies	10	County
Avatar	Avatar/Managed Svc Org	Netsmart Technologies	10	County
Avatar	Avatar/OrderConnect (InfoScriber)	Netsmart Technologies	10	County
Avatar	MyAvatar (upgrade-user interface)	Netsmart Technologies	10	County

The DMC-ODS Priorities for the Coming Year

- Create a SUD Diagnostic Criteria Form.
- Create a SUD LOC for Youth in order to capture ASAM information.
- Streamline the tracking of perinatal services in comparison to non-perinatal services in order to reduce the administrative burden associated with closing a perinatal episode and opening a non-perinatal episode for the same “episode” of care.
- Explore new VDI solutions for providers to access Avatar. If viable, move from WebConnect to a new solution to increase connection stability.

Major Changes since Prior Year

- ODS Optimization, Outcomes, and Compliance: Workflows have been optimized and additional program staff were assigned to ensure timely handling of authorization and re-authorization requests. Additional efficiencies that have been developed in order to facilitate this process have included the development of reports, (e.g., the SUD Residential Authorization Gap Report), the SUD Residential Console, and an Authorization widget that displays information in a manner that does not require running several reports.
- Expanding ODS to more SUD Residential programs: Three additional programs (Epiphany, Latino Commission, and Friendship House) were implemented.
- Recovery Plan: Implemented the recovery plan into the existing form and renamed it to be more inclusive: SUD TPOC/Recovery Plan.
- As DMC-ODS contract provider agencies purchased/upgraded equipment, licenses, and software for Windows 10, IT supported their efforts by updating the Webconnect environment to sustain access to Avatar data, reports, and billing under the new platform. This migration was reinvigorated with the impact of COVID-19 as providers moved from their offices to their homes.

Plans for Information Systems Change

- New system selected, not yet in implementation phase.
- As mentioned previously, San Francisco is moving forward with Epic implementation and continues to plan for DMC-ODS implementation; however, this implementation will follow the behavioral health implementation, which is not expected to be completed until 2023 at the earliest.

DMC-ODS EHR Status

ISCA Table 10 summarizes the ratings given to the DMC-ODS for EHR functionality.

ISCA Table 10: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar	☒	☐	☐	☐
Assessments	Avatar/Epic	☒	☐	☐	☐
Care Coordination	CCMS/ Avatar	☒	☐	☐	☐
Document Imaging/ Storage	On-Base	☒	☐	☐	☐
Electronic Signature—DMC-ODS Beneficiary	Avatar	☒	☐	☐	☐
Laboratory results (eLab)	Avatar	☒	☐	☐	☐
Level of Care/Level of Service	Avatar	☒	☐	☐	☐
Outcomes	Avatar	☒	☐	☐	☐
Prescriptions (eRx)	Avatar	☒	☐	☐	☐
Progress Notes	Avatar	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	Avatar	☒	☐	☐	☐
Summary Totals for EHR Functionality:		11		1	
FY 2020-21 Summary Totals for EHR Functionality:		11		1	
FY 2019-20 Summary Totals for EHR Functionality:		10		2	

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

- As described in the IS-related achievements, workflows have been optimized to ensure timely handling of the authorization and re-authorization requests.
- San Francisco has signed a contract with Netsmart for Care Connect, the Health Information Exchange (HIE) between Avatar and other vendors, including Epic.

- With uncertainty about whether Epic will be implemented for DMC-ODS services, San Francisco needs to continue improving Avatar functionality, streamlining workflows, and improving screen functionality by developing Netsmart widgets and console features.

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the DMC-ODS's EHR system, by type of input methods.

ISCA Table 11: Contract Providers' Transmission of Beneficiary Information to DMC-ODS EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to DMC-ODS EHR system and return message or medical information to contractor EHR	n/a	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and DMC-ODS EHR system	n/a	Not used
Electronic batch files submitted to DMC-ODS for further processing and uploaded into DMC-ODS EHR system	75%	Monthly
Direct data entry into DMC-ODS EHR system by contract provider staff	25%	Daily
Electronic files/documents securely emailed to DMC-ODS for processing or data entry input into EHR system	n/a	Not used
Paper documents submitted to DMC-ODS for data entry input by DMC-ODS staff into EHR system	n/a	Not used

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

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

Some contact providers have EHR systems which they rely on as their primary system to support operations. ISCA Table 12 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the DMC-ODS.

ISCA Table 12: EHR Vendors Supporting Contract Provider to DMC-ODS Data Transmission

EHR Vendor	Product	Count of Providers Supported
Netalytics	Metasoft	5
Welligent	Welligent	1

Special Issues Related to Contract Agencies

- Technical support to contract agencies was quite extensive this past year. BHS IT continued to host a quarterly Avatar Technical Workgroup where providers are informed of upcoming changes and are provided guidance regarding configuration. IS staff have also provided on-site support to at least 20 agencies. Additionally, BHS IT hosted 100 individualized Webex meetings to provide technical assistance regarding configuration issues with each agency, usually as a follow up to an initial in-person site visit.
- Data from Welligent and Methasoft, the EHRs used by the NTPs, flow into Avatar via service uploads.

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

	Yes	No
ASAM Criteria is used for assessment for clients in all DMC Programs.	x	
ASAM Criteria is used to improve care.	x	
ASAM screening is entered directly into the EHR.	x	
ASAM assessment is entered directly into the EHR.	x	
TPS is administered in all Medi-Cal Programs.	x	
CalOMS is administered on admission, discharge, and annual updates.	x	
CalOMS is used to improve care by tracking discharge status and other outcomes.	x	

Highlights or challenges of use of outcome tools above:

- San Francisco has a low administrative discharge rate per CalOMS—7.9 percent, compared to 46.6 percent statewide.

Overview and Key Findings

Operations and Structure

- COVID-19 presented San Francisco with multiple challenges that required the entire county to alter workflows, staffing patterns, and IS infrastructure. Specifically, staff required laptops and remote capabilities to be able to switch to working from home. Both county and contract providers experienced bandwidth challenges with working from home and attempting to access the EHR. The county onboarded over 300 civil service providers with VDI for connectivity.
- IS staff helped DPH ramp up telehealth services so that clients continued to receive care.
- Prior to COVID-19, IS staff had been pulled into support the Epic implementation efforts. After COVID-19, Project Room Key drew IS staff for data support and deployed QM managers and supervisors to support efforts such as contact tracing.
- Three residential treatment providers were certified in FY 2019-20. IS staff provided extensive technical support to each of these providers related to submitting claims through Avatar.

- Billing during COVID-19 dropped significantly; however, utilization is now leveling off, and contract providers are beginning to submit claims from March.
- Discussions with the HIE about how to interface have begun, with consideration of 42CFR.2 restrictions. San Francisco should consider how the functionality in Care Connect might help them with their HIE and other interface plans.

Key Findings

- COVID-19 created unanticipated demands on the county, impacting the priorities and day-to-day work of DPH.
- San Francisco IS, QM, and research staff work closely and collaboratively to generate high-quality outcomes reports, create usable and informative dashboards, and present key data indicators to leadership for data-driven decision-making.
- Staffing for IS decreased this past year, which will continue to limit San Francisco's ability to comply with reporting requirements and ability to support Avatar functionality, including documentation and billing. While San Francisco has taken steps to restructure staffing responsibilities to meet these demands, the lean budget and staffing for IS responsibilities hinders their ability to address priorities in a timely way.

  With uncertainty about whether Epic will be implemented for DMC-ODS services, San Francisco needs to continue improving Avatar functionality, streamlining workflows, and improving screen functionality by developing Netsmart widgets and console features.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Francisco, the time and distance requirements are 15 minutes and 30 miles for SUD services and 15 minutes and 30 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

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

Review Sessions

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

Findings

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

As part of the annual monitoring process carried out by the DPH Business Office of Contract Compliance, an American Disabilities Act (ADA) Accommodations Checklist is issued to and filled out by all agencies, with shortcomings noted on the form. The ADA Coordinator for DPS fields any grievances pertaining to programmatic/physical access issues pertaining to either county-operated or contracted providers and works with the Mayor's Office and the program on workable solutions to address problems.

San Francisco is a geographically small county with excellent public transit; hence, in general, clients are able to manage their own transportation to and from treatment. Residential programs have vans to provide transport for clients needing to make essential appointments outside the residential facility such as medical appointments. SFDPH's Street Medicine and Shelter Health Program operates a street medicine team that conducts outreach and provides MAT and counseling services to over 100 homeless persons monthly. The San Francisco AIDS Foundation and Bay View Hunters Point provide addiction counseling services and various types of harm reduction interventions to persons with SUDs who were recently homeless and then moved into hotel rooms through Project Room Key.

San Francisco County operates six Navigation Centers, the first of which opened in March 2015. These centers are designed to shelter San Francisco's highly vulnerable and long-term homeless residents who are often fearful of accessing traditional shelter and services. Navigation Centers provide these otherwise unsheltered San Franciscans room and board while case managers work to connect them to income, public benefits, health services, shelter, and housing. Navigation Centers are different from traditional shelters in that they have few barriers to entry and intensive CM. Unlike traditional shelters, people with partners, pets and possessions are welcome at Navigation Centers. The purpose of a Navigation Center is to offer a respite from life on the street and to support people in changing their lives by making lasting social service and housing connections.

While not required previously for Network Adequacy, San Francisco currently deploys substantial telehealth services to address COVID pandemic constraints. Privacy issues have been eased/expedited to allow continued service via online platforms such as Zoom, MS Teams, etc. Telehealth services have proved especially helpful for clients who need American Sign Language (ASL) services or have mobility issues.

San Francisco contracts with one residential treatment program that serves multiple Native American tribes. San Francisco is assisting this program, which recently became DMC certified, with technical assistance to develop expertise in Medi-Cal documentation and billing and use of ASAM criteria for assessments and referrals.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as “a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner.” CMS’ EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each DMC-ODS that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

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

San Francisco DMC-ODS PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs, one Clinical and one Non-Clinical. Both PIPs are in early stages of implementation, so it was premature to validate them. Following is a description of the main elements of each PIP:

PIP Table 1: PIPs Submitted by San Francisco

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	One	Increasing referrals to substance use residential treatment for Zuckerberg San Francisco General Hospital patients with severe substance use concerns
Non-clinical	One	Improving Efficiency of the Residential Treatment Admissions Process

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	San Francisco
PIP Title	Increasing referrals to substance use residential treatment for Zuckerberg San Francisco General Hospital patients with severe substance use concerns
PIP Aim Statement	Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) is a general acute care hospital providing a complete array of health services, including inpatient, outpatient, trauma, emergency, skilled nursing, diagnostic, mental health, and rehabilitation services for adults and children. ZSFG is a Level 1 trauma center and the City's safety net, serving anyone in need. Individuals present to ZSFG with a wide variety of acute medical concerns, as well as mental health and/or substance use issues. A significant proportion of patients who visit ZSFG have substance use issues, yet there is no systematic and/or standardized protocol for screening and referring patients with severe substance use concerns to substance use residential treatment. The aim of this PIP is to implement standardized screening for substance use residential treatment at ZSFG and thereby increase the proportion of patients referred to residential treatment.
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): The population on which this PIP focuses are adult patients who present to ZSFG with substance use issues on their problem list.	

DMC-ODS Name	San Francisco
San Francisco described ZSFG serves a diverse patient population. Staff at ZSFG provide services in more than 20 languages. Recent data from San Francisco indicates that ZSFG patients are ethnically and racially diverse: 18 percent are African American, 21 percent are Asian/Pacific Islander, 24 percent are Caucasian, and 31 percent are Hispanic. ZSFG serves about the same number of men as women (51 percent men, 49 percent women). About 57 percent of patients are under the age of 45, and about 34 percent are between 45 and 64 years old. ZSFG's inpatients payer mix includes those insured by Medi-Cal (39%), Medicare (19%), commercial insurance and other sources (9%). ZSFG's outpatient payer mix includes those insured by Medi-Cal (24%), Medicare (16%), commercial insurance and other sources (20%). ZSFG is the major health care provider for the estimated 150,000 people in San Francisco who are without health insurance coverage. Although about 8% of patients served at ZSFG are homeless, a large number of these uninsured patients are working full time.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Participate in ASAM Criteria-based screening for SUD treatment at ZSFG if, upon admission to ZSFG, the physician indicated a possible substance use condition on the patient's initial problem list. 2. Participate in an assessment at the Treatment Access Program (TAP) if referred there by the SUD staff screener at ZSFG. 3. Show for the intake appointment at residential treatment if referred there by the TAP assessor.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Conduct ASAM Criteria-based screening of ZSFG patients who were listed by their physician as having a substance use condition on their initial problem list. 2. Conduct trainings for screeners in ASAM Criteria for LOC referrals and in use of the new LOC screening form. 3. Refer hospital patients to TAP for a full ASAM Criteria-based assessment whose screening results indicate the need for SUD treatment.

PIP Interventions (Changes tested in the PIP)
4. Conduct ASAM Criteria-based assessments for hospital patients when indicated by the ASAM.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): 1. Establish ASAM Criteria-based screening function in ZSFG for patients who were listed by their physician as having a substance use condition on their initial problem list. Include development of screening form and required training of screeners in use of ASAM criteria and use of the screening form. 2. Develop and implement policies and procedures for referral of ZSFG patients to TAP for SUD assessments. Train the screeners to implement those referral procedures.

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
The proportion of patients presenting to ZSFG with a substance use issue on their problem list who are screened for SU residential treatment needs	NA	NA	NA	NA	NA	NA
The proportion of patients screened at ZSFG for SU residential treatment needs who are referred to TAP for further assessment	NA	NA	NA	NA	NA	NA

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
The proportion of patients who present at TAP from ZSFG and who are then referred to residential treatment	NA	NA	NA	NA	NA	NA
The proportion of patients referred by TAP to a residential treatment program who present at the program to begin the pre-admission process	NA	NA	NA	NA	NA	NA

Was the PIP validated?	☐ Yes ☒ No
Validation phase: ☒ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): This PIP involves the establishment and study of new clinical functions which had not previously existed at ZSFG. It is in an early phase of implementation, so validation of that implementation is not yet possible.	
Validation rating: NA ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.	
EQRO recommendations for improvement of PIP: The PIP focuses on a vital and complex set of processes with meaningful implications for hundreds of clients to be served. The PIP is well-designed and articulated and is in early stages of implementation. San Francisco should be careful to monitor the implementation for fidelity to the design, including both the interventions and the data collection.	
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: 1. Conceptualization of the PIP including detailed specifications for the interventions and performance measures. 2. Writing up the PIP within the structure of the new PIP worksheets.	

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

Non-Clinical PIP

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

DMC-ODS Name	San Francisco
PIP Title	Improving Efficiency of the Residential Treatment Admissions Process
PIP Aim Statement	The PIP seeks to reduce the wait time for clients to enter into residential treatment. This will involve tracking the wait time from the initial contact with a client to the Level of Care (LOC) assessment for residential treatment, and from the LOC assessment to opening a residential treatment episode at the four new DMC-ODS residential treatment providers.
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): The PIP will focus on the four residential programs newest to DMC, each of which serve adult clients at the ASAM 3.1 residential treatment level of care. They each serve different specialty populations as follows: Latino Commission Casa Quetzal – Specialty: Spanish speaking men Latino Commission Aviva House – Specialty: Spanish speaking women Epiphany – Specialty: Women and children (pre and postpartum) Friendship House – Specialty: Native American beneficiaries In the PIP Development and Implementation Tool, San Francisco provided a more detailed breakdown of the client population each treatment program serves in terms of age, gender, race/ethnicity, and diagnoses.	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): NA
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Residential treatment program staff will be retrained on the requirement to complete the Timely Access Log for each request for service, explaining the importance of this data for monitoring timely access. Quality management will produce and distribute compliance reports monthly to program managers for monitoring completion of the Timely Access Log. 2. Programs will hire additional staff and/or reallocate existing staff time to ensure adequate staffing to conduct timely intake LOC assessments. 3. Residential treatment program staff will be trained in the use of ASAM criteria for LOC placement, Medical Necessity for clinical decision making, and DSM-5 criteria for diagnoses. It is expected that these trainings will enable staff to become more accurate and efficient in completing the LOC assessment and will result in fewer assessments being returned for revisions. This will free up staff time so that they can initiate the LOC assessment more quickly for new clients. 4. The ASAM, Medical Necessity and DSM-5 trainings will support the staff to ensure that the LOC request forms are submitted with an appropriate justification that will facilitate fast approval, thereby reducing the wait time for admission into residential treatment.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): NA

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
The percentage of clients with an LoC assessment who are recorded on the Timely Access Log	NA	NA	NA	NA	NA	NA
The proportion of clients who get an assessment within 2 days of initial contact	NA	NA	NA	NA	NA	NA
The proportion of clients with an LoC approved after the first submission	NA	NA	NA	NA	NA	NA
The proportion of clients who wait 3 days or less from the LoC assessment to opening a residential treatment episode	NA	NA	NA	NA	NA	NA

Was the PIP validated?	☐ Yes ☒ No
Validation phase: ☒ PIP submitted for approval ☒ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):	
Validation rating: NA ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.	
EQRO recommendations for improvement of PIP: The PIP focuses on improving the timeliness of treatment admission processes for clients needing residential treatment. The PIP is well-designed and articulated and is in early stages of implementation. San Francisco should be careful to monitor the implementation for fidelity to the design, including both the interventions and the data collection.	
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: 1. Conceptualization of the PIP, including detailed specifications for the interventions and performance measures. 2. Writing up the PIP within the structure of the new PIP worksheets.	

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

CLIENT FOCUS GROUPS

CalEQRO conducted two client focus groups during the San Francisco DMC-ODS site review. The group surveys were administered through an online platform (Survey Monkey) several days prior to the group session, and the focus group was held through another online platform (Zoom) due to the COVID-19 pandemic that prevented in-person meetings. As part of the pre-site planning process, CalEQRO requested that each focus group include six to eight participants, the details of which can be found in each section below. San Francisco explained that youth have difficulty arranging privacy alone in their homes for an extended period of time, so arrangements were made for the youth group to be divided into two smaller segments of 45 minutes each rather than one larger group of 90 minutes duration.

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 discussion topics were structured in parallel with the survey questions that most of the client participants completed prior to the group session. The participants' responses and the subsequent discussion 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 Focus Group

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

Group One took place from 3:15-4:45 PM on Tuesday, August 18, 2020, through video conferencing on a Zoom platform. Four adult clients receiving DMC-ODS treatment from a variety of programs participated; however, only three completed the survey forms. Of the three, all were adults between 25 and 59 years of age. They were a mix of males and females and Whites and Latinos, all of whom had English as their primary language.

Number of participants: 4

Participants were first asked to rate each of nine items on a survey through an online platform prior to the group session. The survey items invited ratings on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. When the group session was later held, the facilitators used the items to structure a discussion, explaining that 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.	4.6	4-5
2. I got my assessment appointment at a time and date I wanted.	4.6	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.6	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.3	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.0	3-3
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.6	4-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4;6	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.6	4-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.3	4-5

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

- All participants said it was easy to obtain services. They each said they got assessed and into services quickly (within one week).
- All participants thought their counselors were great and very helpful.
- Participants said they would feel comfortable going to their counselor with an urgent matter.
- All participants said they would definitely recommend their program to a friend or family member.

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

- Counselors were diverse in both ethnicity and language
- One participant said the services were helpful for resuming his job

Recommendations for improving care included the following:

- Publicize the programs more in the community and advertise the suggestion box.
- Hold meetings where the counselors from all the treatment programs get together to discuss what is working and what challenges they are facing so they get suggestions from each other.
- More virtual groups. With COVID, the group classes have diminished, and participants miss them.

- Have better coordination with CPS and county programs to help reunite families.
- More one on one counseling.
- More outside support when not at the program.

Interpreter used for focus group 1: No

Focus Group Two: Youth Outpatient Focus Group

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

Group Two took place on Wednesday, August 19, 2020 through video conferencing on a Zoom platform. The group was held in two segments at San Francisco's request to accommodate constraints experienced by youth at home during the COVID Pandemic limited private room time. Two youth clients met with CalEQRO facilitators from 2:15-3:00 PM and three others met from 3:15-3:45PM. The youth clients were all under 18 years of age and were recent graduates of a DMC-ODS outpatient treatment program. They were a mix of male and female and a mix of White and Hispanic/Latino. They each spoke English as their preferred language.

Number of participants: 5

Participants were first asked to rate each of nine items on a survey through an online platform prior to the group session. The survey items invited ratings on a five-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. When the group session was later held, the facilitators used the items to structure a discussion, explaining that 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. Of the five participants, only two completed the survey.

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.0	4-4
2. I got my assessment appointment at a time and date I wanted.	4.5	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.5	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.5	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.0	4-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	5.0	5-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.5	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.0	4-4
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.5	4-5

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

- Participants said they were able to enter services right away.
- All gave positive remarks about their counselors and treatment program
- They were taught moderation at first in habits they had difficulty stopping. One participant still smokes but not while working and only in appropriate settings.

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

- Participants said their program provided treatment to them at flexible times that accommodated their work and school schedules. They each received group and individual counseling every week.
- Participants said they felt comfortable in the program, not judged, and it “did not seem like a drug treatment program” because it was more accepting.
- Counselors talked to participants about life problems outside of just addiction, which the participants said they greatly appreciated. They characterized their counselors as “kind and caring”.
- Although they had recently graduated from the program successfully, two participants said they still check in regularly for individual and group support sessions.
- Participants heard about MAT in group sessions but neither felt the need for it.
- Participants said the program involved their families in the treatment.

Recommendations for improving care included the following:

- Have healthier foods and since there is a kitchen, maybe cooking class to make healthy snacks.

- More field trips and outside activities.
- In person meetings with social distancing.
- Advertise more. Let people know the positive help the program has to offer

Interpreter used for focus group two: No

Client Focus Group Findings and Experience of Care

Overview

CalEQRO facilitated two client focus groups for this review, one with adult clients from a range of treatment programs, and one with youth clients who had recently graduated from outpatient treatment programs. Because of the health safety precautions required due to the COVID-19 pandemic, the format of the groups differed in several respects from what is usually done in onsite reviews. An online platform (Zoom) was used for video conferencing so that participants and facilitators were able to see and hear each other for interactions. The optimal number of participants was less in the videoconferencing format. San Francisco explained that youth had challenges finding a room at home where they could be alone for any length of time, so they were divided into two smaller focus group segments of 45 minutes each instead of one group of 90 minutes. The client survey form was completed by clients through an online platform (Survey Monkey) several days prior to the focus groups instead of onsite at the beginning of the group; approximately half the group participants did not complete the survey.

Access Feedback from Client Focus Groups

- Clients reported on the survey that they found it easy to access the treatment services they needed. They further expressed this sentiment in their comments during the focus group session.
- Clients said their programs had counselors who were diverse in both ethnicity and languages.
- Clients said the program provided treatment to them at flexible times that accommodated their work and school schedules.

Timeliness of Services Feedback from Client Focus Groups

- Clients reported in the survey that they received their services in a timely manner. The services they included in these endorsements were their initial assessment appointment and their first treatment appointment. They also reported feeling comfortable calling the program for help with urgent problems.
- Clients said they got assessed and admitted into treatment within one week.

- Clients said they received treatment services in a timely manner and received both individual and group sessions at least weekly.

Quality of Care Issues from Client Focus Groups

- Clients reported in the survey that their counselors were sensitive to their cultural background, they found it helpful to work with their counselors on solving problems in life, and that they can recommend their counselors to friends and family who might need support and help.
- Youth clients reported in the survey that their treatment programs informed them about the benefits of MAT, but the adult clients thought they could have been better informed.
- In the focus groups, participants uniformly said their counselors were “great”, “very helpful”, and “kind and caring”. They said they would definitely recommend their program to a friend or family member.
- One participant said the services were helpful for resuming their job
- Several clients described what seemed like a harm reduction approach to treatment. They were taught moderation at first in habits they had difficulty stopping. They felt comfortable in the program, not judged, and it “did not seem like a drug treatment program” because it was more accepting.
- Clients in the focus groups expressed appreciation for their treatment programs’ broad focus that included other life problems than just addiction. One participant said the services were helpful for resuming their job. A few others said their programs also got their families involved in their treatment.
- After the COVID-19 health safety precautions were instituted, clients noted (expressing disappointment) a reduction in group sessions and expressed the wish for more virtual groups. They also expressed the wish for more individual counseling and more in-person meetings with social distancing.
- Some clients expressed the wish for better coordination with Child Protective Services (CPS) and county programs to help reunite families.
- Several clients expressed the wish for more field trips and outside activities. They also expressed the wish for more outside support when not at the program.

Client Outcomes Feedback from Client Focus Groups

- Both the youth and adult clients reported in the survey that they are better able to do things they want because of the treatment services they received.
- Youth clients remarked they worked on their attitudes and their life skills as well as their addictions and have been sober for six months at the time of the focus group.

- Although the youth clients had graduated successfully from the program, they still check in with the program regularly for additional support sessions.
- All participants remarked they would call the program if they needed support.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
	Component	**Quality Rating**
1A	Service Access is Reflective of Cultural Competence Principles and Practices	PM
The Office of Equity, Social Justice and Multicultural Education (OESM) produced a FY 2019-20 Cultural Competency Plan Update with nine of the ten pages devoted to an impressive in-depth analysis of linguistic competencies across services and recommendations for improvements. Substance use services were not mentioned anywhere in the report. Regarding other aspects of cultural competency, the report stated very little other than “In July 2019, OESM will release a new Cultural Competence Report with a focus on how civil service programs and contracted CBO providers are integrating the National Standards for Culturally and Linguistically Appropriate Standards (CLAS) into their organizations. Whereas the reports from the past two years focused on Language Resources and Community Advisory Boards (both of which are elements of CLAS), the new report will be a broader assessment of the CLAS Standards, such as hiring/retention of diverse staff, quality control of language resources, data collection, etc.” The departure of the former Director of OESM and other personnel changes within BHS leadership, the formation of the Office of Health Equity (DPH - level), and later, the onset of the COVID pandemic, caused priorities within OESM to shift, thus delaying the completion of this CLAS Assessment report.		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
San Francisco reported it is still in progress, targeted for completion by early November 2020. One of last year's EQRO recommendations was to address service disparities for the API community. A listing of various analyses and plans were given in the Responses to Recommendations. San Francisco reported that implementation of those plans was interrupted by the COVID pandemic. San Francisco has many initiatives devoted to cultural competence. In August 2019, the Board of Supervisors established a countywide Office of Racial Equity. In the Department of Public Health, they have an active Cultural Competence Committee that meets monthly. They list many initiatives with diversity components, including a Racial Equity Champions program, Equity Leadership Team, Equity Governing Council Telehealth/Telepsychiatry Pilot, and a Workforce Development Plan However, it was unclear which if any of these programs had tasks directed towards substance use treatment services. The DMC-ODS or more broadly the behavioral health department would benefit from developing a comprehensive cultural competence plan to clarify shifting priorities under the COVID pandemic and indicate within that plan what initiatives and action plans pertain specifically to substance use services and the DMC-ODS.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
San Francisco met the Network Adequacy time and distance standards for outpatient and NTP services. It is a geographically compact county with a good public transit system. Residential programs have vans to facilitate outside essential visits as a way of maintaining retention in treatment. SF has several initiatives to meet the linguistic needs of the diverse populations they serve. San Francisco addressed public complaints during the previous year regarding wait times for residential treatment despite apparent vacancies. They brought four residential treatment provider programs into DMC-ODS certification and provided training for them in documentation and billing. They brought online a systemwide tracking mechanism with real-time information on residential treatment vacancies that shortened wait times. They expanded bed capacity for both residential treatment and stepdown recovery residences.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
San Francisco closely collaborates with a wide range of county departments and contractor organizations for outreach, CM, and care coordination. The DMC-ODS is organizationally structured within the Department of Public Health and collaborates with many county departments and CBOs on prevention initiatives such as harm reduction and overdose prevention. San Francisco works closely with health plans and physical health services (e.g., FQHCs, hospitals) to coordinate care and to promote MATs. San Francisco is part of an integrated behavioral health division that		

KC Table 1: Access to Care Components	
Component	**Quality Rating**
supports close coordination between mental health and substance use services for clients with co-occurring disorders and also supports several programs that provide concurrent treatment with single programs for both disorders. Notably, San Francisco works closely with many housing programs throughout the county to help clients find and maintain stable housing to support their recovery; these initiatives include harm reduction programs within Project Room Key and expansion of recovery residences for clients actively in outpatient treatment.	

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
San Francisco monitors timeliness from first contact to first face to face appointment for routine visits. Because most prospective clients first request treatment directly with their chosen provider, data entry and analysis are more challenging than in a county where the primary entry point is an access call center. In San Francisco, all county and contracted providers are required to use Avatar; this common technology platform makes the county's tracking efforts easier. The county reports that its median time from first contact to first offered appointment is three days; to first visit is also a median of three days. Its average number of days to first visit is longer at nine days due to some outliers whose circumstances led to longer times, but this average is still within the state standard of ten business days.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
San Francisco monitors the time from first request for methadone MAT to the first appointment. This is an especially important measure for San Francisco since methadone treatment is the predominant service in the DMC-ODS. San Francisco recognizes the urgency of requests for methadone, since prospective clients whose treatment requests are not met in a timely manner are likely to return to an addiction lifestyle that can be life-threatening. San Francisco reports that the mean and median times from first request to first appointment for an assessment are within the		

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
same day. Similarly, they report the median time from the assessment to first treatment visit are within the same day, although the average time is somewhat longer at 2.2 days due to some outliers whose circumstances resulted in longer wait times. In any case, all the statistics are well within the state standard of three business days.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	M
This measure requires each county to first refine a definition of urgent that can be operationalized and measured. San Francisco decided to define "urgent" as a request for admission to WM or NTP services. They report a median time of same day but an average time of 3.6 days due to some outliers with very long lag times and would suggest room for improvement in this area. CalEQRO suggested to San Francisco that they broaden their definition of urgent and shared with them how some other counties define it (e.g. ASAM severity ratings, when callers say it is urgent). CalEQRO also pointed out that the preponderance of San Francisco admissions to residential treatment are for level 3.5, which is defined by ASAM largely in terms of the acute and high-risk condition of the client. This would suggest that SF is receiving requests for treatment from a substantial number of clients with urgent conditions who are being regarded and counted as having routine conditions and warrants reconsideration.		
2D	Tracks and Trends Timely Access to Follow-Up Appointment after Residential Treatment	M
San Francisco tracks the percent and timeliness of stepdown transfers to outpatient treatment following discharge from residential treatment. San Francisco reports a 17 percent rate of stepdown transfers within seven days of discharge and a 25 percent rate inclusive of longer time frames. These percentages are somewhat lower than CalEQRO's analyses based on DMC-only claims, which yielded results of approximately six percent within seven days and 11 percent inclusive of longer time frames. San Francisco's results are slightly below the statewide average for DMC-ODS counties. San Francisco also tracks readmissions into residential treatment or relapse into WM, which showed a combined rate of 19 percent. The CalEQRO data are based upon the performance of HR360's residential treatment program, which was the primary DMC-ODS-Certified program during the year under measurement. Several other residential treatment programs were subsequently certified, and their data will become part of this measure in future years.		
2E	Tracks and Trends Data on Follow-Up and Re-Admission to Residential Withdrawal Managaement	M
San Francisco tracks this measure for its two primary residential WM programs—HR360 and Joe Healey. The HR360 program is located in the same facility as HR360's large residential treatment program, and most of the clients from their WM		

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
program are transitioned seamlessly to residential treatment upon discharge. The Joe Healey Program specializes in a more acute population withdrawing from severe alcoholism and/or benzodiazepines and requiring a longer length of stay. San Francisco tracks readmission rates for both programs. The combined results are similar to the average for all DMC-ODS counties statewide at approximately seven percent for all clients and 8.7 percent for DMC-ODS clients. A related measure is the percent of all beneficiaries who have three or more WM admissions without treatment at any other level of care. San Francisco's results are approximately two percent, which matches the statewide average for all DMC-ODS counties.		
2F	Tracks Data and Trends No Shows for Initial Appointment	PM
San Francisco is able to track the percent of callers requesting a first appointment who subsequently have a first visit. However, they are unable to track the difference between those who scheduled a visit and no showed and those who did not schedule an appointment. The Access Call Center does not use three-way calling to assist callers in making appointments and in recording those appointments. The provider programs do not have a way of opening a case as a pre-admit when making the first appointment and therefore are not easily able to track no shows.		

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
San Francisco has a well-designed QI Workplan and Evaluation with interconnections clearly delineated between goals, measurable objectives, action items with designated staff responsibilities, and results. San Francisco has a strong		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
QI unit and a strong research unit, each of which has talented and well-organized staff. The units have regular meetings with each other and with other units for coordination and are represented in executive management.		
3B	Data is used to inform management and guide decisions	M
San Francisco has a strong research unit that produces dashboards and other reports used regularly by management and other staff for decision-making and QI. San Francisco has a tradition in MH and SUD of strong clinical supervision. It is noteworthy that they developed audit tools to determine staff fidelity to the model for implementing ASAM criteria for assessment of severity levels and for client-treatment matching in referrals.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
San Francisco meets regularly with residential treatment providers and with a broad spectrum of other DMC-ODS providers, including meeting with their clinical line staff, clinical supervisors, and management. Topics of meetings include implementation of the DMC-ODS, adjusting to the COVID pandemic constraints, and Avatar use and redesign issues. San Francisco also meets with hospitals and FQHCs for coordination of care issues. They focus on the medical care of SUD clients, delivery of MAT in physical health care settings, and streamlining referral procedures from physical health care into SUD care. San Francisco supports a Client Council with which they meet regularly. The Council includes clients with lived experience of co-occurring MH/SUDs as well as family members. San Francisco meets and works closely with a wide range of county departments and community groups, including criminal justice agencies, social services, housing, and faith-based agencies. Together they coordinate outreach efforts to engage people with SUDs in prevention and treatment and to coordinate their treatment with other services.		
3D	Evidence of an ASAM continuum of care	M
San Francisco has an extensive continuum of care at all levels required by the Waiver STCs. They have been building further capacity in residential treatment beds, recovery residence beds, and outpatient slots. They measure and monitor client initiation, engagement, retention, and outcomes to ensure the sufficiency and effectiveness of their continuum of care. Their averages for these measures are higher than statewide averages for DMC-ODS clients despite San Francisco clients having higher rates of unemployment, homelessness, and co-occurring physical or mental health disabilities than statewide averages for DMC-ODS clients. San Francisco measures stepdown transitions from residential treatment, which are		

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
slightly lower than statewide averages. One of their residential WM programs is located in the same facility as one of their largest residential treatment programs, making it easier to effect seamless stepdown transitions. San Francisco provides and bills for some CM and recovery support services for clients and their families but needs to develop further capacity in these areas.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
San Francisco supports and encourages the delivery of MAT and seems to have effectively overcome the stigma attached to MAT approaches. Seven NTPs are the predominant treatment sites for Medi-Cal clients throughout the DMC-ODS. They primarily provide methadone as the addiction medicine of choice, although they also provide non-methadone addiction medicines when clients request them. The UCSF-contracted office-based induction buprenorphine clinic (OBIC) within the DMC-ODS does provide buprenorphine to many clients; after induction, the clients are referred to FQHCs for maintenance dosing. Some residential treatment programs, such as HR360, provide non-methadone MAT, although it is through their primary care clinic which receives the higher primary care rate (compared to a DMC-ODS certified outpatient program). Delivery of non-methadone MAT is more widespread within physical health care services. The street medicine team within SFDPH's Street Medicine and Shelter Health Program delivers buprenorphine to 100-200 clients per month in hotels, residential programs, and on the street. Numerous X-waivered providers, estimated at nearly two thirds of San Francisco's physicians, are able to deliver buprenorphine through primary care clinics and a range of non-profit organizations. E.D. Bridge Projects are operative in the emergency departments of all three hospitals, with protocols linking persons with nonfatal overdoses to OBIC and follow-up medications and counseling services. The county behavioral health pharmacy provides directly observed therapies for MAT and mental health medications during initial induction phases to ensure there are no side effects and that the medications are appropriate. The pharmacy remodeling was delayed by the COVID pandemic but will hopefully resume soon to expand its capacity to serve more clients. An Addiction Medicine Fellowship Program adds specially trained physicians in addiction medicine to the workforce in hospitals and primary care.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
San Francisco provides extensive training through workshops, case consultation and supervision to clinicians implementing ASAM criteria for screenings, assessments, and referrals. They also conduct chart audits to ensure fidelity of implementation, which efforts are made easier by inclusion of the six ASAM dimensions in the EHRs		

KC Table 3: Quality of Care Components

Component		Quality Rating
for assessment and treatment planning. San Francisco uses TPS and CalOMS data to measure clients' therapeutic alliance and progress in treatment and to initiate quality improvement activities for selected programs. Clients are provided with a range of LOCs, although the COVID crisis has prompted authorizations for more extensive lengths of stay. Claims data and TPS survey feedback point to high rates of client engagement. San Francisco uses a strong harm reduction approach that supports meeting clients in any stage of change.		
3G	Measures clinical and/or functional outcomes of clients served	M
San Francisco conducts an ongoing study of the success of its treatment programs, using CalOMS data to evaluate whether clients in treatment for at least 60 days maintain abstinence or reduce substance use. Results indicate that 75 percent of clients were achieving this goal. San Francisco reviewed the results by program, shared the results with each program, and for QI purposes followed up with a few programs whose results were relatively lower. San Francisco contracted providers are diligent in their completion of CalOMS discharge summaries and in maintaining a connection with their clients at discharge, as evidenced by their low rate of administrative discharges. Their administrative discharge rate of 7.9 percent is the lowest in California, which averages 46.6 percent statewide. Providers rated 65.4 percent of their clients at discharge as having completed treatment or having made satisfactory progress before leaving treatment without completion. This combined rate of positive results at discharge are compared to the much lower statewide average of 45.8 percent.		
3H	Utilizes information from client perception of care surveys to improve care	M
San Francisco took the initiative to develop and use a client feedback survey for QI several years ago that, in modified form, became adopted statewide as the TPS. San Francisco obtained high ratings from clients across the five TPS domains, similar to statewide averages. The ratings ranged from 80 percent to 90 percent positive per domain, with the relatively lower ratings for care coordination also being similar to statewide averages. San Francisco QI staff review the results by program and follow through with specific programs when their ratings indicate opportunities for improvements.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- San Francisco has a high penetration rate compared to the statewide average. Their system is structured with many entry points including, a call center, walk-in clinic, and direct calls to providers. Multiple agencies provide referrals, including an increasing number of navigation centers since COVID.
- San Francisco initiated significant expansion of many of its services during the previous year, including outpatient slots, residential treatment beds, and recovery residence beds. They also brought four of their residential treatment programs through DMC certification and the beginning of DMC billing.
- San Francisco makes extensive use of MAT. While its predominant DMC-ODS service is methadone MAT provided by NTPs, delivery of non-methadone MAT is also widespread, predominantly through non-DMC-certified physical health sites such as FQHCs and hospitals. The hospitals participate in Emergency Department Bridge Programs. San Francisco operates a showcase DMC-ODS buprenorphine induction center through its pharmacy, transferring stabilized clients to FQHCs for maintenance dosing.

Opportunities:

- COVID-19 presented San Francisco with multiple challenges that required the entire county to alter workflows, staffing patterns, and IS infrastructure. Specifically, staff required laptops and remote capabilities to be able to switch to working from home. Both county and contract providers experienced bandwidth challenges with working from home and attempting to access the EHR. The county onboarded over 300 civil service providers with Virtual Desktop Infrastructure (VDI) for connectivity. As these new patterns continue, San Francisco may learn which aspects of remote working may be worth continuing after the COVID pandemic recedes.
- San Francisco would benefit clients by strengthening its Access Call Center as one of the entry points to treatment, especially during the COVID pandemic when walk-in clinics are not as easily accessed. They should actively communicate the availability of the call center and promote its use to the public. San Francisco should obtain call center software to monitor call volume, wait times and abandonment rates as guides to staffing, per last year's EQRO recommendation. Staff should use three-way calling for warm handoffs when referring clients. Staff should complete the ASAM LOC Referral Data following screening and referral processes. San Francisco QI should conduct test calls for SUD conditions to the Call Center.

- San Francisco should develop a comprehensive Cultural Competence Plan, which they have not had for several years, rather than limiting themselves to annual updates that are narrowly focused. Last year they conducted an excellent study with recommendations for improving linguistic capacity. They began a plan to improve outreach to the API community that was interrupted by the COVID pandemic. They might consider using telehealth for some treatment functions with the API community, especially when treating monolingual clients for whom bilingual counselors are a scarce resource.
- When feasible, San Francisco should continue its service capacity expansion efforts, interrupted by the COVID pandemic. These efforts include to further grow their residential treatment and recovery residence beds to meet treatment demands. They should grow their intensive outpatient treatment, CM, and recovery support services. They should, when possible, resume their efforts to establish a sobering center and related innovative approaches to treating clients with methamphetamine use disorders. They should also pursue redesign of their pharmacy clinic for further capacity expansion.
- San Francisco began a clinical PIP focused on increasing and standardizing screening and referral processes for clients at San Francisco General Hospital with SUDs. This is an important set of processes for vulnerable clients at high risk and should be pursued with diligence.

Timeliness of DMC-ODS Services

Strengths:

- San Francisco implemented FindTreatmentSF during the previous year, which is an electronic system for displaying real-time open treatment slots/beds that enable staff at any entry point to schedule clients for initial assessments and treatment admissions. This was designed to prevent undue wait times when slots/beds are available.

Opportunities:

- San Francisco began a new non-clinical PIP focused on streamlining and strengthening the intake and assessment processes in four residential treatment programs that are newly DMC-certified. The PIP involves training in use of an Access Log, an ASAM criteria-based LOC form, medical necessity criteria, and skill in making diagnostic decisions.

Quality of Care in DMC-ODS

Strengths:

- San Francisco is committed to using ASAM Criteria in its assessments and reassessments for client-treatment matching. Their commitment to implementation of ASAM Criteria is evidenced in training, supervision, and chart audits to ensure quality implementation.
- San Francisco continues to innovate model programs that address challenging client conditions. These include harm reduction approaches using alcohol management within Project Room Key for homeless clients with severe alcohol use disorders, contingency management for clients with methamphetamine use disorders, and several harm reduction approaches to other types of SUDs. Since the COVID pandemic, navigation centers have grown to replace shelters and serve as referral sources for substance use treatment when appropriate.
- San Francisco has invested in an exceptionally strong staff within its research and quality improvement units, although many of those staff were temporarily detailed to COVID-related efforts during recent months. Nevertheless, these units maintained many useful timeliness and outcome data reports for management decision-making and QI. Their QI Workplan and Evaluation was well-conceived and well-written.
- Clients uniformly rated their counselors and treatment programs as delivering treatment in a high-quality manner. Clients reiterated these perceptions in their comments during client focus groups facilitated by CalEQRO.

Opportunities:

- In response to COVID-19 health safety precautions, San Francisco began using telehealth for many of their outpatient treatment services. They provided early assistance to providers in documenting and billing for these services. Their strong research team is able to produce robust telehealth trend reports that provide information that may be helpful with efforts to continue some telehealth services after the COVID crisis recedes.
- San Francisco continues to face challenges in hiring sufficient behavioral health staff for county and contractor positions. Some challenges, such as those posed by the high cost of living in the city, will continue. San Francisco should enlist the support of HR and leadership in streamlining their position approval and hiring processes
- With uncertainty about whether Epic will be implemented for DMC-ODS services, San Francisco needs to continue improving Avatar functionality, streamlining workflows, and improving screen functionality by developing Netsmart widgets and console features.

- Discussions with the HIE about how to interface have begun, with consideration of 42CFR.2 restrictions. San Francisco should consider how the functionality in Care Connect might help them with their HIE and other interface plans to support care coordination for their clients.

Client Outcomes for DMC-ODS

Strengths:

- CalOMS data indicate that San Francisco clients have a significantly higher rate of homelessness, disability, and unemployment compared to the statewide average. Considering this, it is especially noteworthy that claims data indicate San Francisco achieves higher rates of initiation, engagement, and retention in treatment.
- The CalOMS administrative discharge rate is significantly lower than statewide (7.9 percent compared to 46.6 percent). This indicates that county staff are continuing to excel at training and supervising contract provider staff on administering the CalOMS summary forms at intake and discharge. It also indicates that CalOMS data results are likely to be accurate and useful representations of client progress in treatment.
- Results of CalOMS discharge data indicate substantially higher provider ratings of positive client progress in treatment than statewide (65.4 percent vs. 45.8 percent). San Francisco went further to conduct pre-post studies across most of their treatment programs of how well clients were able to maintain abstinence or reduce substance use while in treatment. The data indicate that approximately 75 percent of clients who participated in some form of treatment for at least 60 days were able to maintain abstinence or reduce their substance use while in treatment.
- Adult clients rated their outcomes positively (“better able to do things”) in the TPS.

Recommendations for DMC-ODS for FY 2019-20

1. San Francisco continues to face challenges in hiring sufficient behavioral health staff for county and contractor positions. Some challenges, such as those posed by the high cost of living in the city, will continue. San Francisco should address staffing challenges by:
    a. Enlisting the support of HR and leadership in streamlining their position approval and hiring processes.
    b. Reviewing contractor staffing levels and rates to improve staff recruitment and retention.

    c. Ensuring sufficient IS staffing to provide the necessary support and further development of Avatar implementations.

2. San Francisco would benefit clients by strengthening its Access Call Center as one of the entry points to treatment, especially during the COVID pandemic when walk-in clinics are not as easily accessed. San Francisco should strengthen the Access Call Center by:
    a. Actively communicating and promoting the availability of the call center to the public.
    b. Obtaining call center software to monitor call volume, wait times and abandonment rates as guides to staffing, per last year's EQRO recommendation.
    c. Using three-way calling for warm handoffs when referring clients.
    d. Completing the ASAM LOC Referral Data following screening and referral processes.
    e. Conducting test calls for SUD conditions to the Call Center.
3. San Francisco conducts many ongoing cultural competence activities. However, it would benefit from developing a comprehensive Cultural Competence Plan for its substance use treatment services which they have not had for several years, rather than limiting themselves to annual updates that are narrowly focused. If a Plan is undertaken that includes attention to mental health services, care should be taken to give explicit attention to substance use treatment activities. The Plan should include efforts at prioritization of activities during the COVID time of stretched resources.
4. When feasible, San Francisco should continue service capacity expansion interrupted by the COVID pandemic. These efforts should include:
    a. Further grow residential treatment and recovery residence beds to meet ongoing high demands.
    b. Grow intensive outpatient treatment, CM, and recovery support services.
    c. Resume efforts to establish a sobering center and related innovative approaches to treating clients with methamphetamine use disorders.
5. San Francisco began two new PIPs that focus on important processes for vulnerable clients at high risk. The clinical PIP focuses on increasing and standardizing screening and referral processes for clients at San Francisco General Hospital with substance use conditions, and the non-clinical PIP focuses on streamlining and improving the timeliness of admission processes into residential treatment. These are important processes for vulnerable clients at high risk and should be pursued with diligence. Pursue existing PIPs, using EQRO TA early and frequently.
6. Continue improving Avatar functionality, streamlining workflows, and improving screen functionality by developing Netsmart widgets and console features.

    a. San Francisco might also explore how existing HIE functions in Avatar and Epic might be deployed to create the bridges needed between the two EHR systems for care coordination.

7. San Francisco's Community Behavioral Health Services (CBHS) Pharmacy serves a vital role in providing timely and flexible access to medications for clients with serious substance use and mental health disorders, including directly observed inductions for clients taking those medications. San Francisco should proceed as quickly as possible with the pharmacy remodel recommended in last year's DMC EQRO review to expand its service capacity for the benefit of the community. Especially during the COVID-19 pandemic with its associated higher rates of suicides and overdoses, the importance of the pharmacy's delivery of MATs cannot be overstated.

8. San Francisco's Public Health Department is implementing the recent passage of SB 159 by the State Legislature, which provides prophylaxis guidelines for pre-exposure and post-exposure to HIV. San Francisco should undertake a feasibility study to evaluate the potential client benefits and operational feasibility of implementing SB 159 provisions at CBHS Pharmacy for SUD clients at high risk for HIV/AIDS.
    a. The study should then be provided to the County Public Health Officer and appropriate staff for consideration.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: County Highlights

- Covid-19's Impact on the Use of Telehealth and Telephone Services in San Francisco's Behavioral Health Services

Attachment D: Continuum of Care Form

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO On-site Review Agenda

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

Table A1: CalEQRO Review Sessions - San Francisco DMC-ODS
Opening session: System Overview, Significant Changes and Initiatives, Responses to CalEQRO DMC Recommendations from Previous Review, Performance Measure Results from FY2018-19
Quality Management: QI Workplan and Evaluation, Cultural Competence Plan, Timeliness Assessment, Network Adequacy
Clinical Line Staff: DMC-ODS impact on staff and on services to clients, and involvement of line staff in ongoing DMC-ODS design and QI efforts
ISCA/Billing/Fiscal: ISCA Review, EHR status, telehealth, interoperability with MH and primary care, contractor access, HIE, claims processing, performance measures
General data use: data analytics staffing, processes for analytic requests and prioritization, development and use of dashboards and other reports
Coordination with Health Plan and Physical Health Care Services: MOUs for interconnections and data sharing; system within primary and acute care for working with SUD clients; outreach to and treatment of high need populations; opioid safety coalition
Medication-assisted treatments (MATs): MAT client triage policies for admission, type of addiction medicine, and discharge; non-methadone MAT provider capacity, service and billing challenges, utilization data; ED Bridge activities, telemedicine support, pharmacy access
Recovery Residences and other Housing Support: Overview of housing initiatives for persons recovering from addictions; status of recovery residences
Adult client focus group: Clients from a range of outpatient and residential treatment programs
Youth client focus group: Clients from a range of outpatient treatment programs
Access Center: Group discussion with managers and line staff of Access Call Center regarding workflow for interviewing, screening, and referring callers; data access and entry, and data systems for tracking timeliness metrics
Withdrawal Management: Discussion with managers regarding client admission policies; processes and documentation workflows; client discharge planning policies; coordination and data tracking for referrals and linkages to other services
Coordination with mental health services: Bi-directional referral processes, coordination of care, integrated concurrent treatment programs for co-occurring disorders, data sharing

Contract Provider Directors: Use and effectiveness of ASAM criteria; DMC-ODS impact on treatment services, documentation, staffing and productivity; EHR implementation and data uploads; bi-directional communications with county
ASAM Continuum and Fidelity: Review Continuum of Care form and discuss related service delivery activities and strategies; implementation of new levels of care and capacity expansion; training in ASAM criteria for client placement decisions
Performance Improvement Projects: Status and progress with new PIPs and technical assistance
Wrap-up and Exit Sessions: Questions needing clarification, overview of strengths and opportunities, review next steps, obtain feedback on review processes

Attachment B: Review Participants

CalEQRO Reviewers

Tom Trabin, Ph.D., MSM, Lead Reviewer and Deputy Director, DMC-CalEQRO
Rama Khalsa, Ph.D., Quality Reviewer and Director, DMC-CalEQRO
Melissa Martin, Ph.D., Senior IS Reviewer
Harriet Markell, Quality Reviewer
Laura Bemis, 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.

Table B1: Participants Representing San Francisco			
Last Name	**First Name**	**Position**	**Agency**
Absher	Michelle	Nurse Manager	PRC Joe Healy
Akiona	Lynn	Counselor	Horizons Unlimited
Alcorn	Radawn	Director of Primary Care Behavioral Health	SFDPH
Almeida	Angelica	Director of Forensic/ Justice-Involved BHS	DPH-BHS
Anderson	Portia	Counselor	HR360
Ayankoya	Josephine	Interim Director, OESM	DPH-BHS
Barack	Michael	SUD Training Officer	DPH-BHS
Barteaux	Maria J.	Billing Manager	DPH-BHS
Batongbacal	Edwin	Director of AOA SOC	DPH-BHS
Benwell	Stephen	Withdrawal Management Counselor	HR360
Blancas	Sal	Director, Men's Services	Latino Commission
Nigusse Bland	Anton	Director for Mental Health Reform	UCSF
Bleecker	Tom	Assistant Director - Research & Evaluation	DPH-BHS
Cai	Shirley (Yu Xian)	CBHS Billing Analyst	DPH-BHS
Carnini	Peter	Clinical Supervisor	Stonewall Project
Chattfield	Garrett	Deputy Director and Interim BHS Compliance Officer	DPH-BHS
Ciprez	Luis	Counseling Supervisor	Latino Commission
Cozzie	Marjorie	Clinical Supervisor	Fort Help
Cruz	Angelica Gutierrez	Intake Counselor	SFDPH
De La Rosa	Liliana	QI Coordinator	DPH-BHS
Desmond	Suzi	Adult Services Program Director	Epiphany Center

Table B1: Participants Representing San Francisco			
Last Name	**First Name**	**Position**	**Agency**
Dixon	James	Director of Residential Services (890 Hayes)	HR360
Donald	Fiona	San Francisco Health Plan	SFHP
Dubon	Erik	ODS Project Manager	DPH-BHS
Dunkin	Charlie	Clinical Social Worker	UCSF Alliance Health Project
English	Alicia	Behavioral Health Manager	SF Health Plan
Evans	Danielle	Director, Residential Stepdown	HR360
Eveland	Joanna	Medical Director - CMHC	SFDPH
Foster	Doug	Counselor	Stonewall Project
Frederico	Gloria	Director of Private Provider Network	SFDPH
Garcia	Braulio	Behavioral Health Services Manager	Alliance Health Project
Geier	Michelle	Psychiatric Clinical Pharmacist Supervisor	SFDPH
Gilgenberg-Castillo	Kimberly	Clinical Supervisor	UCSF Citywide
Gilmore	Pamela	Division Director	Bayview Hunters Point Foundation
Gonzalez	Ana	Deputy Medical Director	DPH-BHS
Gorndt	Joseph	Assistant Auditor and Acting Data Sharing Officer	DPH-BHS
Gruber	Valerie	Clinical Professor, Dept. of Psychiatry	UCSF – STOP
Guinn	Karen	Counselor	Fort Help
Guzman	Jose Luis	Program Manager, SUDS System of Care	DPH-BHS
Hammer	Hali	Director of Ambulatory Care	SF Health Network
Weisbrod	Heather	Acting Director for TAY SOC	DPH-BHS
Hoffman	Robert R	Director of SAS	SFAF

Table B1: Participants Representing San Francisco			
Last Name	**First Name**	**Position**	**Agency**
Hom	Kellee	Clinical Health Informaticist	DPH-BHS
Icabalceta	Berman	Intake Coordinator	Latino Commission
Inman	Lisa	Deputy Medical Director, SFHN	DPH-BHS
Lam	Sherry	Epidemiologist/ SUD Analyst	DPH-BHS
Lovoy	Chris	Director of School-Based Mental Health Services	DPH-BHS
Ly	Joanna	Clinical Supervisor	UCSF- OTOP
Martin	Judith	Medical Director, Substance Use Services	DPH-BHS
Martin	Marlene	Assistant Clinical Professor Addiction Care Team Director	UCSF
Meyer	Jeff	TAP Authorization Unit	DPH-BHS
Mitchell	Terry	Quality Assurance Compliance Director	Bayview Hunters Point Foundation
Mosley	Kevin P.	Director of Clinical Operations	Stonewall Project
Mosqueda	Annette Goldman	Clinical Psychologist and Consultant	Horizons Unlimited
Moughamian	Alice	Director, Sobering Center	SFDPH
Murdock	Craig	Director, SF Health Network-Behavioral Health Access Programs	DPH-BHS
Pariseau	Paul	Addiction and Substance Abuse Counselor	Bayview Hunters Point Foundation
Pating	David	Addiction Psychiatry Specialist, SUD Services	SFDPH-BHS
Pelote	Andre	SUD Compliance Manager	DPH-BHS

Table B1: Participants Representing San Francisco			
Last Name	**First Name**	**Position**	**Agency**
Perez	Linda	Clinical Director, Family Treatment Program	Epiphany Center
Perez	Rita	Program Manager, SUD CYF System of Care	DPH-BHS
Ramos	Louie	Counselor	DSAAM
Romero	Isabella	Counselor	Citywide
Rose	Monica	Director, Research & Evaluation	SFDPH
Saenz	Gilbert	Counseling Supervisor	BAART
Shapiro	Brad	Medical Director, OTOP	UCSF - OTOP
Sherwood	Deborah	Director of Quality Management	DPH-BHS
Shone	Kevin	Clinical Supervisor	Alliance Health Project
Silk	Kathleen	Managing Director of Clinical Programs	HR360
Silva	Michael	Counselor	OBIC
Simmons	Marlo	Acting Director, Behavioral Health Services	DPH-BHS
Sisic	Hasia	Program Director/Nurse Manager	DPH-BHS
Smith	David	Pharmacy Director, BHS	DPH-BHS
Snead	Laurel	Principal Administrative Analyst	DPH-BHS
Snyder	Hanna	Addiction Medicine Fellow	UCSF
Soran	Christine	Medical Director OBIC	UCSF - OBIC
Spohn	John	Counselor	Curry Senior Center
Stillwell	James	SUD Fiscal Analyst	DPH-BHS
Swift	Mary	Clinical Supervisor	HR360
Temple	Kyle	Program Manager	Stonewall Project

Table B1: Participants Representing San Francisco			
Last Name	**First Name**	**Position**	**Agency**
Thompson	Avis	Eligibility Worker	SFDPH
Tompkins (Andy)	David	Addiction Psychiatrist	UCSF
Torres	Mauricio	IT Business Analyst	DPH-BHS
Troung	Michelle	TAP Nurse Practitioner	DPH-BHS
Turner	Shannon	Nurse	PRC Joe Healy
Tuszynski	Ann	Clinical Director	Curry Senior Center
Valdez	Anna	Medical Director	HR360
Velez	Elissa	Managed Care Policy and Planning Coordinator	DPH-BHS
Voelker	Kimberly	Ambulatory Care Applications Manager	DPH-BHS
Yoongjung	Kim	Assistant Director BHS - Adult/Older Adult System of Care	DPH-BHS
Yu	Teresa	Acting Director of MHSA	DPH-BHS
Zevin	Barry	Medical Director Street Medicine	DPH-BHS

Attachment C: County Highlights

Covid-19's Impact on the Use of Telehealth and Telephone Services in San Francisco's Behavioral Health Services

Prepared by BHS Quality Management Research & Evaluation Unit

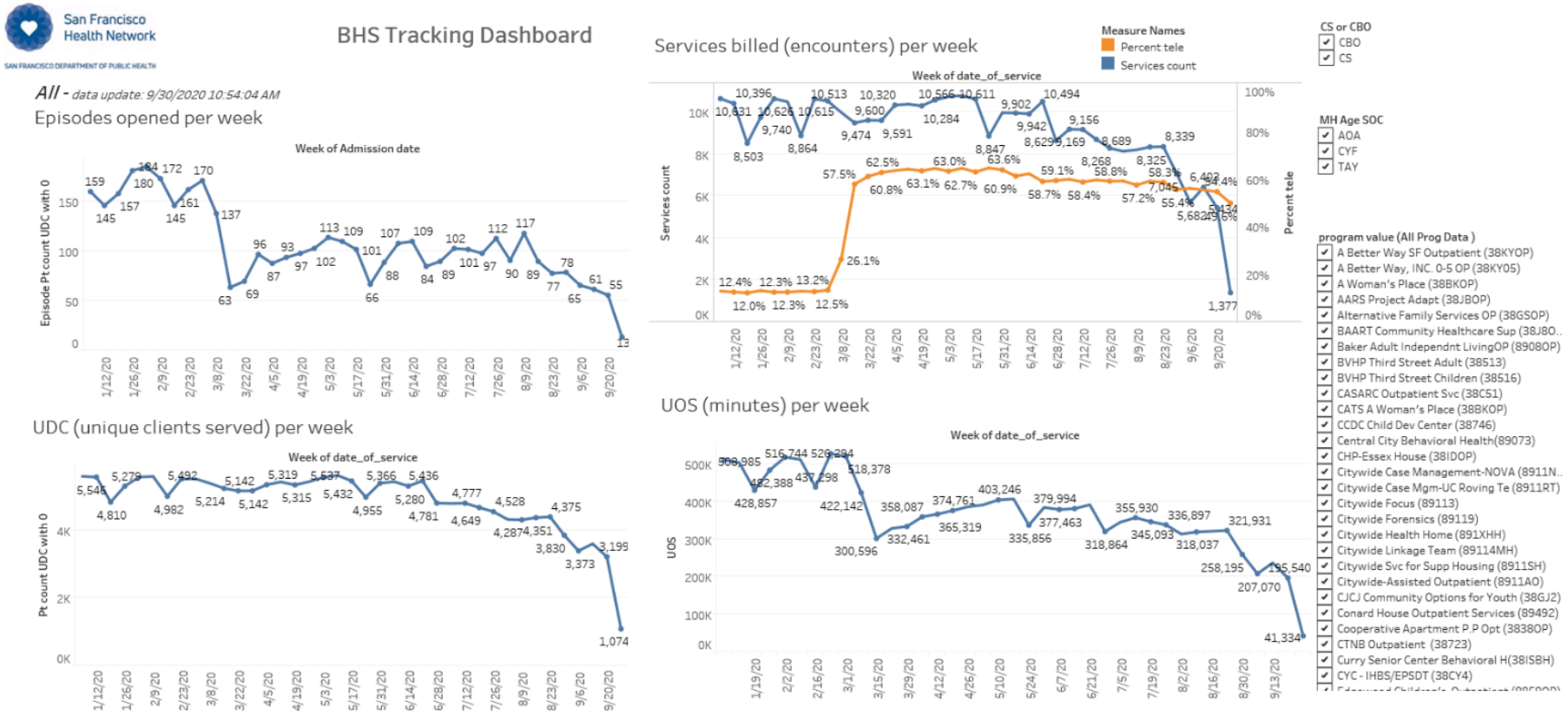
In response to the COVID-19 pandemic, many BHS outpatient services are now being delivered via telehealth and telephone, as opposed to in-person.[4] Prior to March 2020 (when the Shelter in Place order became effective), about 12% of Mental Health outpatient services were delivered remotely, compared to about 60% after March. To help us understand the effect of shelter in place and providing services in a pandemic, we have analyzed service delivery data from the Avatar database (our EMR). The BHS Tracking Tableau dashboard (see screenshot below) contains weekly totals for Mental Health Outpatient programs displaying:

- Number of episodes opened;
- Unduplicated clients served;
- Minutes of services provided (units of services); and
- Number of service encounters, including the proportion of those services that were provided by telephone or telehealth.

The impact of the Shelter in Place (SIP) health orders on services within the mental health outpatient clinics can be clearly seen in the graphs below. Many fewer episodes were opened, and a much greater proportion of services were delivered by telehealth/telephone. The number of unique clients served stayed relatively constant (until it dipped around June), but the length of sessions decreased markedly.

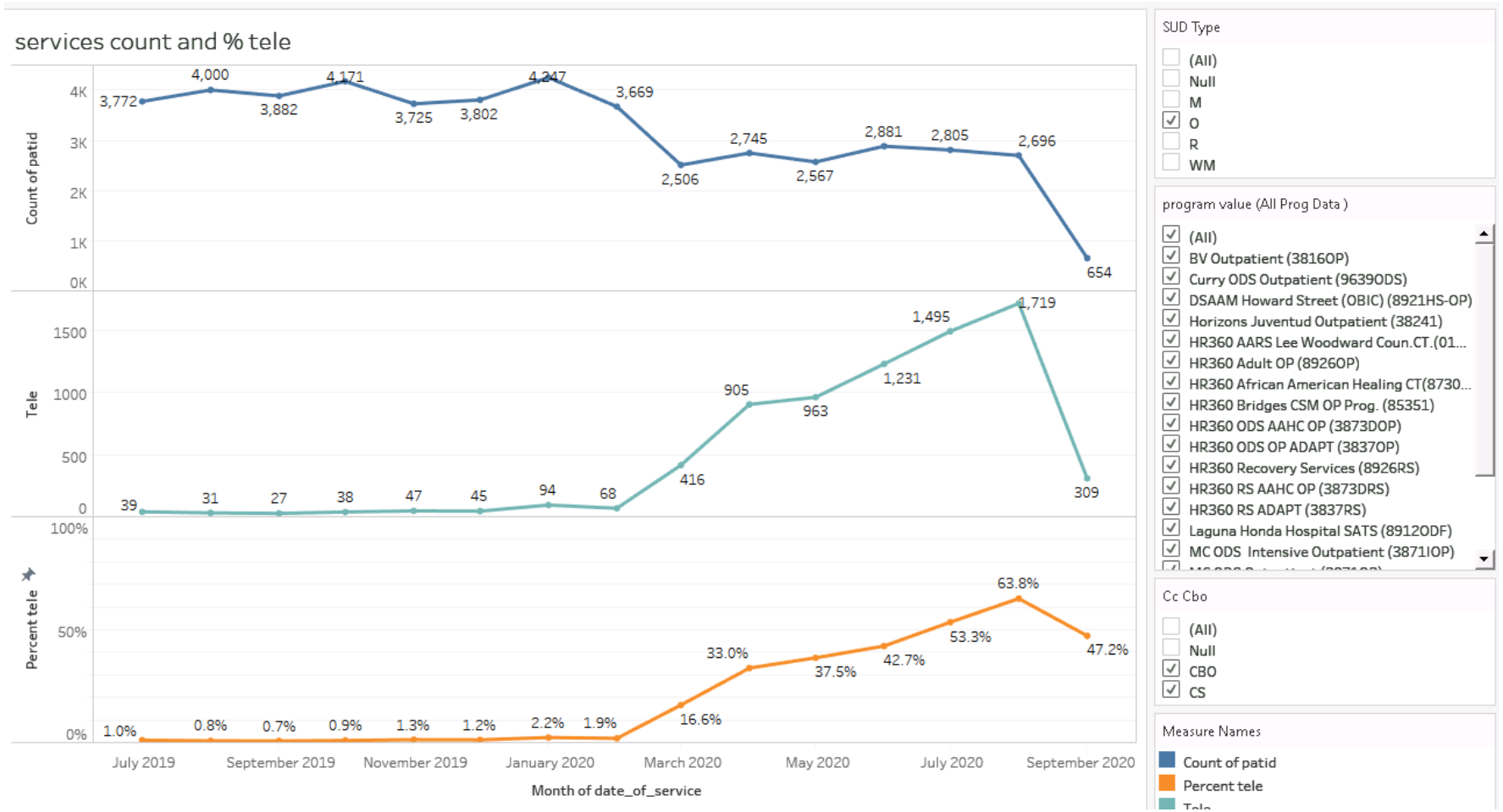
This dashboard is posted to the SFDPH Tableau server, where it is available for review by BHS leadership staff who request access. It allows users to choose specific programs or groups of programs to view data on their performance and it is being used for a variety of purposes including tracking and planning.

[4] For the purposes of this report, both Telephone and Telehealth are considered together and referred to as "remote."



It is important to note that because of delays entering services into Avatar, all numbers for the last several weeks (on the right side of the graphs) are lower than actual because of delays entering data and will likely be revised upwards as more providers enter services data.

Very similar effects appear in the SUD system. The dashboard screenshot below profiles the number of services provided (blue line), the number of those services delivered via telephone or telehealth (green line) and the associated percent (orange line). In the screenshot, the dashboard displays only Outpatient SUD services -- excluding Methadone, Residential, and Withdrawal management. Although Methadone clinics are providing some counseling services remotely, dispensing of medications takes place in person.



We have undertaken further analyses to learn more about how remote services are being provided within BHS.

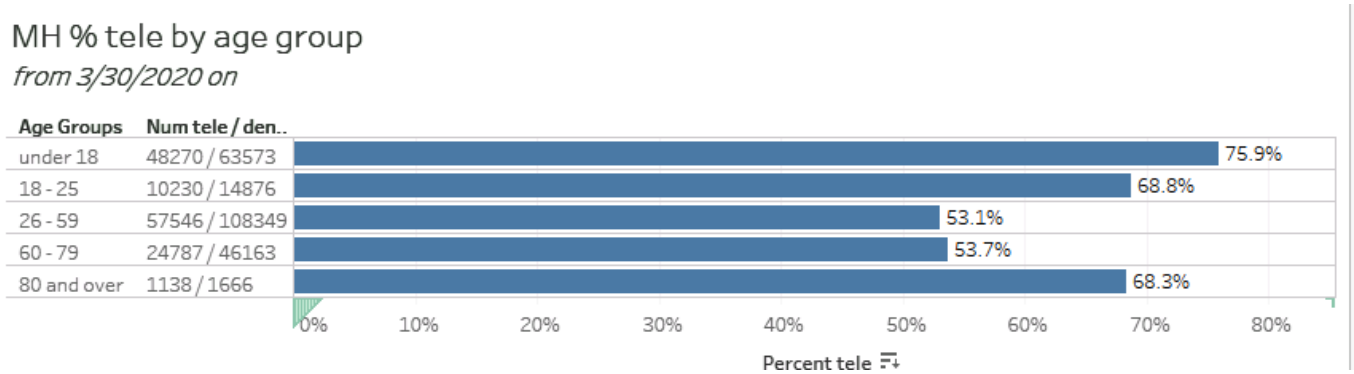
Provider type: BHS provides services through a network of Civil Service (county-run) clinics and contracted Community Based Organization (CBOs) providers. The data suggest that the CBOs and Civil Service programs provide remote services at approximately the same rate.

Race: We aggregated clients by their racial/ethnic background to explore possible disparities in service provision. The following Table shows the proportion of clients by race at outpatient clinics who received telehealth services from April to Sept 2020. The data suggest that telehealth services tend to be used at very different rates between different client racial groups. These differences are apparent in both Systems of Care, but are particularly noticeable within the SUD system.

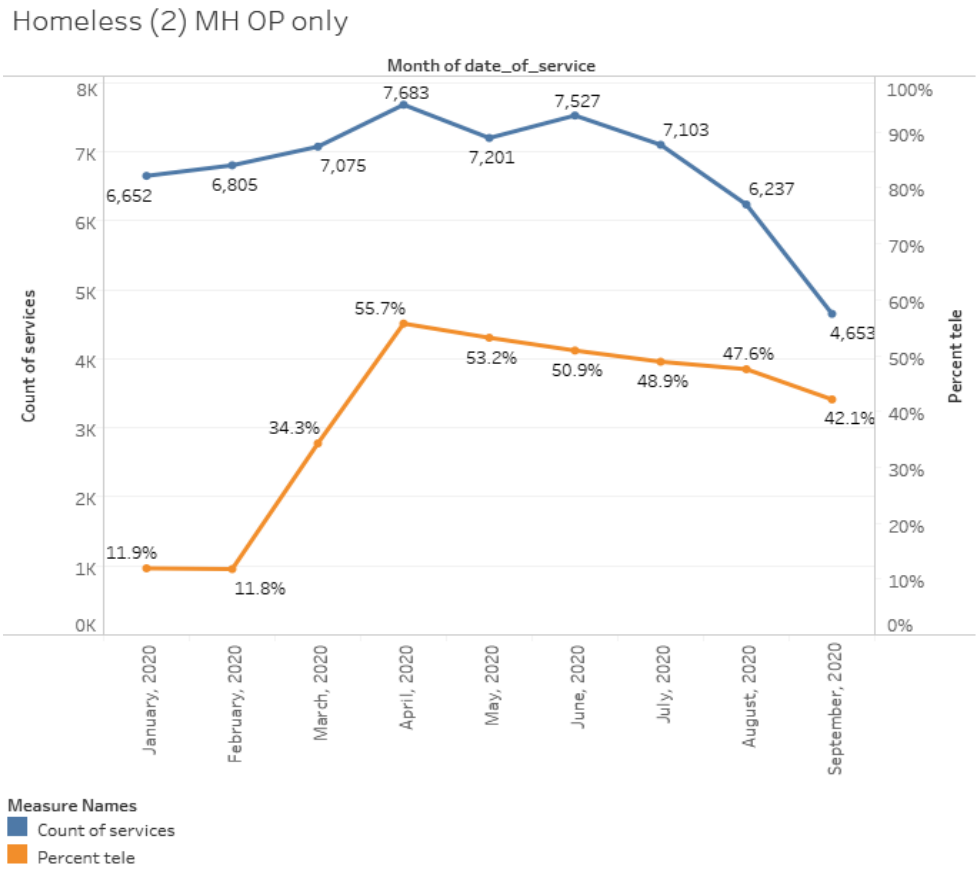
	MH - OP		***SUD - OP***	
CLIENT RACE	*% tele*	*Num tele / all*	*% tele*	*Num tele / all*
MULTI-ETHNIC	64.4%	*3299 / 5124*	54.6%	*239 / 438*
LATINX	65.5%	*34132 / 52078*	32.1%	*1258 / 3915*
ASIAN	59.0%	*28054 / 47552*	62.4%	*459 / 736*
WHITE	57.8%	*34136 / 59017*	53.3%	*2703 / 5068*
BLACK / AFRICAN AMERICAN	57.3%	*24448 / 42669*	58.3%	*1504 / 2580*
NHOPI	52.0%	*656 / 1261*	59.6%	*106 / 178*
NATIVE AMERICAN	51.0%	*1433 / 2812*	49.0%	*123 / 251*
OTHER	65.4%	*1602 / 2448*	67.7 %	*86 / 127*
MISSING / UNKNOWN	69.1%	*13183 /19703*	15.6%	*176 / 1121*

Gender: Telephone/ telehealth services are provided at a higher rate to women (64% MH, 68% SUD) than men (57% MH, 38% SUD).

Age groups: Remote services are provided to outpatient mental health clients under the age of 18 at a higher rate than other age groups (see below).



Homeless: The number of homeless people receiving outpatient mental health services has decreased, as has the number of services given to the homeless, and the percentage of those services that are provided by telehealth.



We have not explored the underlying reasons for these differences. They might relate to differences in client acuity/severity among different groups, differential access to telephone equipment by different groups, different cultures/preferences among providers and their agencies, or other reasons. Providers may be more likely to meet clients in person at clinics if the clients are more severely disturbed, more emotionally fragile, or are less likely to be able to manage scheduling and keeping appointments over the phone.

In order to understand whether the population of clients served by BHS has changed post-COVID and the SIP orders, we compared the composition of the clients served during January through February to April through May 2020.

These two cohorts may have some overlap, but the analysis is not longitudinal – the clients served during those time periods are simply treated as two serial cross sections. Also, this analysis does not consider whether clients were served in person or remotely, via telehealth – just that the clients received a billed service during the interval.

		UDC	UDC Homeless	Race	Top MH diagnoses	Primary language
Mental health outpatient services	Pre covid Jan-Feb 2020	9988	1546	White 2637 Asian 2082 Latinx 2151 Black 1836	Mood 4345 Psychosis 2878 PTSD 2434 Anxiety 2233	English 6552 Spanish 994 Cantonese 839 Russian 212 Vietnamese 104
	Post covid Apr-May 2020	9166	1386	White 2293 Asian 2001 Latinx 1979 Black 1613	Mood 3837 Psychosis 2785 PTSD 2212 Anxiety 1996	English 5867 Spanish 941 Cantonese 817 Russian 123 Vietnamese 109
	Difference N (%)	*-822 (-8.2%)*	*-160 (-10.3%)*	*White -344 (-13.0%)* *Asian -81 (-3.9%)* *Latinx -172 (-8.0%)* *Black -223 (-12.1%)*	*Mood -508 (-11.7%)* *Psychosis -93 (-3.2%)* *PTSD -222 (-9.1%)* *Anxiety -237 (-10.6%)*	*English -685 (-10.5%)* *Spanish -53 (-5.3%)* *Cantonese -22 (-2.6%)* *Russian -89 (-42.0%)* *Vietnamese +5 (+4.8%)*
SUD outpatient services	Pre covid Jan-Feb 2020	697	220	White 272 Asian 31 Latinx 162 Black 160	Stimulant 323 Alcohol 293 Opioid 194 Cocaine 125 Cannabis 123	English 586 Spanish 53
	Post covid Apr-May 2020	569	178	White 216 Asian 31 Latinx 132 Black 130	Stimulant 251 Alcohol 243 Opioid 173 Cocaine 103 Cannabis 91	English 481 Spanish 44
	Difference N (%)	*-128 (-18.4%)*	*-42 (-19.1%)*	*White -56 (-20.6%)* *Asian 0 (0%)* *Latinx -30 (-18.5%)* *Black -30 (-18.8%)*	*Stimulant -72 (-22.3%)* *Alcohol -50 (-17.1%)* *Opioid -21 (-10.8%)* *Cocaine -22 (-17.6%)* *Cannabis -32 (-26.0%)*	*English -105 (-17.9%)* *Spanish -9 (-17.0%)*

As can be seen, the number of clients served decreased between the two periods, by -8.2% for MH and -18.4% for SUD services. The proportion of Asian clients decreased the least, compared to White, Latinx, and Black clients. Among diagnoses for MH clients, the largest decreases were Mood and Anxiety disorders, with the least decrease seen among clients with psychotic disorders. This suggests that during April and May, at least, providers may have made special efforts to ensure that they remained in contact with their clients with psychotic disorders. Among SUD clients, the least decrease was seen among opioid users. Looking at clients' language, the largest decrease occurred among MH clients with a preferred language of Russian, while MH clients who spoke Cantonese barely decreased, and the number of Vietnamese speaking clients actually increased slightly.

As with the findings about differential utilization of telehealth services among different cohorts of clients explored earlier in this report, we do not fully understand the reasons behind the differences in service utilization among different groups pre- and post-COVID. To ensure that Behavioral Health services are provided equitably, the composition of the BHS cohort should continue to be monitored to learn if the effects noted above are random artifacts or if they are the effect of some underlying barrier to services.

To understand these issues more fully, we have fielded a survey to our providers about their experiences providing telehealth services, the results of which will be available in late Fall of 2020.

Attachment D: Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: **San Francisco** Review date(s): **August 18-20**

Person completing form**: Judith Martin and Laurel Snead**

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

Percent of all treatment services that are contracted: 100%

<u>County role for Access</u> and coordination of care for persons with SUD requiring social work/linkage to coordinate care and ancillary services.

Describe county role and functions linked to access processes (Access Call Center) and coordination of care linked to access services:

County offers central access program with walk-in hours on weekdays, as well as professional/faxed referrals. We also support 'no wrong door' access directly at programs. County offers support for primary care by doing buprenorphine inductions and stabilization at 1380 Howard, using our BHS pharmacy.

<u>Case Management</u>- Describe if it's done by DMC-ODS via centralized teams or integrated into DMC certified contract or county programs or both:

Monthly estimated billed units of case management: **310**

Comments:

Programs offer CM, sometimes as part of overall treatment, and sometimes as a specific service. Hospital CM communicate with programs for expedited access.

<u>Recovery Services</u> – 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 program 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

Choices: **2**

Total Legal entities offering recovery services: **1**

Total number of legal entities billing DMC-ODS recovery services: 1

Monthly estimated billed units of recovery services**: 190**

Comments:

We have recovery services included in outpatient sites and one residential site so far as step downs.

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

Number of Sites: ?
Total number of legal entities billing DMC-ODS: 0
Estimated billed units per month: 0
How are you structuring it? - *Pick 1 or more as applicable and explain below*

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

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

All opioid withdrawal management is outpatient and most of it occurs in the OTPs, and claimed as OTP services. Anywhere buprenorphine is offered in outpatient setting, for example OBIC, and primary care clinics offer tapers when patient requests, with close monitoring for relapse.

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

Number of sites: 3
Total number of legal entities billing DMC-ODS: 2
Total number of beds: 50
Estimated billed days/units per month: 396
Pick 1 or more as applicable and explain below:

1) Freestanding
2) Within residential treatment center

Choice(s): 1 and 2
Comments:

Some of these beds are 'social model' at present, but planning to have medical services as well. One program is specifically medication withdrawal, mostly for alcohol.

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

Total legal entities in county: 6
In county NTP: Sites 10 Slots: 4000
Out of county NTP: Sites 0 Slots: 0
Total estimated billed counseling units per month: 12,468
Are all NTPs billing for non-methadone required medications? ☒ Yes ☐ No
Comments:

Three programs have not claimed NTP buprenorphine, this is part of our PIP, and found to be somewhat tied to upload of claims from the methadone EHR

<u>Non-NTP-based MAT programs</u> - 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: 2 Number of sites: 2
Total estimated billed units per month: 197
Comments:

One program is specifically created for buprenorphine MAT, but any outpatient program is able to offer MAT. Some residential programs also offer it, but via PC linkage.

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

Total legal entities: 9 Total sites: 14
Total number of legal entities billing DMC-ODS: 9
Average estimated billed units per month: 3385
Comments:

San Francisco reports needing more outpatient capacity. Youth outpatient services new since last EQRO visit.

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

Estimated billed hours per month: 53
Total legal entities: 2 Total sites for all legal entities: 4
Total number of legal entities billing DMC-ODS: 2
Average estimated billed units per month: 215
Comments:

Smooth transition between IOP and OP is sometimes a challenge. Youth IOP is dual diagnosis, claimed via CYF MH.

<u>Level 2.5: Partial Hospitalization</u> – 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 units per month: 0

Comments:

IOP fills this.

Level 3.1: Residential 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: 8 total sites
Total number of legal entities billing DMC-ODS: 3
Number of program sites: 6 sites billing DMC
Total bed capacity: 85 (some flexed with 3.3 and 3.5)
Average estimated billed bed days/units per month: 173
Comments:

Level 3.3: Clinically Managed, 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: 3
Number of program sites: 3
Total number of legal entities billing DMC-ODS: 1
Total bed capacity: 31 (can be flexed with 3.1 and 3.5)
Average estimated billed bed days/units per month: 178
(Can be flexed and combined in some settings with 3.5)
Comments:

Specific to cognitive challenged people.

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: 3
Number of program sites: 3
Total number of legal entities billing DMC-ODS: 1
Total bed capacity: 80 (can be flexed with 3.1 and 3.3)
Average estimated billed bed days/units per month: 2676
(Can be flexed and combined in some settings with 3.5)
Comments:

High level of supervision and monitoring, often the first level at entry to residential.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services/ or WM – 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/units per month: 0

Comments:

San Francisco reports having an inpatient consult service, and hospitalized people are provided withdrawal management as well. These are people admitted for medical, surgical or psychiatric problems that may or may not be addiction-related. This is included in hospital bill, may not show up as addiction treatment.

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

Number of program sites: Enter total number of program sites.
Total number of legal entities billing DMC-ODS: Enter the total number of legal entities billing.
Number of legal entities: Enter total number of legal entities.
Total bed capacity: Enter total bed capacity.
Average estimated billed bed days/units per month: Enter number of bed days/units.

Comments:

San Francisco reports having an inpatient consult service, and hospitalized people are provided withdrawal management as well. These are people admitted for medical, surgical or psychiatric problems that may or may not be addiction-related. This is included in hospital bill, may not show up as addiction treatment.

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: 6
Number of program sites: 6
Bed capacity for women with children: 14 for women with children, 15 for men or women with children
Total bed capacity: 197

Comments:

Residential step-down beds is still a need because of high homeless population.

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

Attachment E: Acronym List Drug Medi-Cal EQRO Reviews

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

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

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