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2019-20
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

VENTURA DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
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VENTURA DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2018-19 — 2,514
Ventura Threshold Language(s) — Spanish
Ventura Size — large
Ventura Region — southern
Ventura Location — Located east of Santa Barbara County, south of Kern County, west of Los Angeles County, north/east of the Pacific Ocean and includes two Channel Islands, Anacapa and San Nicolas.
Ventura Seat — City of Ventura
Ventura Onsite Review Process Barriers — none

Introduction

Ventura is a large urban county that is part of an integrated behavioral health department. Ventura's roll out was well planned and thoughtfully focused on extensive education and increased awareness about the new service system.

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

Ventura County reported a population of 850,802 according to the most recent United States census data. Approximately 90 percent of the county's population ethnicities are somewhat evenly distributed between Caucasian and Latino/Hispanic with the remainder primarily Asian. The median property value is high; however, the homeownership rate is over 60 percent. Ventura industries include health care and social assistance, retail trade, manufacturing and agriculture. The issues of homelessness are slightly lower in Ventura compared to other California counties.

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

Access

Ventura's planning for implementation began with Ventura County Health, Mental Health (MH) and Substance Use Services (SUS). In addition, stakeholder workgroup meetings focused on four program areas including adult, adolescent, residential and fiscal/technology. A webpage was created to keep all interested persons and organizations informed about meetings and planning. Collaboration and communication took place with community-based organizations, the inpatient psychiatric unit, ambulatory clinics, Health Management Associates (HMA), Whole Person Care, probation and the court systems, public health, school systems, hospitals and emergency departments and Gold Coast Health Plan.

An excellent web page is able to provide both education about the disease of addiction as well as clearly explain the new SUS system. The web page is easy to navigate although multiple clicks are necessary to reach the Provider Directory; specific programs or access points are easy to find. The clear but limited number of words makes this easy to read and understand. It could be a model for other counties looking to make their information easier to access.

Ventura has a higher penetration rate compared to the average of other large counties and the average for all other counties currently implementing. Their average overall penetration rate is 1.52 percent compared to 1.02 percent in other large counties and .93 percent in all other counties. The higher penetration occurs across all age groups and ethnic groups.

A centralized Beneficiary Access Line (BAL) to screen and refer was in place for the go live date, with 50 percent of the counselors and clinicians Spanish-speaking, to respond to the needs of those persons who preferred to speak Spanish. The BAL uses both the electronic health record (EHR) Netsmart Avatar and CISCO Unified Intelligence Center Reporting Solutions to provide data and reports. The BAL is embedded in an Access Unit that includes staff who provide plan level case management and assessments.

The Ventura go live date, in December 2018, followed a two-year 12 percent overall decline in admissions to SUS and in the first year of implementation there was a significant 34 percent increase in admissions. Due to the unanticipated demand for services the BAL was initially overwhelmed. Ventura made procedural adjustments, expanded access points to clinics, and reassigned functions in order to better meet the demand. The plan for a new centralized care coordination team, designed to assist clients as they transitioned between levels of care, was delayed in this initial phase; however, case management at the provider level began at implementation. Additional streamlining of the BAL will help to improve efficiencies including the addition of a brief ASAM Criteria-based screening tool.

One narcotic treatment provider (NTP) was approved to expand 500 additional treatment slots at the time of the implementation. In addition, non-methadone medication assisted treatment (MAT) began in one NTP provider with multiple sites and

one county-operated outpatient program with expansion to others planned for the spring (another NTP) and summer (remaining outpatient clinics). Strong physician leadership is assisting with the MAT expansion through the Medical Center and its thriving Addiction Medicine Fellowship Program. New protocols for transferring clients from methadone to buprenorphine provide additional access to persons currently on methadone.

Ventura planned for an in-county male residential treatment and withdrawal management (WM) provider to be a part of the continuum of service. Unfortunately, this provider was not state-certified and as a result, all male residential and WM services are currently provided out of county. Ventura released a request for services (RFP) very quickly after receiving this notification; however, there were no responses to the RFP. A new RFP is being developed and will be released in June, but meanwhile there is a need for a transportation plan to assist beneficiaries to access the available treatment options.

Ventura's youth treatment primarily consists of five outpatient sites and five school sites, but there is also contract residential treatment and residential WM out of county. The majority of youth served are from the criminal justice system, but Ventura believes there are youth not in the criminal justice system in need of services. Services to adolescents could be expanded through outreach and engagement activities to the youth population.

Timeliness

Ventura can track first contact for all county operated programs and for most of the contract-operated programs in order to track timeliness to service. A request for services (RFS) Avatar screen was added in Avatar in December 2018 and providers are now required to use it in order to track all requests for services. The NTP providers currently do not report in Avatar but do report the required data to Ventura.

Ventura has developed and operationalized a definition of urgent conditions using criteria that include SAMHSA priorities (e.g. injection-using drug users, pregnant women) and ASAM severity ratings. The client is asked whether their request is urgent and then screened to determine if criteria for urgent services is met. These two steps are indicated by two Avatar check boxes. The timeliness from request to urgent conditions within the state standard of two days is met 65 percent of the time. Ventura has identified this issue as a performance improvement project (PIP) to decrease the average number of days below the two-day standard.

Ventura did not have the ability to track the first offered routine appointment until 12/11/2019 when a field for entering first offered appointment was added to Avatar as part of the RFS screen. All providers are now required to use this form to track required data. The NTP providers are not using the form but are sending the required information to Ventura.

Ventura tracks the length of time between first request to first face to face appointment, and reports the average is 13.6 days and the standard of ten business days is met 60 percent of the time. They track the length of time from initial MAT request to first NTP appointment, report the average length of time is less than one day and report the standard of three business days is met 91.2 percent of the time.

Ventura tracks the timeliness of follow up services post residential treatment. During the onsite review, CalEQRO determined that the tracking calculation was different than the one used by CalEQRO. Discussion clarified the process but CalEQRO analysis of claims data shows that only ten and one half percent of residential placements reach a lower level of care (LOC) within any days and one percent within seven days. The Care Coordination Team, established as part of the Ventura Plan but only partially implemented, is designed to assist clients to move more quickly to a lower LOC. This will be fully implemented in year two.

Ventura tracks the percentage of persons admitted to WM who have readmissions within 30 days and reports that only 2.9 percent are readmitted within this time frame. They also were able to report that no clients had three or more WM episodes with no other treatment.

Quality

The rollout of the Ventura system involved a thoughtful approach with pre-planning, a problem-solving and learning approach, and flexibility when challenges and needs for corrections emerged. In addition, it is clear from focus groups at all levels that dedicated staff, leadership and providers want to reach out to provide assistance to persons who need SUS in Ventura. Recovery orientation was validated by clients who reported they felt respected and understood, and staff were sensitive to their cultural differences.

Ventura showed commitment to an ASAM Criteria-based approach and provided extensive training to staff at all levels so the approach could be well implemented, assuring staff really understood and could use the instrument. Ventura provided an extensive training calendar showing both ASAM training at multiple levels as well as many other evidenced based practice (EBP) trainings.

The congruence data between ASAM Criteria-based findings and subsequent LOC referrals was absent for initial screenings because those screenings are brief and do not use ASAM Criteria. The data for the initial assessments and the follow up assessments both show high congruence between the ASAM Criteria-based findings and the LOC referrals. The main reasons for any differences between LOC assessment and referral were most frequently patient preference, and to a lesser extent, clinical judgement.

The Ventura rollout included robust services in outpatient and NTPs, which had been the primary services covered under the previous DMC state plan. Ventura had a strong rollout of non-methadone MAT services through several pilots across the system in the first year. There is also good coordination with MAT services occurring in the many

county-operated ambulatory care clinics across the county. The residential treatment and residential WM are more limited, especially for males, but Ventura hopes to significantly expand these services in year two. Recovery services were implemented; however, some confusion about how to bill caused a delay in this service area. That has been resolved so these services are expected to expand in year two. The lack of recovery residences is a challenge for Ventura affecting engagement in intensive outpatient. Ventura is planning to include this service option in the RFP planned for residential treatment.

In anticipation of the need for additional staff, Ventura leadership had foresight and effective advocacy to add an entry classification for SUS counselors and initiate pay raises resulting in improved staff recruitment and retention at county-operated programs. Ventura would benefit from working collaboratively with contract providers to plan for strategies to assist in recruitment of counselors with contract organizations.

As part of their commitment to quality Ventura implemented a data analytics team comprised of staff from the EHR, quality improvement research and clinical subject matter experts. This team meets weekly to coordinated efforts at promoting and utilizing data for feedback to all levels of the organization.

Ventura's client-centered approach is validated by clients reporting they have a say in their treatment plan and have been supported to make changes in their plans based on what they wanted.

Ventura is implementing use of collaborative documentation to streamline documentation while enhancing client engagement. This is an EBP to involve the client with entries into their electronic clinical record during the assessment in order to increase engagement and to have a transparent process and record.

In discussions with clients in focus groups it appears that many do not know about the grievance appeal process. This was validated by Ventura reporting very few grievance and appeals. Ventura would benefit from encouraging programs to communicate more directly with new clients about the appeal/grievance procedures and their beneficiary rights to use them.

Outcomes

The Treatment Perception Survey (TPS) uses a scoring metric of one to five for client ratings of their care, with five being the most positive. While all domains were rated positively, Ventura looked for differences that might suggest opportunities for improvements. The two areas that were rated slightly lower transportation and location convenience (4.27) and coordination of care with mental health staff (4.29). There were many areas of strength including clients report that staff treated them with respect (4.60) and that they felt welcomed at treatment (4.57). Clients also reported they received the help they needed (4.43) and they would recommend the agency to a friend or family member (4.50).

Ventura has a much lower percent of unplanned adult administrative discharges at 15.2 percent than the statewide average of 37.9 percent, suggesting that Ventura treatment programs are effectively engaging their clients. However, the 42.6 percent of clients rated by their providers at discharge as making successful progress is somewhat lower than the statewide average of 51.9 percent. Ventura is encouraged to review this data and explore what could be done to make improvements.

Client/Family Impressions and Feedback

Three stakeholder groups were held in Ventura County that included a women's perinatal outpatient program, an adult MAT group with clients who participated in methadone and non-methadone programs, and a group of adult clients who were Spanish speaking. There was a total of 23 participants across the three groups. The scores were primarily in the four range of a scoring metric of 1 – 5.

Clients reported they got into services quickly; however, most went directly to the provider to access services and almost no client had heard of the BAL. Most clients agreed they were treated with dignity and respect and they participated in developing their treatment plan. Some clients felt that counselors needed more training. Clients reported that the process to make a change in their counselors was clear and changes were made quickly upon request. They reported since the Waiver that individual counseling is more available and helpful, and that group sessions are less lecture and more interactive making them seem more personal.

The clients in services that did not provide MAT treatment said that MAT was never discussed, and they wanted to receive information about MAT. Clients reported they wanted more therapy, grief counseling and family counseling. They felt housing and transportation were challenges.

Recommendations

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

EXTERNAL QUALITY REVIEW COMPONENTS

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

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

This report presents the FY 2019-20 EQR findings of Ventura's FY 2018-19 implementation of their DMC-ODS by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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

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

Performance Improvement Projects[2]

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

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

DMC-ODS Information System Capabilities[3]

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

Validation of State and County Client Satisfaction Surveys

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

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

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

to the specific 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 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 adult clients, youth clients, parent/guardians and clients from different ethnic groups and languages. Focus group forms which guide the process of the reviews include both structured questions and open questions linked to access, timeliness, quality and outcomes.

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

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

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

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

A significant and unexpected change occurred when the only in-county male residential treatment and detoxification provider was not certified by DHCS. A statewide request for proposal (RFP) was immediately issued but no organizations responded.

Past Year's Initiatives and Accomplishments

- Added a new Beneficiary Access Line.
- Hired more Spanish-speaking clinicians, counselors and Access Line clerk.
- Hired more counselors and licensed practitioners of the healing arts (LPHA's).
- Added a new care coordination team to facilitate level of care transitions.
- Developed a new assessment based on the ASAM Criteria to determine level of care and improve the referral process.
- Developed a new Request for Service screening.
- Developed a new treatment authorization request (TAR).
- Added new levels of care including low intensity residential, withdrawal management, population specific high intensity residential and high intensity residential.
- Added Medication-Assisted Treatment services in outpatient clinics.
- Added recovery services.
- Stronger collaborations with Community Based Organizations (CBOs), Inpatient Psychiatric Hospitals, ambulatory clinics, HMA, whole-person care, probation and court systems.
- Greater integration within Behavioral Health department: coordinating more with mental health services and facilitating transitions between services.
- Stronger provider relations: delivered trainings and informational sessions.
- Developed a more intensive utilization review (UR) process with more attention on grievances and appeals, Notice of Adverse Benefit Determinations (NOABTs) and monitoring chart compliance.
- Ventura used results of the Treatment Perception Survey (TPS) for feedback on access, quality and outcomes, and used data elements from the CalOMS data set as an outcome measure. Ventura also implemented ASAM Level of Care Referral Data for screening and assessment of clients. For more information about CalOMS, TPS, and ASAM Level of Care, go to:

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 Level of Care Data Collection System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

Goals Set by Ventura for the Coming Year

- Initiate Telehealth services.
- Continue to seek residential providers for male clients.
- Continue working with Addiction Medicine Fellowship to:
    - Expand non-NTP-based MAT services in Ventura County Behavioral Health (VCBH) outpatient services;
    - Begin ambulatory withdrawal management services in VCBH outpatient clinics.

PERFORMANCE MEASURES

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

The first six PMs are used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal levels of care based on ASAM assessments, and outcomes. The additional six measures could be modified in subsequent years if better, more useful metrics are needed or identified.

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

- The total number of 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;
- The total costs per beneficiary served by each county DMC-ODS by ethnic group;
- Cultural competency of DMC-ODS services to beneficiaries;
- Penetration rates for beneficiaries, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes);
- Coordination of Care with physical health and mental health (MH);
- Timely access to medication for NTP services;
- Access to non-methadone MAT focused upon beneficiaries with three or more MAT services in the year being measured;
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after residential treatment;
- Availability of the 24-hour access call center line to link beneficiaries to full ASAM-based assessments and treatment (with description of call center metrics);

- Identification and coordination of the special needs of high-cost beneficiaries (HCBs);
- Percentage of clients with three or more WM episodes and no other treatment to improve engagement.

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

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

HIPAA Guidelines for Suppression Disclosure:

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

Year 2 of Waiver Services

This is the first year that Ventura began implementing DMC-ODS services. 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 from CY 2018. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2018-19 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS, and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2018-19

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

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

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

The penetration rate for adults ages 18-64 is slightly higher than the statewide rate (1.83 percent vs. 1.12 percent). The penetration rate for youth ages 12-17 is almost twice as high as the statewide rate (0.47 percent vs. 0.26 percent). Ventura has been successful in efforts to engage youth in substance use services.

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

Table 1: Penetration Rates by Age FY 2018-19					
Ventura				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	29,639	140	0.47%	0.28%	0.26%
Ages 18-64	117,436	2,152	1.83%	1.24%	1.12%
Ages 65+	18,783	222	1.18%	0.79%	0.70%
TOTAL	**165,857**	**2,514**	**1.52%**	**1.02%**	**0.93%**

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

Table 2 below shows Ventura'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. Ventura DMC-ODS program went live during December 2018, as a result FY 2018-19 data does not represent a full year. Therefore, average approved claims overall were $2,844, which was lower the statewide average of $3,868. Likewise, Ventura's average approved claims across age groups were consistently lower compared to the statewide averages.

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

Table 2: Average Approved Claims by Age FY 2018-19			
Ventura			Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	$82,082	$586	$1,750
Ages 18-64	$6,214,153	$2,888	$3,898
Ages 65+	$852,760	$3,841	$4,560
TOTAL	**$7,148,994**	**$2,844**	**$3,868**

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total beneficiaries served as clients.

Those covered by Medi-Cal who are Hispanic/Latino comprise 56.1 percent of Drug Medi-Cal (DMC) eligibles and 40.5 percent of DMC-ODS clients served. Individuals who identify as White comprise 22.4 percent of the DMC eligible population and disproportionately comprise 38.7 percent of clients served.

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

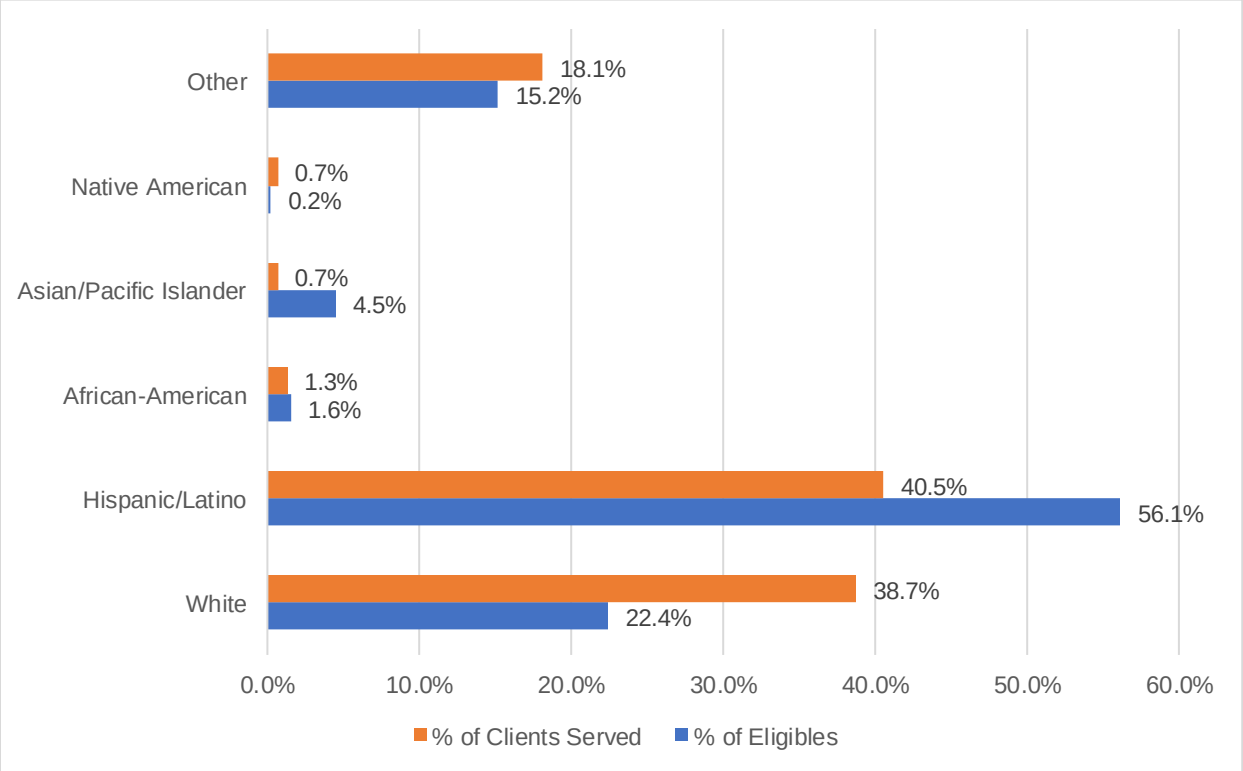


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. The penetration rates reflect the trends noted above, with rates for clients who are "White", "Latino/Hispanic," Asian/Pacific Islander," "Native American," and "Other" higher in Ventura than statewide. The penetration rate for clients who are "African-American" was equal to the statewide rate. The penetration rate for "Asian/Pacific Islander" was 0.23 percent for Ventura, the lowest penetration rate for any race/ethnicity group countywide.

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

Table 3: Penetration Rates by Race/Ethnicity FY 2018-19					
Ventura				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	37,173	973	2.62%	2.11%	1.76%
Latino/Hispanic	93,064	1,019	1.09%	0.72%	0.67%
African-American	2,578	33	1.28%	1.33%	1.28%
Asian/Pacific Islander	7,466	17	0.23%	0.17%	0.16%
Native American	406	17	4.19%	2.44%	1.55%
Other	25,172	455	1.81%	1.11%	1.05%
TOTAL	**165,859**	**2,514**	**1.52%**	**1.02%**	**0.93%**

Table 4 below shows Ventura's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. Affordable Care Act (ACA) eligible clients made up 53.9 percent of those served, followed by "Family Adult" (21.7 percent), and "Disabled" (16.8 percent). Penetration rates for those three categories were higher than statewide rates. While the numbers served are small, it is worth noting that the penetration rate for youth eligibility categories were either on par or higher than statewide rates.

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

Table 4: Clients Served and Penetration Rates by Eligibility Category FY 2018-19				
	Ventura			Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	15,010	439	2.92%	1.62%
Foster Care	471	*	n/-	1.72%
Other Child	16,881	84	0.50%	0.28%
Family Adult	29,301	565	1.93%	0.95%
Other Adult	28,326	39	0.14%	0.10%
MCHIP	13,321	67	0.50%	0.20%
ACA	62,365	1,406	2.25%	1.46%

Table 5 below shows Ventura's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. The average approved claim for "ACA" was the highest across all eligibility categories ($5,166) and higher than the statewide average. The other adult categories had lower average claims compared to statewide rates.

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

Table 5: Average Approved Claims by Eligibility Category FY 2018-19				
	Ventura			Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	15,010	439	$3,618	$4,207
Foster Care	471	*	$443	$1,117
Other Child	16,881	84	$516	$1,690
Family Adult	29,301	565	$2,778	$3,255
Other Adult	28,326	39	$3,185	$4,269
MCHIP	13,321	67	$580	$1,810
ACA	14,412	540	$5,166	$3,867

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

Children 12 and under rarely need treatment for SUD. Foster Care, Other Child and Maternal and Child Health Integrated Program (MCHIP) include children of all ages contributing to a low penetration rate.
Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2018-19. The majority of clients in Ventura are served in NTPs (52.2 percent), 33.9 percent were served in outpatient services and 6.9 in residential. Residential treatment was the service category with the highest average approved claims ($4,780).

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

Table 6: % of Clients Serviced and Average Approved Claims by Service Categories, FY 2018-19			
Service Categories	**# of Clients Served**	**% Served**	**Average Approved Claims**
Narcotic Tx. Program	1,454	52.2%	$3,623
Residential Treatment	193	6.9%	$4,780
Res. Withdrawal Mgmt.	134	4.8%	$1,785
Ambulatory Withdrawal Mgmt.	-	-	$0
Non-Methadone MAT	*	n/a	$1,082
Recovery Support Services	*	*	$101
Partial Hospitalization	-	-	$0
Intensive Outpatient Tx.	46	1.7%	$334
Outpatient Drug Free	945	33.9%	$727
TOTAL	**2,475**	**100.0%**	**$2,844**

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).

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 number of days for clients to receive their first dose of methadone in Ventura was less than one day, matching the statewide median.

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

Table 7: Days to First Dose of Methadone by Age FY 2018-19						
	Ventura			Statewide		
Age Groups	Clients	%	Median Days	Clients	%	Median Days
Age Group 12-17	-	-	-	*	n/a	n/a
Age Group 18-64	1,240	86.8%	<1	28,929	80.04%	<1
Age Group 65+	189	13.2%	<1	*	n/a	n/a
Total Count	**1,429**	**100%**	**<1**	**36,144**	**100%**	**<1**

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

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

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

Ventura reports that through the health plan buprenorphine was provided to 311 patients in urgent care and 101 patients in county-operated ambulatory outpatient medical clinics.

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

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

Ventura served 15 clients, which is 0.6 percent of their total clients served, with at least one non-methadone MAT service. Of the clients served, nine (60 percent) received three or more services, Ventura should explore ways to both increase the number of clients receiving non-methadone MAT in general, and the number of clients who receive three or more services.

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

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

	Ventura				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	-	-	-	-	*	n/a	*	n/a
Ages 18-64	15	0.7%	9	0.5%	3,200	4.15%	1,335	1.73%
Ages 65+	-	-	-	-	*	n/a	*	n/a
TOTAL	**15**	**0.6%**	**9**	**0.4%**	**3,462**	**3.81%**	**1,417**	**1.57%**

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

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

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

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

days and 30 days after discharge from residential treatment. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

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

Of the 200 clients who were discharged from residential treatment, 10.5 percent received a lower level of care within any days of discharge. Only one percent of clients had a transition to a lower level of care within the standard of seven days. Compared to statewide, Ventura's transitions in care following residential treatment is lower suggesting room for improvement.

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

Table 9: Timely Transitions in Care Following Residential Treatment FY 2018-19				
	Ventura (n= 200)		Statewide (n= 24,582)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	*	*	2,034	8.3%
Within 14 Days	*	*	2,728	11.1%
Within 30 Days	12	6.0%	3,383	13.8%
Any days (TOTAL)	**21**	**10.5%**	**4,607**	**18.7%**

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

Access Line Quality and Timeliness

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

telephone wait times. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

Table 10 shows Access Line critical indicators from December 1st, 2018 through September 30th, 2018. The average call volume is relatively low for a large county. The call abandonment rate is high, and should be closer to five percent. The call wait time is low at 24 seconds, making the high call abandonment rate puzzling.

Table 10 – Access Line Critical Indicators, 12/1/18 - 9/31/19

Ventura Access Line Critical Indicators 12/1/18 through 9/31/19	
Average Volume	475 calls per month
% Dropped Calls	14.1
Time to answer calls	24 seconds
Monthly authorizations for residential treatment	Call center does not provide authorizations.
% of calls referred to a treatment program for care, including residential authorizations	Ventura is not able to track this data currently.
Non-English capacity	There are bilingual staff for Spanish-speaking callers. Ventura offers language assistance services through contracts with vendors.

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 Ventura. 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 $10,554 in approved claims per year. The table lists the average approved claims costs for the year for Ventura HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

Only one percent of all clients served in Ventura met the threshold to be designated a high cost beneficiary. Overall, the average approved claims for high cost beneficiaries in Ventura is $13,827. Both these statistics are lower than the statewide average.

Table 11a – High Cost Beneficiaries by Age, Ventura, FY 2018-19

Table 11a: Ventura High Cost Beneficiaries by Age FY 2018-19						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	140	-	-	-	-	-
Ages 18-64	2,152	24	1.1%	$13,927	$334,259	5.4%
Ages 65+	222	-	-	-	-	-
TOTAL	**2,514**	**24**	**1.0%**	**$13,927**	**$334,259**	**4.7%**

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

Statewide High Cost Beneficiaries FY 2018-19					
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	**63,842**	**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 case management.

Ventura served a significant number of clients in residential withdrawal management—135 clients. Of those, less than one percent (0.7 percent) received three or more WM episodes and no other treatment.

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

Table12: Withdrawal Management with No Other Treatment FY 2018-19				
	Ventura		**Statewide**	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	135	0.7%	5,010	2.4%

Use of ASAM Criteria for Level of Care Referrals

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

For the assessment, there is a 78.6 percent congruence rate, with "Patient Preference" the most common reason cited when differences arise (7.2 percent).

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

Congruence of Level of Care Referrals with ASAM Findings, FY 2018-19						
Ventura ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
January to June 2019	#	%	#	%	#	%
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	*	n/a	2,755	78.6%	445	86.9%
Patient Preference	-	-	252	7.2%	25	4.9%
Level of Care Not Available	-	-	36	1.0%	*	n/a
Clinical Judgement	-	-	178	5.1%	24	4.7%
Geographic Accessibility	-	-	*	n/a	*	n/a
Family Responsibility	-	-	*	n/a	-	-
Legal Issues	-	-	-	-	-	-
Lack of Insurance/Payment Source	-	-	-	-	-	-
Other	-	-	224	6.4%	12	2.3%
Actual Referral Missing	46	92.0%	56	1.6%	*	n/a
TOTAL	50	100.0%	3,505	100.0%	512	100.0%

Diagnostic Categories

Table 14 compares the breakdown by diagnostic category of the Ventura and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2018-19. "Opioid" was the most common diagnosis code for clients served in Ventura (65.5 percent), a higher percentage than statewide (46.9 percent). "Other Stimulant Abuse" was the next most common diagnosis (15 percent), followed by "Alcohol Use Disorder (11.8 percent).

Table 14 – Percentage Served and Average Cost by Diagnosis Code, FY 2018-19

Table 14: Percentage Served and Average Cost by Diagnosis Code FY 2018-19				
Diagnosis Codes	Ventura		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	11.8%	$1,911	15.8%	$4,232
Cannabis Use	6.4%	$700	8.7%	$1,953
Cocaine Abuse or Dependence	0.6%	$824	2.1%	$4,593
Hallucinogen Dependence	0.04%	$4,378	0.2%	$3,847
Inhalant Abuse	0%	$0	0.02%	$3,119
Opioid	65.5%	$3,748	46.9%	$4,286
Other Stimulant Abuse	15.0%	$1,835	24.4%	$3,736
Other Psychoactive Substance	-	-	0.4%	$5,521
Sedative, Hypnotic Abuse	0.6%	$906	0.5%	$4,033
Other	0.2%	$1,276	1.0%	$2,586
Total	**100%**	**$2,844**	**100%**	**$3,868**

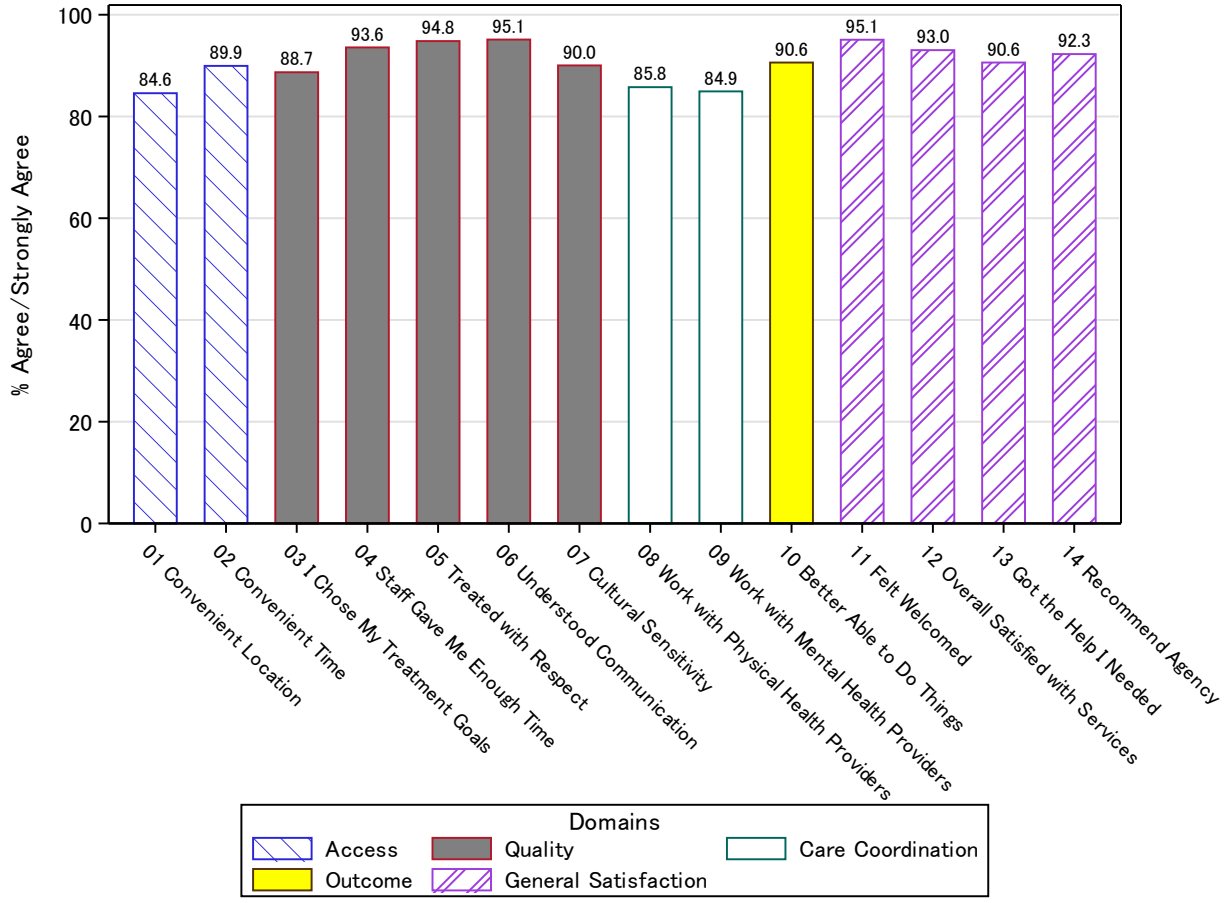
Asterisks, n/a and - indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Client Perceptions of Their Treatment Experience

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

Ventura received surveys from 681 adults and the results are positive across all domains. As with most counties, the ratings were slightly lower for coordination with physical health care services and with mental health care services, but still rated high at 85.8 and 84.9 percent, respectively.

Figure 2 - Percentage of Participants with Positive Perceptions of Care, Ventura, TPS Results from UCLA (n = 681)



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

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

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

Ventura had a lower percentage of clients who were homeless at admission compared to statewide (16 percent compared to 26.2 percent), but more clients whose status was “Dependent Living” compared to statewide (38.9 percent vs. 28.6 percent).

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

CalOMS Living Status at Admission CY 2018				
Admission Living Status	Ventura		Statewide	
	#	%	#	%
Homeless	388	16.0%	24,020	26.2%
Dependent Living	940	38.9%	26,296	28.6%
Independent Living	1,090	45.1%	41,472	45.2%
TOTAL	**2,418**	**100.0%**	**91,788**	**100.0%**

Ventura served many AB 109 clients who are on post-release supervision—42.1 percent of all clients. Just under half of clients in Ventura had no criminal justice involvement, compared to nearly 60 percent statewide.

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

CalOMS Legal Status at Admission CY 2018				
Admission Legal Status	Ventura		Statewide	
	#	%	#	%
No Criminal Justice Involvement	1,151	47.6%	54,930	59.8%
Under Parole Supervision by CDCR	42	1.7%	2,288	2.5%
On Parole from any other jurisdiction	42	1.7%	890	1.0%
Post release supervision - AB 109	1,018	42.1%	28,801	31.4%
Court Diversion CA Penal Code 1000	124	5.1%	1,259	1.4%
Incarcerated	-	-	389	0.4%
Awaiting Trial	41	1.7%	3,221	3.5%
TOTAL	**2,418**	**100.0%**	**91,778**	**100.0%**

Slightly more clients in Ventura are employed either full-time or part-time compared to statewide (29.9 percent compared to 21.1 percent). Correspondingly, fewer clients are unemployed and not seeking work (40.4 percent compared to 51.1 percent).

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

CalOMS Employment Status at Admission, CY 2018				
Current Employment Status	Ventura		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	400	16.5%	12,134	13.2%
Employed Part Time - Less than 35 hours	259	10.7%	7,259	7.9%
Unemployed - Looking for work	587	24.3%	25,522	27.8%
Unemployed - not in the labor force and not seeking	1,172	48.5%	46,873	51.1%
TOTAL	**2,418**	**100.0%**	**91,788**	**100.0%**

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

The administrative discharge rate in Ventura is 15.2, substantially lower than statewide (37.9 percent). The standard adult discharge rate is 41.3 percent, slightly lower than statewide (49.6 percent).

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

CalOMS Types of Discharges, CY 2018				
Discharge Types	Ventura		Statewide	
	#	%	#	%
Standard Adult Discharges	1,177	41.3%	43,654	49.6%
Administrative Adult Discharges	531	15.2%	33,344	37.9%
Detox Discharges	316	41.8%	8,470	9.6%
Youth Discharges	97	1.7%	2,609	3.0%
TOTAL	**2,121**	**100.0%**	88,077	**100.0%**

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

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

42.6 percent of clients had a positive discharge status in Ventura, lower than the 51.9 percent statewide.

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

CalOMS Discharge Status Ratings, CY 2018				
Discharge Status	**Ventura**		**Statewide**	
	#	**%**	**#**	**%**
Completed Treatment - Referred	451	21.3%	20,190	22.9%
Completed Treatment - Not Referred	171	8.1%	6,070	6.9%
Left Before Completion with Satisfactory Progress - Standard Questions	162	7.6%	12,220	13.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	119	5.6%	7,259	8.2%
Subtotal	*903*	*42.6%*	*45,739*	*51.9%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	806	38.0%	16,253	18.4%
Left Before Completion with Unsatisfactory Progress - Administrative	340	16.0%	24,781	28.1%
Death	-	-	96	0.1%
Incarceration	72	3.4%	1,208	1.4%
Subtotal	*1,218*	*57.4%*	*42,338*	*48.0%*
TOTAL	**2,121**	**100.0%**	**88,077**	**100.0%**

Performance Measures Findings—Impact and Implications

Access to Care PM Issues

- Ventura served 140 youth ages 12-17 with a 0.47 percent penetration rate, nearly twice that of the statewide rate.
- Of the client population served, over 40 percent were Hispanic/Latino, resulting in a penetration rate of 1.09 percent for this race/ethnicity group,

higher than the statewide rate of 0.67 percent. Overall, Ventura's penetration rates were at or higher than statewide across race/ethnicity groups.

- The percentage of dropped calls at the Access Call Center is high at 14.1 percent.

Timeliness of Services PM Issues

- Ventura tracks timeliness to urgent and routine first appointments and meets state standards 65 percent of the time for urgent and 60 percent of the time for routine appointments.
- The BAL responds quickly to callers, answering the phone within 30 seconds, in contrast to its high call abandonment rate. Ventura may want to explore the methods and accuracy of measuring these two metrics.
- Clients in narcotic treatment programs receive medication within less than one day of the first face to face session.

Quality of Care PM Issues

- Clients rated various aspects of quality of care in the Treatment Perception Survey that is administered annually. Average ratings were high on all items.
- Only 10.5 percent of clients had a transition to a lower level of care within any days after discharge from residential. Based on six months of claims data (January – June 2019), CalEQRO was unable to determine if transportation or availability of outpatient and intensive outpatient resources resulted in few clients stepping down into one of these service levels.
- Ventura is using ASAM-based criteria in their initial assessment and had a 78.6 congruence rate for assessed level of care to referral. Patient preference and clinical judgment were the top reasons for the difference.

Client Outcomes PM Issues

- Ventura's provider ratings of positive client outcomes at discharge using CalOMS were somewhat less positive (42.6 percent) than the statewide average (51.9 percent).
- Ventura's planned discharges of adults (41.3 percent) are slightly lower when compared to the statewide average (49.6 percent) and their unplanned discharges (15.2 percent) are considerably lower compared to the statewide average (57.9 percent).

INFORMATION SYSTEMS REVIEW

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

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

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

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

ISCA Table 1: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	58%
Contract providers	42%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 1.2 percent.

The budget determination process for information system operations is:

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

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

☐ Yes ☒ No ☐ In Pilot phase

Summary of Technology and Data Analytical Staffing

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

ISCA Table 2 – Summary of Technology Staff Changes

ISCA Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
3	0	0	0

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

ISCA Table 3 – Summary of Data and Analytical Staff Changes

ISCA Table 3: Summary of Data and Analytical Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2	0	0	0

The following should be noted regarding the above information:

- IS technology staff serve both DMC-ODS and Short-Doyle/Medi-Cal programs and provide support for 900 or so Avatar users.
- Technology and data analytical staffing numbers are county resources.
- County IT is responsible for network connectivity and support.

Current Operations

The Ventura Avatar system (version 2019) is vendor hosted. Most software maintenance and system upgrades are performed by the vendor. BHS and County IT staff support desktop and internet browser issues. Avatar Helpdesk phone support is available Monday through Friday from 8:00AM to 5:00PM.

Although Avatar has been in use for ten years to support Short-Doyle/Medi-Cal program, the system was modified during FY 2018-19 to support the DMC-ODS implementation. Required clinical forms (screens), new services and rates were built into the system and new workflows were created.

Ventura continues to implement Avatar EHR functions to support additional service categories: ambulatory withdrawal, recovery support, residential 3.7, and hospital 4.0 services.
ISCA Table 4 lists the primary systems and applications the DMC-ODS county uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third-party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

ISCA Table 4 – Primary EHR Systems/Applications

ISCA Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Avatar/CalPM	Practice Management	Netsmart	10	Netsmart
Avatar/CWS	Electronic Health Record	Netsmart	6	Netsmart
Avatar/Order Connect	Medication & Lab Orders	Netsmart	6	Netsmart

Priorities for the Coming Year

- Implement DMC-ODS Operational Treatment Model.
- Implement DMC-ODS Recovery Support Services.
- Improve access to Service Collection & Reporting.
- Collect and report Network Adequacy Certification Tool (NACT) data to DHCS.
- Implement DHCS 274 Companion Guide.

Major Changes since Prior Year

- Implemented DMC-ODS Phase I.
- Implemented incident Report Tracking System.

Other Significant Issues

- Ventura plans to add clinical functionalities and has support from contract providers to increase their use of Avatar EHR. Given these plans, the lack of adequate levels of IT and subject matter experts to support operations is a barrier for deployment and training.

- Without adequate levels of data analytical resources, it will be difficult to achieve a data-driven organization with plans to expand reporting capabilities to develop more performance dashboard indicators and provide contract providers with access to timely and relevant data.
- Education and treatment information are easily accessed on the Ventura Behavioral Health website; however, for clients who seek the provider directory it requires too many "click-throughs" to access it. Refer to MHSUDS Information Notice 18-020 for additional requirements.
- Many contract providers maintain local EHRs, which requires double data-entry by their staff into Avatar to support disparate systems for data input/exchange. Ventura has no current plans to implement electronic data exchange for providers with EHRs to improve interoperability thereby provide timely and seamless portability of client information.

Plans for Information Systems Change

- No plans to replace current system.

Current Electronic Health Record Status

ISCA Table 5 – EHR Functionality

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

Summary Totals for EHR Functionality:	**9**	**0**	**3**	**0**

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

- Ventura continues to work with contract providers on charting in Avatar. Staff continue to provide training to support providers on authorization forms and clinical documentation necessary for the DMC-ODS requirements.
- Ventura continues to rely on a hybrid medical record model (electronic forms and paper chart) to support current operations.

Clients' Chart of Record for county-operated programs (self-reported by DMC-ODS):
☐ Paper ☐ Electronic ☒ Combination

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

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

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings			
	Yes	**No**	**%**
ASAM Criteria is being used for assessment for clients in all DMC Programs.	X		
ASAM Criteria is being used to improve care.	X		
CalOMS being administered on admission, discharge and annual updates.	X		
CalOMS being used to improve care. Track discharge status. Outcomes.	X		
Percent of treatment discharges that are administrative discharges.	X		15.2
TPS being administered in all Medi-Cal Programs.	X		

Highlights of use of outcome tools above or challenges:

- There is no ASAM criteria-based screening tool, so all clients receive a full ASAM assessment.

Drug Medi-Cal Claims Processing

- Ventura estimates 67 percent of DMC-ODS services provided are being claimed to Drug Medi-Cal.

- Ventura reports about 58 percent of services are provided at county-operated clinics, while contract providers delivered 42 percent of client services.
- Ventura submitted claims for NTP services, MAT, withdrawal management, residential treatment, intensive outpatient and outpatient treatment services.
- Based on submitted claims for period January – June 2019, the use of case management services to support and document clients' transition of care from residential treatment and withdrawal management and recovery support and intensive outpatient treatment services is not apparent.

Special Issues Related to Contract Agencies

- Double data entry of client data into Avatar for contract providers with their own EHR vendors remains a huge expense of staff resources and is prone to data entry errors.
- Screening and initial assessment processes are often duplicated by providers. Initially there were issues with consistent and timely client referrals to providers; however, this issue was being resolved with increased communication between providers and Ventura.
- Cisco system data regarding Access Line client referral numbers are not being widely distributed or discussed with providers as part of client engagement and access to services discussions.

Overview and Key Findings

Access to Care

- Ventura has an equal mix of county-operated and contract providers.

Timeliness of Services

- The timeliness of the Ventura plan to expand the clinical functionality in the EHR will be impacted by lack of adequate levels of IT and subject matter experts to support this implementation.

Quality of Care

- Ventura continues to work with county staff and contractors, providing training and support on authorization forms and clinical documentation necessary for the DMC-ODS requirements.

Client Outcomes

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

NETWORK ADEQUACY

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

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

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

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

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

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

CalEQRO reviewed separately and with Ventura County staff all documents and maps submitted to DHCS. CalEQRO also reviewed the special form created by CalEQRO for

identification of services closest to each zip codes. Ventura did not request alternative access for any zip codes as all populations and zip codes were certified to meet network adequacy standards.

Also discussed were access issues for physically disabled clients. Ventura has assured that all facilities have accommodations for people with physical disabilities. Large font auxiliary materials and services are available through SUDSServices@ventura.org. The Ventura provider directory provides the detail so beneficiaries can easily identify what is available in each of the clinics.

All perinatal clients have the option to attend A New Start for Moms and this program includes a county operated transportation program for all participants. For clients who are not perinatal, Gold Coast (insurance plan) provides door to door transportation for scheduled appointments. Scheduling must be done forty-eight hours prior to the appointment.

Interpreter services are available at no cost to clients at all facilities with two contracted organizations that can provide translation into any language. Ventura is aware that there is a special need in translation for those who are Mixtec farmworkers, who lack access to services due to cultural barriers, limited fluency in Spanish and English, and low literacy rates. They work with Mixteco Indigena Community Organizing Project (MICOP) an organization who provide mental health outreach, interpretation, and other support services to this population, estimated to be approximately 20,000 in Ventura. MICOP and Ventura are now leaders in bringing awareness to this community's needs

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CalEQRO has a federal requirement to review a minimum of two PIPs in each DMC-ODS county. A PIP is defined by CMS as "a project designed to assess and improve

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

Ventura PIPs Identified for Validation

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

Clinical PIP—Study of Care Coordination Post-Discharge

Date PIP Began: 4/1/2019 **Status of PIP:** Active and ongoing

Brief Description of the problems the PIP is designed to address: The objective of the PIP is to identify interventions to improve transitions between levels of care after discharge from DMC-ODS residential treatment. By improving efficiency and consistency in treatment coordination post-discharge, Ventura aims to increase the number/percentage who reach a timely lower level of care, resulting in better outcomes across client episodes, including lower relapse rates.

PIP Question:
Ventura presented its study question for the clinical PIP as follows:
Can the percentage of clients discharged from residential services, who transition to follow up services at a lower level of care within 30 days, be increased from 70% to 80% by implementing an intervention in which care coordination staff initiate case management and discharge planning seven days prior to discharge from residential treatment?

Indicators:
Ventura listed the following PIP indicators:

1. Number and percent of residential discharges with a follow-up admission to a lower level of care within 30 days of discharge.
2. Number of days from a residential discharge to a lower level of care.

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

Interventions:
Ventura cited the following interventions:

1. Care Coordinator position established.
2. Care Coordinator receives reminder upon admission to residential treatment.
3. Care Coordinator contacts program and/or client in residential treatment.
4. Care Coordinator assists program and/or client in developing transition or discharge plan for client prior to their leaving the residential program.
5. Care Coordinator uses motivational interviewing skills to engage client in this process.

Results/Impact upon Clients:

1. Preliminary data shows post intervention increases in percentage of admission to outpatient at 7, 14 and 30 days, compared to baseline.

Technical Assistance Provided: Conference calls to review the PIP concept and provide feedback on implementation occurred 7/31/19, 11/6/2019, 12/9/2019 and during the review. Recommendations include: 1) Continue the PIP for another year; 2) include measures to determine if care coordination occurred; 3) separate residential detox from treatment; 4) receive feedback from clinical staff; 5) receive feedback from clients; and 6) identify and address barriers that occur.

PIP Score: 75%

Non-Clinical PIP— Study of Timeliness from First Contact to Assessment

Date PIP Began: 4/1/19 **Status of PIP:** Active and ongoing

Brief Description of the problems the PIP is designed to address: The objective of the PIP is to identify interventions to improve access to services by studying timeliness of RFS to assessment for DMC-ODS treatment programs. By allowing clients quicker access to needed substance use treatment services (SUTS), they can engage and start the recovery process sooner. The focus of the PIP will be on both urgent and routine service requests.

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

Can the number of days between initial request for urgent service and assessment for outpatient treatment be reduced from 3 to less than 2 days by initiating an intervention where outpatient clinics schedule a rotating counselor to accommodate walk-in assessments.

Indicators:

Ventura listed the following PIP indicators:

1. Number of days from initial RFS to actual assessment for services at outpatient programs.

Number and percentage of RFS's with actual assessment at outpatient programs taking place within 10 days for routine appointments and within 2 days for urgent appointments

Interventions:

Ventura cited the following interventions:

1. Make the Clinic Administrator (CA) calendar accessible.
2. Make the CA responsible to ensure clinician no show notes and appointment availability are up to date.
3. Clarify expectations of those involved in the processes targeted by this PIP, particularly those of the CAs.
4. Establish the length of time for each step in the completion of the assessments and treatment planning.

Results/Impact upon Clients:

Ventura was not able cite client outcomes at the time of the review as data was not yet collected. This was due to necessary changes made to the PIP interventions discovered during the initial implementation.

Technical Assistance Provided: Conference calls to review the PIP concept and provide feedback on implementation occurred 11/6/2019, 12/9/2019 and during the review. Recommendations include*:* 1) Continue the PIP for an additional year in order to track data over a longer period of time; 2) Add a measure to track timeliness to first treatment appointment following the assessment; 3) Add the date of first offered appointment; 4) Complete and administer tools to solicit feedback on timely service access from clients, clinicians and counselors; 5) To ensure multiple clinician documentation is entered the same way, establish a validation process.

PIP Score: 78%

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

PIP Table 1: PIP Validation Review

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

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

PIP Table 2: PIP Validation Review Summary

Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	9	9
Number Partially Met	9	7
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	18	16
Overall PIP Rating Clinical: ((9*2)+(9))/(18*2) Non-clinical: ((9*2)+(7))/(16*2)	**75%**	**78%**

PIP Findings—Impact and Implications

Overview

The Ventura PIPS identified important issues through the use of their data as well as new standards established in the DMC-ODS to study. Their goals to increase timeliness to urgent and routine outpatient treatment and increase transitions from residential treatment to lower levels have the potential to improve client outcomes.

Access to Care Issues related to PIPs

The clinical PIP address access to care, utilizing a new model of county or plan care coordinators, who engage clients to assist them with their transitions between levels of care.

Accessing services following discharge from residential treatment is a critical and vulnerable time for many clients. The study of this model will provide information to other counties as a potential strategy to address this important issue state-wide.

Timeliness of Services Related to PIPs

The non-clinical PIP addresses timeliness from first RFS to first urgent or routine appointment. The timeliness to urgent appointments is particularly critical for clients and has potential to increase the percentage of clients who engage in treatment.

Timeliness to routine appointments is also important and Ventura added this as a measure to expand the PIP.

Quality of Care Related to PIPs

Ventura has established a team to review data and address quality of service issues as part of their regular business practice. They have a history of addressing quality in their system and are continuing this practice through the study of these PIPs.

The quality of the care coordinator services with providers and clients will be a focus of the clinical PIP in its second year.

Client Outcomes Related to PIPs

The PIPS are designed to improve client outcomes by improving timeliness to urgent and routine assessments as well as transitions from discharge to lower levels of care. Ventura also has the capacity to track client status and outcomes through all levels of care to discharge.

CLIENT FOCUS GROUPS

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

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

Focus Group One: Women's Perinatal Focus Group

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

Six adult women participated in this group, held at A New Start for Moms, the county operated Perinatal Intensive Outpatient program. The facilities were clean, modern and welcoming. The rooms for children's programs were cheerful with many toys. The women included young adults, adults and older adults and included persons who identified as Caucasian, Hispanic/Latino or both Caucasian and Hispanic/Latino.

Number of participants: 6

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

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.67	4 - 5
2. I got my assessment appointment at a time and date I wanted.	4.33	4 - 5
3. It did not take long to begin treatment soon after my first appointment.	4.50	3 - 5
4. I feel comfortable calling my program for help with an urgent problem.	4.17	2 - 5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.00	1 - 5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.20	4 - 5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.67	4 - 5
8. Because of the services I am receiving, I am better able to do things that I want.	4.33	3 - 5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.83	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:

- Not aware of all services that are offered and would have liked more information at screening or assessment on how to access all services provided for SUS.
- Would like more information on medications.
- Getting into the treatment program was fairly quick and easy.

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

- More integration, including trips, with NA and AA, to help get beneficiaries involved in their community and recovery resources.
- Program is flexible and treatment sessions are adjusted according to client needs.
- Appreciated several program elements that engage and keep them in treatment: 1) individualized care, 2) sense of community among the clients, 3) availability of counselors to talk, and 4) the option of bringing their kids for a great day care program.

Recommendations for improving care included the following:

- I would like more group therapy.

- I would like more groups or classes on self-care.

Interpreter used for focus group 1: NO

Focus Group Two: Adult Clients in MAT

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

The focus group was held at the Aegis NTP in Oxnard, a facility located adjacent to a public high school. Clearly Aegis has managed to establish and maintain an excellent relationship with the school and surrounding neighborhoods. Nine persons participated in the group all of whom were receiving MAT services. Their age range included young adults, adults and older adults but were primarily adults ages 25-59. Most reported their preferred language was English. Participants identified as Caucasian/white, Hispanic/Latino and African American/Black; however, the majority were Hispanic Latino. There were five males and four females.

Number of participants: 9

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

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.5	4 - 5
2. I got my assessment appointment at a time and date I wanted.	4.1	1 – 5
3. It did not take long to begin treatment soon after my first appointment.	4.67	4 – 5
4. I feel comfortable calling my program for help with an urgent problem.	4.44	3 - 4
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.87	2 - 5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.5	4 - 5

Question	Average	Range
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.89	4 – 5
8. Because of the services I am receiving, I am better able to do things that I want.	4.67	4 - 5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.55	4 - 5

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

- I would like nutritious food provided, specifically fruit smoothies.
- All participants said they did not know the Access Line existed, but most said they easily and quickly found their way into the NTP through direct request.

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

- I want more education on how to stay clean, including workbooks.
- I would like access to computers for help with my job search.
- The NTP offers group sessions daily on various aspects of recovery and coping.
- I was sleeping in parks and on the streets but it often wasn't safe so I would take drugs to stay awake. My counselor helped me with resources to figure out how to get housing.
- All participants said they were treated with dignity, even when found to be still using.

Recommendations for improving care included the following:

- Counselors should receive ongoing training as not all have the skills needed to help me.
- Counselor turnover is high and that makes treatment challenging.
- Some clients did not seem aware of complaint/appeal/grievance procedures and their beneficiary rights to use them.

Interpreter used for focus group two: No

Focus Group Three: Latino/Hispanic Client Focus Group

CalEQRO requested a culturally diverse group of client beneficiaries, who preferred Spanish as their primary language, including a mix of existing and new clients who have initiated/utilized services within the past 12 months.

The focus group was held at the Oxnard clinic with eight clients who identified as Latino/Hispanic with an emphasis on language preference being Spanish. The clients were all adults or older adults. Some described themselves as preferring English or Spanish and four described themselves as bilingual. Most described themselves as Hispanic/Latino but not all answered that question. The majority of those who participated were female.

Number of participants: 8

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

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.75	4 - 5
2. I got my assessment appointment at a time and date I wanted.	4.62	3 – 5
3. It did not take long to begin treatment soon after my first appointment.	4.5	2 – 5
4. I feel comfortable calling my program for help with an urgent problem.	4.5	2 – 5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.63	3 – 5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.5	2 – 5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.75	4 – 5
8. Because of the services I am receiving, I am better able to do things that I want.	4.75	4 – 5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.87	4 - 5

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

- There was general satisfaction with comments including "all is well" and "keep on".

- The program was described as a supportive environment among beneficiaries, who help each other learn of services and cope with struggles.

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

- More recovery services are needed.

Recommendations for improving care included the following:

- More counseling for my family.
- More counseling with my family.
- More groups with spiritual leaders and focus on faith and healing.

Interpreter used for focus group three: Yes

Client Focus Group Findings and Experience of Care

Overview

Three stakeholder groups were held in Ventura County that included a women's perinatal outpatient program, an adult MAT program and a group with clients who were Spanish speaking with a total of 23 participants across the three groups. The scores were primarily in the four range of a scale of 1 – 5.

Access Feedback from Client Focus Groups

- Clients knew where services were, and most accessed them by going directly to the provider.
- Clients did not seem aware of the BAL as they continue to receive timely services by going directly to provider sites as they had previously.

Timeliness of Services Feedback from Client Focus Groups

- Clients generally reported that services were accessed without extensive waits and most felt they got assessed and into programs rather quickly.
- Most clients waited what felt to them as a long time to receive assistance for housing.

Quality of Care Issues from Client Focus Groups

- Most clients reported they were treated with dignity and respect even when they were relapsing.
- Clients reported they participated in developing their treatment plan and changes were made at their request.
- If a client wanted to change their counselor, the process was clear and the request to change occurred quickly.
- Some clients reported that medication options, to address addiction and craving, were not discussed with them and would have been beneficial.
- Clients reported that the individual treatment was appreciated, and even groups have less of a lecture format now, are more interactive and feel more personal.
- Transportation challenges are an issue for some clients, affecting their care; however, others were able to use the Health Plan-sponsored transportation assistance successfully.
- Some clients were not aware of the complaint/appeal/grievance procedures and their beneficiary rights to use them.
- Recovery services are delivered only by phone in some programs and this was not adequate for some clients.
- Some clients, in particular those who identified as Hispanic/Latino wanted more treatment with and for their families.

Client Outcomes Feedback from Client Focus Groups

- Some clients received help with job search resources, coping skills and housing and believed that support was helping them to be successful.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1

Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	M
In the client focus groups the Ventura clients reported they felt, not just respected and understood, but that staff were sensitive to their differences. Ventura has made an effort to hire bilingual staff to address the language needs of those who are more comfortable speaking Spanish. Over fifty percent of the beneficiary access line are bilingual in Spanish and bilingual staff are providing individual and group sessions at the three clinic sites with the highest percentage of persons who speak Spanish. Ventura tracks the penetration rate of persons who speak Spanish in various programs. Ventura consistently analyzes demographic data to review ethnic and racial differences in treatment and outcome. They have added a required field in the EHR to indicate the language preference of each client.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	PM
In their start up Ventura's tracking of service demands and caseload allowed them to respond quickly to the unanticipated and dramatic increase in service requests to the new DMC-ODS. Ventura relies on their data to determine clinical needs; however, there continues to be severe shortages of residential and residential WM beds. Ventura is preparing an RFP to address this issue, but it is not expected to be		

Table 1: Access to Care Components		
Component		**Quality Rating**
released until July 2020. A PIP was established to study how to increase responsiveness to clients with urgent service requests.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
Ventura has a history of collaboration and has good working relationships with other county departments, health organizations, community-based organizations and education. They partner with the county-operated Federally Qualified Health Centers (FQHCs) to provide increased MAT services. In addition, Ventura is part of a unique partnership using Addiction Medicine Fellows to increase non-methadone MAT treatment in opioid treatment programs, emergency departments, and outpatient substance use programs. Their collaborative courts are extensive and include programs for many populations and partnerships with all criminal justice partners including programs in juvenile hall and jail. Ventura has a strong presence in the schools and multiple programs engaging youth in prevention activities.		

Timeliness of Services

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

KC Table 2

Table 2: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
Ventura operated programs use the Avatar EHR to track initial contact and Ventura require most providers to input into this system; however, the NTP providers submit the required documentation through a different process. Ventura is tracking timeliness to all services and working to reduce wait times when possible. They are challenged, with limited residential and WM bed capacity for males, but developed strategies to reduce wait times and track persons who need that limited service while offering alternatives in the interim.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
Ventura has a robust methadone continuum and the two contracted NTPs report their initial contact data to Ventura in an electronic version but not through Avatar. Ventura produces reports to track the wait time and CalEQRO used their claims data to validate that wait times for methadone meet state standards		

Table 2: Timeliness of Services Components		
Component		**Quality Rating**
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment:	M
The Non-methadone MAT programs are relatively small as they continue to ramp up at this time. Ventura tracks and trends data for these programs with reporting primarily in Avatar except for the NTP contractors. Ventura can provide specific data on the number of persons receiving non-methadone MAT by site and the timeliness of the service.		
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	M
Ventura has defined the conditions warranting an urgent response in ways that are thoughtful and operationalizable. The criteria they used include SAMHSA priorities (e.g. injection-using drug users, pregnant women) and ASAM severity ratings. A checkbox has been added to Avatar to track. The [urgent request] check box is a required field in the Avatar RFS screening form. Ventura is working to improve the timeliness for urgent requests with interventions that will be reviewed through a PIP process.		
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	M
Ventura is tracking how many clients discharged from residential treatment or residential WM reach a lower level of care within 30 days. They also track the number who have reached a lower level of care within seven days. Ventura is using a PIP to study a new service element of care coordinators who will assist clients with transitions between levels of care in an effort to increase the percentage of clients who reach a lower level of care within 30 days.		
2F	Tracks and Trends Data on Follow-up and Re-Admissions to Residential Withdrawal Management	M
Ventura regularly tracks the number of clients who have re-admissions to residential WM within 30 days. Ventura data shows that only seven clients or 2.9% were re-admitted within 30 days. Ventura also tracks the number of persons who were admitted into residential WM three times with no other treatment. Their data showed that percentage to be less than one.		
2F	Tracks Data and Trends No Shows	M
Ventura has a process that includes regular reports to track no shows for scheduled appointments. They can distinguish between a client who no shows or a cancellation as these have different codes. Ventura has recently implemented a new requirement to assure that a note is written for the time a client does not show for an appointment. The clinic administrator is responsible, for ensuring that staff document no show notes as soon as possible, ideally during the time of the missed appointment.		

Quality of Care

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

KC Table 3

Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
Ventura developed an integrated MH and DMC Quality Assurance Performance Improvement Plan as part of DMC-ODS implementation. The plan was initially designed to be high level with increased refinement in future years. The Quality Improvement team will be fully staffed once the Quality Improvement team manager is hired. The Quality Management Action Committee has been established to assure there is representation from consumers, family members, and providers. This Committee includes subcommittees (such as SUS) that are able to meet separately and bring back recommendations to the full group. The Quality Management (QM) team function includes data extracts and analysis that address access, timeliness, quality and outcomes. The QM team developed a new model of partnership to better prioritize timely analysis of data through a weekly meeting between EHR staff, QM research staff and clinical subject matter experts. An evaluation of the integrated plan has not yet occurred but is planned.		
3B	Data is used to inform management and guide decisions	M
Ventura has a culture that is data driven and managers use data to make decisions; however, there are insufficient staff to produce timely data reports. Ventura had extensive ASAM training both in person and online. There is a required process in place for county and contract provider staff to complete specific ASAM training prior to their authorization to bill for services. To maintain fidelity to the evidence-based practice curriculum, VCBH SUTS clinic administrators conduct quarterly observations of the scheduled group activities, utilizing a matrix for rating the counselor's compliance to group processes and procedures as well as adherence to curriculum and clinical content of the group session. The data from the rating scales are used to improve performance, compliance, and uniformity in providing group services to clients and maintaining a high-quality service delivery.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M

Table 3: Quality of Care Components		
Component		**Quality Rating**
Line staff report that they hear about changes from their managers and that twice a year there are all staff meetings in which staff can provide feedback. Staff can also provide feedback at their clinical and staff regular meetings. Staff and contract providers are alerted to policy changes through email. One program reported that family members are welcome to all programs. The roll out of DMC-ODS was extensive and reached multiple community groups and organizations. Ventura has also done extensive training on MAT. There was a lot of information and education available about multiple relevant issues for all age groups; however, if a client had a complaint, it was not clear they understood there was a process other than talking to their counselors. Clients do have feedback options in Ventura including a clinic exit survey when treatment is completed.		
3D	Evidence of an ASAM continuum of care	PM
Ventura was able to roll out NTPs and outpatient programs quickly. By the end of year one, some non-methadone MAT was provided to clients in programs across most levels of care. Ventura does some analysis of engagement and retention of clients in the system. Ventura established a model of two levels of case management: a systemwide county-operated case management to facilitate client transitions in levels of care, and a provider-based case management for assistance while in a specific program. Ventura does not currently provide in-county services for male residential treatment and residential WM, and instead contracts for those services to out of county programs with insufficient capacity and long waits for service. Ventura has adjusted salaries and entry requirements to increase the number of SUS counselors hired in county-operated programs; however, staff vacancies remain an issue with contract providers. Recovery support services have only recently become established but are anticipated to increase in year two.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M
Ventura expanded its NTP by 500 slots. One of their NTP providers currently offers both methadone and non-methadone MATs across four sites. A second NTP provider expects to have non-methadone MATs available by April 2020. Non-methadone MAT is being piloted in one outpatient clinic, perinatal IOP, and women's residential. Ventura contracted with HMA to help with MAT education initiatives throughout the health care system, including through the hospitals and FQHCs. Specific MAT questions are cued in the EHR assessment with check boxes to identify what was discussed and what referral information was provided. A report from December 2019 showed 30 referrals had been made to MAT services. Ventura participates with partners in the Rx Abuse and Heroin Workgroup Coalition that monitors overdose deaths and provides education about prescribing practices to local physicians. They also have an expansive initiative, training many first responders, families and clients in the use of Narcan and currently distributes kits through 35 channels.		

Table 3: Quality of Care Components		
Component		**Quality Rating**
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
Initial ASAM training was provided locally for all county and contract provider staff at all levels of the organization. Office administrators were also trained to better understand the change that was taking place in the new DMC-ODS. After the initial training new county and contract provider staff use the online software purchased by Ventura from the Change Company. Staff cannot bill for services until this training has been completed. Fidelity in implementation is assured through ASAM assessment case discussions in clinic meetings where staff work to achieve consensus. Care coordinators are in place to assist clients in their transitions between levels of care. Clients reported feeling they had a say in their treatment plan and had made changes in their treatment plan based on what they wanted. The six ASAM dimensions are included in the EHR. Client relapse does not result in discharge but in assistance to intervene and make changes as necessary.		
3G	Measures clinical and/or functional outcomes of clients served	PM
Ventura collects some client level outcomes that are geared toward system-wide outcome evaluation using CalOMS discharge data, a local client satisfaction survey and TPS. The client satisfaction surveys are reviewed at the clinic level, but this data, is not reported quarterly and it is not yet used regularly to make system improvements or system adaptations. Outcomes are not yet evaluated with subpopulations. It is expected that this work will begin in year two.		
3H	Utilizes information from client perception of care surveys to improve care	PM
With their December 1st start date Ventura has participated in only one TPS since implementation and had only recently received the results back prior to the EQRO review. They did review the data, analyzed by demographic groups and evaluated their two highest and two lowest levels of scores. The plan is to distribute to clinic administrators to share with their staff and respond to the feedback.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Ventura's implementation planning included outreach and engagement of multiple stakeholders who partnered in the implementation including community-based organizations, inpatient psychiatric unit, ambulatory clinics, HMA, Whole Person Care, probation, the court systems, public health, school systems, hospitals, emergency departments and Gold Coast Health Plan.
- Ventura has a higher penetration rate compared to other counties. Their overall penetration rate is 1.52 percent compared to 1.02 percent in other large counties and .93 percent in all other counties. The higher penetration occurs across all age groups and ethnic groups.
- A centralized BAL to screen, assess and refer was in place for the go live date, with over 50 percent of the counselors and clinicians Spanish-speaking, to respond to the needs of those persons who preferred to speak Spanish. The BAL uses both the Netsmart Avatar EHR and the CISCO Unified Intelligence Center Reporting Solutions to provide data and reports. Examples provided showed excellent use of Cisco data for reports to manage BAL.
- One NTP was approved to expand 500 additional treatment slots at the time of the implementation. In addition, non-methadone MAT began in one NTP provider with multiple sites and one county-operated outpatient program with expansion to others planned for year two.
- Ventura has strong physician leadership through the Medical Center and Addiction Medicine Fellowship, providing a residency training program to assist with expansion of non-methadone MATs. They have established new protocols for transferring clients from methadone to buprenorphine, providing additional access to persons currently on methadone. Their rotations to provide assistance include Fridays at an NTP site.
- Ventura has strong collaboration with multiple agencies and other departments, most notably with criminal justice agencies.
- An excellent web page is able to provide both education about the disease of addiction as well as clearly explain the new SUS system. The web page is easy to navigate although multiple clicks are necessary to reach the Provider Directory. Specific programs or access points are easy to find.
- Ventura's youth treatment primarily consists of five outpatient sites and five school sites but there are also contract residential treatment and residential WM out of county. The majority of youth served are from the criminal justice system.

Opportunities:

- Due to the unanticipated demand for services the BAL was initially overwhelmed. Ventura made procedural adjustments, expanded access points to clinics, and reassigned functions in order to better meet the demand. Additional streamlining of the BAL will help to improve efficiencies including the addition of a brief ASAM criteria-based screening tool.
- Continued expansion of MAT treatment services are planned with Western Pacific Medical Corporation NTP (spring 2020), remaining county-operated outpatient clinics (summer 2020) and residential treatment programs.
- Recovery Services, recently implemented, are currently limited and need to be expanded (as planned).
- There are no recovery residences and no real coordination with existing sober living environments (SLEs) in the community. Ventura should assure the development of recovery residences as planned and coordinate with existing SLEs when possible.
- Ventura should expand adolescent services through outreach and engagement activities to the non-criminal justice youth population, and increase staffing as needed to accommodate the growth in service demand.
- Transportation challenges to out-of-county services are impacting clients. Ventura should develop a plan to assist clients with transportation to services, especially withdrawal management and residential treatment. This would improve engagement and successful step-down upon discharge.
- Ventura should streamline the screening and assessment processes to provide more timely assessments for clients, especially those clients calling who appear to need intensive services.

Timeliness of DMC-ODS Services

Strengths:

- Ventura tracks first contact for all county-operated programs and contract-operated programs in order to track timeliness to services. An RFS Avatar screen is now in place and county-operated providers are required to use it to track all requests for services. The NTP providers currently provide this report to Ventura outside of Avatar.
- Ventura has developed and operationalized a definition of urgent conditions using criteria that include SAMHSA priorities (e.g. injection-using drug users, pregnant women) and ASAM dimension severity ratings. The timeliness from request to urgent conditions within the state standard of two days is met 65 percent of the time. Ventura has chosen to study this issue with a PIP to increase the percent of clients who meet the two-day standard.

- The two levels of case management, care coordination provided by identified county staff for linkage between programs and program-specific case management provided within each program are examples of a new strategy that will improve level of care transitions in addition to traditional resource assistance.
- As part of their commitment to quality Ventura implemented a data analytics team comprised of staff from the EHR, quality improvement research and clinical subject matter experts. This team meets weekly to coordinate the promotion and utilization of data for informed feedback to all levels of the organization.

Opportunities:

- Ventura needs to increase staffing for Care Coordinators at the Access Unit in order to reach their goal of improved transitions of care between levels of service.
- Additional counselors and clinicians are needed at the county-operated outpatient clinics in order to provide timely assessments and treatment.
- There is a significant need for additional residential withdrawal management and residential treatment.
- There are staffing shortages at the contract provider level impacting timeliness for treatment. Partnership between Ventura and contract providers is needed to develop strategies to increase the workforce across the system.
- The current assessment form is long, resulting in delays of access to treatment. Venture should continue the current review of assessment processes and consider efficiencies, including a brief ASAM screening and placement tool so clients become and stay engaged.

Quality of Care in DMC-ODS

Strengths:

- Ventura supports a culture that has resulted in dedicated staff, leadership and providers who reach out to provide assistance to persons who need SUS.
- Ventura is very recovery oriented as validated by clients who reported they felt not only respected and understood but felt staff were sensitive to their differences.
- The rollout of the DMC-ODS involved a thoughtful approach with pre-planning, and a problem-solving and learning approach with flexibility when challenges and needs for corrections emerged.

- Ventura showed commitment to an ASAM criteria-based approach and provided extensive training to staff at all levels so the approach could be well-implemented, assuring staff really understood and could use the instrument.
- Ventura has begun a process for increased use of data to begin to analyze system level data and how to improve what is being implemented.
- The Treatment Perception Survey (TPS), showed high scores across all elements showing that clients were overall very satisfied with the services they received. There were many areas of strength including clients report of respectful treatment, feeling welcomed, and receiving the help they needed.
- Ventura has created a client-centered treatment culture, with clients reporting they have a say in their treatment plan and are supported to make changes in their plans when they request it.
- Ventura's collaborative documentation model not only streamlines documentation but also enhances client engagement.
- Leadership showed foresight and effective advocacy to utilize an entry level classification for SUS counselors and initiate pay raises resulting in improved staff recruitment and retention at county-operated programs.

Opportunities:

- Additional training will continue the development of collaborative documentation for all staff.
- Clients report they are not familiar with the grievance appeal process and based on the small volume of grievances and appeals this may be valid. Ventura should encourage programs to communicate more directly with new clients about grievance/appeal procedures and their beneficiary rights to use them
- There are not enough IT or data analytic staff to respond to the system demands. Additional staffing will be necessary to meet and respond to the data needs and reporting requirements of the new system. IT staff is a specific concern with the anticipation of adding clinical functionalities and supporting contract providers to increase their use of Avatar.

Client Outcomes for DMC-ODS

Strengths:

- The TPS showed high ratings by clients of positive outcomes, particularly endorsing they were "better able to do things" as a result of their treatment.
- Ventura has a higher percentage of adult clients with planned discharges, indicating that clients stay engaged until they are ready for discharge.

Opportunities:

- Although the TPS reported overall high scores, there were indications of some concerns in the areas of transportation, location convenience and coordination of care with mental health staff.
- Ventura data shows there is a somewhat higher percentage of clients leaving treatment with unsatisfactory progress compared to statewide data. Ventura is encouraged to review this data and explore what could be done to make improvements.
- Ventura, like many counties, is faced with housing challenges. This has impacted the intensive outpatient enrollment. Ventura is encouraged to work collaboratively to find solutions to this problem with a continuum of options including Recovery Residences and SLEs.
- Ventura does not have any contracts for either recovery residences or SLEs and is encouraged to establish standards for recovery residences and SLEs as they move forward to develop these resources.

Recommendations for DMC-ODS for FY 2019-20

1. Establish in-county facilities or expanded options for residential treatment and residential detox for both youths and adult men.

2. Establish in-county facilities for recovery residence beds, and set quality standards for them.

3. Expand both IT and data analytical staff resources to ensure adequate levels of support are available for data analyses, dashboard reporting, and training needs going forward.

4. Develop a transportation plan to assist clients who are receiving services out of county with transportation after the initial assessment and then back to Ventura County for stepdown treatment.

5. Streamline the screening and assessment processes by developing an ASAM criteria-based screening tool and more quickly assessing those callers appearing to need intensive services.

6. Assure sufficient clinical staffing to meet the treatment service demands in Ventura with particular attention to care coordination staff, assessment staff, and contract provider vacancies impacting program delivery.

7. Update the Behavioral Health provider directory so it meets all the technical requirements of MHSUDS Information Notice 18-020 and there is an easy pathway to find it on the Behavioral Health webpage.

8. Expand adolescent services through outreach and engagement activities to the non-criminal justice youth population, increasing staff as needed to accommodate the growth in service demand.

9. Encourage programs to communicate more directly with new clients about complaint/appeal/grievance procedures and their beneficiary rights to use them.

10. Study and develop strategies to improve interoperability between Avatar EHR and contract providers' other EHRs for enhanced electronic data exchange that supports timely and seamless portability of client information across systems.

11. Enhance the usefulness for quality improvement purposes of the 24/7 Beneficiary Access Line Comparative Summary Report by producing and distributing it on a monthly basis to all relevant managers for quality improvement purposes, and add into it a table featuring the number of referrals to each program.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: County Highlights

- None at this time.

Attachment E: Continuum of Care Form

Attachment F: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A—On-site Review Agenda

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

Table A1—CalEQRO Review Sessions - Ventura DMC-ODS
Opening session – Changes in the past year, current initiatives, status of previous year's recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of performance measures
Quality Management Activities: QI implementation activities and evaluation results, network adequacy, cultural competence plan
Medication-assisted treatments (MATs) Plan including NTP
EHR Demonstration
Information systems capability assessment (ISCA)/fiscal/billing
Data analytics and Use of Data: Coordination between IT, data analytic and program staff, dashboard development, performance measures, timeliness metrics, DMC-specific measures
Women's perinatal focus group including onsite tour of residential treatment facility
Residential withdrawal management site visit and staff group interview
Performance Improvement Projects (PIPs)
Health Plan, primary and specialty health care coordination with DMC-ODS
Site Visit to NTP and Focus Group with Clients Who Receive Medication-Assisted Treatments (MATs)
Access Call Center Site Visit and Staff Group Interview
Criminal justice coordination with DMC-ODS
Contract providers group interview
Clinical line staff group interview – county and contracted
Latino/Hispanic Client Focus Group
ASAM Continuum of Care and Fidelity to ASAM Placement Criteria
Exit Interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Maureen F. Bauman, LCSW, MPA, Lead Quality Reviewer
Tom Trabin, PhD., Quality Reviewer
Bill Ullom, Information Systems
Robin Walton, Client/Family Member Consultant

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

Sites for Ventura's DMC-ODS Review

DMC-ODS Sites

Ventura County Behavioral Health and Recovery Services
1911 Williams Drive,
Oxnard, CA 93010

A New Start for Moms
1911 Williams Drive Suite 140
Oxnard, CA 93010

Contract Provider Sites

Prototypes Woman's Center
2150 N. Victoria Avenue
Oxnard, CA 93036

Alternative Actions Program
314 West Fourth Street
Oxnard, CA 93030

Aegis
2055 Saviers Road Suite A
Oxnard, CA 93033

Table B1 - Participants Representing Ventura			
Last Name	**First Name**	**Position**	**Agency**
Aguila	Gabriela	BH Manager	VCBH
Alvarez	Lissette	Detox Coordinator	Prototypes/Healthright360
Barretto	Lizeth	Business Support Manager	NC HCA - AC
Burt	Sloane	Senior Program Administrator	VCBH – Quality Improvement
Calica	Anne	Clinic Manager	Aegis - Ventura
Campos	Sergio	Alc/Drg T S II	VCBH – ADP Programs
Carnaghe	Kimbra	Supervising Deputy Probation Officer	Ventura County Probation Agency
Castro	Chris	Quality Assurance Behavior Clinician IV	VCBH – Quality Assurance
Catapusan	Anita	DMC-ODS Plan Manager	VCBH – ADP Programs
Cobos	Heidiann	Supervising Deputy Probation Officer	Ventura County Probation Agency
Connelly-Cunning	Nancy	ADTS 1	VCBH – ADP Programs
Cooper	Dr. Jason	Medical Director	VCBH – Adult Services
Corona	Eileen	Clinic Administrator – Oxnard ADP	VCBH – ADP Programs
Cortez	Yvette	OA IV	VCBH - ADP
Chen	Yvette	Program Administrator	VCBH – Quality Improvement
Clemore	Brandy	Substance Use Disorder Counselor	Alternative Action Programs
Cruz	Danielle	Management Assistant II	VCBH – Quality Improvement
Daly	Rebecca	LVN	Prototypes/Healthright360
Davis	Dr. Jessica	ADP Treatment Services Manager	VCBH – ADP Programs
Del Cid	Jennifer	Office Assistant IV	VCBH – ADP Programs
Denering	Dr. Loretta	Division Chief	VCBH - ADP Programs
Donis	Lucy	Early Recovery Specialist	Aegis - Oxnard
Donovan	Leisa	Senior Manager - Accounting	VCBH - Fiscal

Table B1 - Participants Representing Ventura			
Last Name	**First Name**	**Position**	**Agency**
Duenas	Alicia	Program Administrator III	VCBH – Data System Implementation
Duran	Jose L	Alc/Drg T S III	VCBH – ADP Programs
Egan	Narci	Assistant Chief Financial Officer	HCA
Estrada	Noemy	Alc/Drg T S III	VCBH – ADP Programs
Fekete	Doreen	Program Administrator	VCBH - Billing
Ford	Cris	Simi Valley ADP/DUI	VCBH – ADP Programs
Gassett	Sharon	CA DUI	VCBH
Glantz	Julie	STAR/CRISIS/RISE/Assist Manager	VCBH – Adult Services
Gonzalez	Dr. Patricia	Research Psychologist	VCBH – Quality Improvement
Handel	Deanna	Whole Person Care Manager	Ventura County Health Care Agency
Hicks	Dan	Alcohol & Drug Program Prevention Manager	VCBH – ADP Programs
Howard	Andrea	Program Manager	Western Pacific Med Corp.
Huey	Chris	Clinic Administrator	VCBH – ADP Programs
James	Destiny	DMC-ODS Care Coordination Manager	VCBH – ADP Programs
Johnson	Dr. Sevet	Behavioral Health Director	VCBH
Juarez	Michael	Executive Director	Alternative Action Programs
Khan	Tipu	Medical Director	Prototypes
Kramer	Barbara	Program Administrator II	VCBH - Contracts
LaPerriere	Richard	Clinic Administrator III – A New Start for Moms	VCBH – ADP Programs
Lemalu	Tamara	Clinic Manager - Aegis Santa Paula	Aegis
Leza	Mimi	PHN, PSUTF co-chair	VCPH
Lopez	Cindi	Clinical Director	Alternative Action Programs
Lucas	Ellie	Counselor	Western Pacific
Macaluso	Russ	Supervising Manager for Probation	Ventura County Probation Agency

Table B1 - Participants Representing Ventura			
Last Name	**First Name**	**Position**	**Agency**
Malandra	Nicole	Intake Specialist	Prototypes/Healthright360
McDuffee	Rachel	Regional Clinic Manager	Aegis Treatment Centers - Ventura County
McKee	Erica	Program Director	Prototypes Women's Center
Medina	Leo	Alc/Drg T S III	VCBH – ADP Programs
Mesa	Marady	Program Administrator II	VCBH – Quality Improvement
Meyer-Frank	Brett	No Information Given	No Information Given
Mikkelson	Sandra	Program Administrator III	VCBH – Quality Improvement
Mulford	Kathy	Senior Behavioral Health Manager	VCBH – ADP Programs
Nagle	Laura	Clinic Administrator Juvenile Facility	VCBH
Nunez	Esmeralda	BH Clin IV	VCBH – ADP Programs
Olivas	Dina	Division Chief	VCBH – Youth & Family Services
Oretga	Luis	Finance Director	Healthright360
Ortiz	Lillian	Alc/Drg T S III	VCBH – ADP Programs
Pringle	Pete	Division Chief	VCBH – Special Projects
Riddle	Angela	Oxnard Manager	VCBH – Youth & Family Services
Rivera	John	Oxnard DUI	VCBH – ADP Programs
Rojas	Michelle	Program Administrator III	VCBH – Data Systems Implementation
Roman	Dave	Senior Program Administrator	VCBH – Electronic Records
Ruiz	Deanna	Clinic Administrator CalWorks	VCBH
Salas	Cynthia	Cultural Competence Manager	VCBH – Cultural Competency
Schipper	Dr. John	Division Chief	VCBH – Adult Services
Seal	Maryza	Contracts Manager	VCBH - Contracts
Shafa	Shahram	Clinic Administrator - Thousand Oaks ADP/DUI	VCBH – ADP Programs

Table B1 - Participants Representing Ventura			
Last Name	**First Name**	**Position**	**Agency**
Sierra	Melanie	Alc/Drg T S II	VCBH – ADP Programs
Star	Keith	Director, Inpatient Services/Assessment & Referral/Utilization Review	Tarzana Treatment Centers
Stuart	Jennifer	Sr. RN MH	VCBH – ADP Programs
Stuthers	Silvana	Alc/Drg T S I	VCBH – ADP Programs, Access Line
Tormey	John	Supervising Deputy Probation Officer	Ventura County Probation Agency
Torres	April	Vice President of Behavioral Health, Southern California	Prototypes / Healthright360
Tovar	David	Prevention Services Program Administrator	VCBH – ADP Programs
Tovar	Luis	DMC-ODS Access Manager	VCBH – ADP Programs
Ummer	Faizal	Program Administrator III	VCBH – Electronic Records
Valdivia	Angelic	Compliance	Prototypes/Healthright360
VanDruff	Janet	Behavioral Health Clinician III – AB109	VCBH – ADP programs
Villegas	Alexis	Program Administrator II	VCBH – Quality Improvement
Vlaskovits	Joseph	Medical Director	VCBH – SUS Programs
Volf	Dr. Nora	Pharmacist	VCBH - Pharmacy
Washington	Chauntrece	Quality Assurance BH Manager	VCBH – Quality Management
Wright	Megan	Behavioral Health Clinician II	VCBH – ADP Programs
Yanez	Terri	Admin Services Division Chief	VCBH - Administration
Yomtov	Dani	Program Administrator II	VCBH – Quality Improvement
Zanolini	Dr. Shanna	Senior Psychologist	VCBH – Quality Improvement

Attachment C—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
DMC-ODS: Ventura	
PIP Title: Study of care coordination post-discharge	
Start Date: 04/01/19 **Completion Date**: 04/01/20 **Projected Study Period**: 12 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 01/30/20 **Name of Reviewer**: Maureen F. Bauman	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The objective of the PIP is to identify interventions to improve transitions between levels of care after discharge from DMC-ODS residential treatment. By improving efficiency and consistency in treatment coordination post-discharge, we aim to realize a lower level of care and thereby better outcomes across client episodes, including lower relapse rates.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1 Was the PIP topic selected using stakeholder input? Did Ventura develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The issue was identified at the Quality Management Action Committee (QMAC), representing the QIT, contract sites, CBOs, and the Behavioral Health Advisory Board. The lead supervisor of the Care Coordination team was involved, and input was also gathered via Community Services Coordinator and Clinic Administrator representation but no specific input was identified from counselors, providers or clients.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The topic was discussed in meetings at QMAC where research was shown that clients who stay in treatment longer have better recovery outcomes (including reduced homelessness and increased employment). Ventura was also aware of this state-mandated data requirements.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Initial data was selected to identify post discharge to a lower LOC within 30 days. Ventura had reasonable compliance, but felt the issue was so impactful to client outcomes, that it should be identified as critical to client care. The ultimate goal was to impact client engagement by ensuring they remain engaged even during transitions when they might be most vulnerable.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	All persons transitioning from residential discharge to a lower level of care are included in this study. There was no demographic information included about this population.

	Totals 4	**2** Met **2** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? Can the percentage of clients discharged from residential services who transition to follow-up services at a lower level of care within 30 days be increased from 70% to 80%, by implementing an intervention in which care coordination staff initiate management and discharge planning 7 days prior to discharge from residential treatment?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Suggest adding an additional goal of increasing the percentage of clients who transition from residential to a lower level of care in seven days.
	Totals 1	**1** Met 0 Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study identifies the base line population was all clients discharged from residential treatment between December 2018 and September 2019 covering 62 episodes and 57 unique clients. No demographic data of this population was provided.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study includes the entire population discharged from residential treatment. The primary data source will be the client EHR.
	Totals 2	**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		

4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* (1) Number and percent of residential discharges with a follow-up admission to a lower level of care within 30 days of discharge (2) Number of days from a residential discharge to a lower level of care	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, the indicators are clearly defined, objective and measurable however residential is defined as both WM and treatment and needs to be separated into these two quite different program types.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators track the timeliness after discharge from residential to the next level of care. There are no indicators that track health status, member satisfaction or provider satisfaction. There is an interest in having this PIP evaluate the effectiveness of care coordination for clients post discharge and how effectively outpatient clinics can keep clients engaged in recovery over a longer period of time; however, to measure this additional indicators need to be added.
	Totals 2	**0** Met **2** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
5.2 Were valid sampling techniques that protected against bias employed?	☐ Met ☐ Partially Met ☐ Not Met	Not applicable

Specify the type of sampling or census used: <Text>	☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Not applicable
	Totals 3	**0** Met **0** Partially Met **0** Not Met **3** N/A **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	That data must separate out residential and detox programs and then timeliness data collected from the EHR will be clear. However, there is no data to validate that the care coordination activities actually took place. There is a plan to include an indicator to validate the care coordination activities by checking the service codes in the progress notes and comparing the results of patients with and without case management. There is also a plan to collection additional data through a survey for clients.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: EHR	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The source of the timeliness data is clear. Additional data identified: input from several clinical staff member through interviews (however results not reported), validation that the care coordination took place and a planned client survey to begin in March 2020
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The timeliness data has a specific systematic method of collecting data that is valid and reliable.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Outcomes tool ☐ Level of Care tools ☒ Other: EHR	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The timeliness data from the EHR will provide consistent and accurate data. The additional data to validate that care coordination occurred as well as a survey to clients is planned.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The plan includes data extracted at specific times, a process to clean and analyze with statistical software and a review process that will occur with a small group representing operations, analytic and quality improvement staff who will review any abnormalities or discrepancies. Results will be disseminated amongst clinical staff to inform them, but it is suggested that input from clinical staff be solicited at the same time to validate the results or better understand any discrepancies. The study will include a review of clients who fail to enroll into a lower level of care within 90 days to better understand reasons for this occurrence, validation of care coordination and client input.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Shanna Zanolini Title: Senior Psychologist Role: Principal Investigator *Other team members:* Names: Faizal Ummer, Dani Yamtov, Destiny James	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Qualified staff and personnel were used to collect the data
	Totals 6	**3** Met **3** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes?	☐ Met ☒ Partially Met ☐ Not Met	The intervention of the Care Coordinators is well planned and detailed and the timeliness issues is addressed; however, there are no contingencies to address barriers identified in the review including the initial staffing challenges that occurred during the

Describe Interventions: hiring adequate staff	☐ Unable to Determine	beginning phases of this PIP. Other barriers should be identified with input from clinical staff and providers.
Totals 1		**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Preliminary data compared base line and 1 quarter of data that included the number/percent of clients admitted to outpatient after residential discharge within 7, 14 and 30 days.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	One preliminary table was presented that was clear and easy to read.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? *Indicate the time periods of measurements*: *Indicate the statistical analysis used*: *Indicate the statistical significance level or confidence level if available/known:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	As this was preliminary data this cannot be determined at this time There was not yet repeated measurements, statistical significance and identification of factors that might influence comparability of initial and repeat measurements. Factors that might threaten internal and external validity must also be considered. This needs to be included going forward
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable	Too soon and not enough data to interpret the data at this time.

Limitations described: *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☒ Unable to Determine	
	Totals 4	**2** Met **0** Partially Met **0** Not Met **2** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Too soon to determine.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Too soon to determine.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Too soon to determine.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	☐ Met ☐ Partially Met ☐ Not Met	Too soon to determine.

☐ Weak ☐ Moderate ☐ Strong	☐ Not Applicable ☒ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Too soon to determine.
Totals 5		**0** Met **0** Partially Met **0** Not Met **5** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

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

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

Conclusions: The PIP shows initial promise in increasing the number/percentage of clients who are admitted to outpatient after discharge from residential treatment within seven days. The PIP has only provided preliminary data for one quarter and needs to continue in order to further study this intervention and to include additional validation measures and address barriers that are identified.

Recommendations: Continue PIP for another year and include: 1) measure to determine if care coordination occurred, 2) separate residential detox from treatment, 3) receive feedback from clinical staff, 4) receive feedback from clients and 5) identify and address barriers that occur.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☒ Confidence in PIP results cannot be determined at this time

PIP item scoring **PIP overall scoring**

9	**Met**	**((9 x 2) + 9) / (18 applicable x 2) = 75%**
9	**Partially Met**	
0	**Not Met**	
10	**Not Applicable**	

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

GENERAL INFORMATION

DMC-ODS: Study of timeliness from first contact to assessment

Start Date : 04/01/19 **Completion Date** : 04/01/20 **Projected Study Period** : 24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 01/30/20 **Name of Reviewer**: Maureen F. Bauman	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The objective of the PIP is to identify interventions to improve time to service from request for service to assessment for DMC-ODS treatment programs. By allowing clients quicker access to needed SUTS services, we can help them engage and start the recovery process sooner. The focus of the PIP will be on both urgent and routine service requests. The proposed intervention, with an initial focus on urgent appointments, is to have each outpatient clinic schedule a specific counselor to accommodate walk-in assessments, with a focus on urgent appointments. This way, there is always available staff on designated days to process urgent appointments.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did Ventura develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The issue was identified at QMAC) representing the Quality Improvement Team, contract sites, CBOs, and the Behavioral Health Advisory Board however the QMAC and QIT designed the PIP. Clinic Administrators, Clinicians and Counselors were consulted during implementation when intervention issues were identified. Other partners identified, including clients, had not provided input at the time of the review.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Timeliness data showed the Ventura was meeting standards the majority of the time; however, due to the impact of timeliness to persons initiating treatment who may still be in acute stages of withdrawal or still using it was determined the issue of patient care was critical enough to still want more improvement.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The issue addressed was timeliness to assessment, a key step in improving timely access to care; however, including the length of time from assessment to treatment would provide additional data to determine if clients are actually getting into treatment as a result of a timelier assessment.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	All enrolled populations who requested services and were assessed for outpatient treatment services are included. It is assumed that clients with quicker access to assessments will be accessing SUTSs treatment services; however, this is not included in the data.
	Totals 4	**1** Met **3** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative: Can the number of days between initial request for urgent service and assessment for treatment for outpatient services be reduced from 3 to less than 2 days by initiating an intervention where outpatient clinic schedule a rotating counselor to accommodate walk-in assessments.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Suggest slight re-wording: "Will the initiation of a rotating counselor to accommodate walk-in assessments in our outpatient clinics, reduce the number of days between initial request for urgent service and assessment for treatment for outpatient services be reduced from 6.8 to less than 2, and for routine requests from 17.02 to less than 10." This better identifies the focus of the PIP and framework
	Totals 1	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The plan identified all enrollees requesting DMC-ODS services who received an assessment for admission to a county-run outpatient treatment clinic. The base line was identified as 792 episodes for 708 unique client's routine requests and 92 episodes and 86 unique client urgent requests. No other demographic data was provided including age, race/ethnicity, gender, or language
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: ASAM Level of Care Results	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Utilization data from the Ventura EHR was identified as the source of data for the base line data; dates of reporting are proposed monthly.
	Totals 2	**1** Met **1** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Number of days from initial service request to actual assessment for services at an in-scope outpatient program • Number and percentage of RFS's with actual assessment at an in-scope outpatient program taking place within 10 days for routine appointments and within 2 days for urgent appointments	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Ventura should track when the assessment was offered to determine if there is an issue with getting them completed or if scheduling is an issues.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The goal of engagement into treatment is implied but there are no specific data points to validate this. Ventura reported they plan to create a survey that would provide client feedback and should include a satisfaction question as part of the survey. Additional feedback from clinicians and counselors to determine if the interventions increase their satisfaction could also be considered.
	Totals 2	**0** Met **2** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals 3	**0** Met **0** Partially Met **0** Not Met **3** NA **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, EHR RFS records, intake assessment data and specific fields, including client ID, initial service request date, location of assessment site, number of calendar days between date of service and date of assessment
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ASAM ☐ Claims ☐ Provider ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	EHR
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The reporting data was identified as the end of each month

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ASAM ☐ Other: <Text if checked>	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP did not describe how data pulled from the EHR that was documented by clinicians could be assured to be entered in the same way. Ventura states the same clinicians will complete the assessments but does not explain how they are assured it will be the same clinicians. Surveys are planned but not yet implemented
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Results and ongoing progress will be shared at weekly meetings that bring together representatives from VCBH operational, analytical, and quality improvement staff. Abnormalities and discrepancies in the data will be brought to the attention of staff as soon as they are identified and discussed at weekly check-in meetings. Results will be disseminated amongst VCBH clinical staff to inform them whether results demonstrate improvement or lack of improvement
6.6 Were qualified staff and personnel used to collect the data? *Project co-leaders:* Name: Shanna Zanolini Title: Senior Psychologist, Role: Principal Investigator *Other team members:* Names: Dani Yamtov, Faizal Unmer	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data will be pulled by Faizal Unmer, electronic health record specialists. Dani Yomtov, analyst will clean, vet, analyze and monitor the extracted data
	Totals 6	**5** Met **1** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:* 1. Request to make CA calendar accessible 2. CA responsible to ensure clinician no show notes and appointment availability are up to date 3. Expectations clarified 4. Assessments and treatment planning length of time established	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Issues addressed during implementation included: need for standardized approach across sites, need to grant visibility to all clinician calendars, timeliness of no-show notes, staff availability. Expectations for clinicians and clinic administrators was clarified and scheduling etiquette was to be discussed at each clinic.
	Totals 1	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: Claims encounter data during brief stay in residential WM and for treatment intake within 7 and 14 days post-discharge Indicate the statistical analysis used: percentages Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interventions:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
	Totals 4	**0** Met **0** Partially Met **0** Not Met **4** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data not available
	Totals 5	**0** Met **0** Partially Met **0** Not Met **5** UTD

ACTIVITY 2: SCORING

PIP Item Scoring: **PIP Overall**

9 Met **((9 x 2) + 7) / (16 x 2) = 78%**

7 Partially Met

0 Not Met

12 Not Applicable

ACTIVITY 3: VERIFYING STUDY FINDINGS (OPTIONAL)

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

ACTIVITY 4: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions: The Non-clinical PIP was delayed, due to the identification of operational challenges in the initial implementation, resulting in changes and clarification of the interventions in order to proceed with the PIP. Therefore, although the PIP process was validated there was only preliminary, but encouraging three months of data, available at the time of the review.

Recommendations: 1) Continue the PIP for an additional year in order to track data over a longer period of time, 2) Add a measure for timeliness to treatment following the assessment, 3.) Add the date of first offered appointment, 4) Complete and administer tools to solicit feedback from clients, clinicians and counselors about this PIP, 5) To ensure clinician documentation is entered the same way, establish a validation process.

Check one:

☐ High confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☒ Confidence in PIP results cannot be determined at this time

☐ Low confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

Attachment D—County Highlights

None at this time.

Attachment E—Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: **Ventura** Review date(s): **January 29 – 31**
Person completing form**: Dani Yomtov**
Please identify which programs are billing for DMC-ODS services on the form below.

Percent of all treatment services that are contracted:

	County-run Sites	Contractor Sites	% Contracted
Outpatient	6	1	14.3%
Residential	-	2	100.0%
Withdrawal management	-	2	100.0%
NTP	-	5	100.0%
Total	6	10	62.5%

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

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

A component of the VCBH Drug Medi-Cal Organized Delivery System (DMC-ODS) includes Ventura County Centralized Care Coordination (VCCCC). Care Coordination services are provided to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative or other community services to support their recovery, as defined in the Special Terms and Conditions (STCs). To receive care coordination services, the beneficiary must be Medi-Cal eligible, reside in Ventura County, and meet established medical necessity criteria (as defined in Title 22) determined by a medical director or Licensed Practitioner of the Healing Arts (LPHA).

Each beneficiary receives an assigned Care Coordinator who assists them throughout the course of treatment and subsequent recovery services, as medically necessary. Care Coordinators are responsible for coordinating case management services for the beneficiary in all elements of program involvement, including collaborating with county-contracted providers to assist the client throughout treatment. Care Coordinators also coordinate necessary services with physical and/or mental health to ensure appropriate level of care.

Care Coordination services focus on coordination of substance use disorder (SUD) care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system as necessary.

Care Coordination services may be provided anywhere in the community via face-to-face, telephone, or telehealth with the beneficiary. Care Coordination services can be provided at DMC provider sites, county locations, regional centers or as outlined by the county in the implementation plan. Services may be provided by LPHA or certified AOD (alcohol and drug) counselors.

As outlined in the STCs, Care Coordination services include:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of care
2. Transition to a higher or lower level SUD of care
3. Development and periodic revision of a client plan that includes service activities
4. Communication, coordination, referral and related activities
5. Monitoring service delivery to ensure beneficiary access to service and the service delivery system
6. Monitoring the beneficiary's progress
7. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services
8. Compliance with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

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

Monthly estimated billed hours of case management	200.51

Comments:

Case management in VCBH is done both by programs and centralized teams.

Various Case Management services may be provided by an LPHA and/or certified AOD counselor. Case Management services assist a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of substance use treatment services (SUTS), (SUD) care, integration around primary care (especially for beneficiaries with a chronic SUD), and interaction with the criminal justice system, if needed. Case Management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

Case Management services include:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of Case Management services;
2. Transition to a higher or lower level SUTS of care;
3. Development and periodic revision of a client plan that includes service activities;

4. Communication, coordination, referral and related activities;
5. Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
6. Monitoring the beneficiary's progress; and
7. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

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

Pick 1 or more as applicable and explain below		
1)	Included with Access sites for linkage to treatment	✓
2)	Included with outpatient sites as step-down	✓
3)	Included with residential levels of care as step down	✓
4)	Included with NTPs as stepdown for clients in remission	✓
Total Legal entities offering recovery services		6
Total number of legal entities billing DMC-ODS		3

Comments:

VCBH currently has six providers offering recovery services, three of which currently bill to DMC-ODS.

Recovery Services 1) focus on the beneficiary's central role in managing his/her health, 2) promote the use of effective self-management skills, and 3) ensure linkage to community resources. These services may be accessed, if medically necessary, after the beneficiary has completed a course of treatment and is triggered, has relapsed, or as a preventative measure to prevent relapse. If Recovery Services are provided in the community, the provider must be linked to a physical site that is a DMC-certified, County-contracted facility. Based on treatment recommendations, type of service, and preferences of the client, services can be provided in-person, by telephone or via telehealth.

The components of Recovery Services are:
1. Outpatient Counseling: Individual or group counseling to stabilize the beneficiary and reassess if further care is needed.
2. Recovery Monitoring: Recovery coaching and monitoring in-person, by telephone or via telehealth.
3. Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
4. Support for Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
5. Family Support: Linkages to childcare, parent education, child development support

services, and family/marriage education. 6. Support Groups: Linkages to self-help and faith-based support. 7. Ancillary Services: Services may include but are not limited to linkages to housing assistance, vocational services, transportation, and individual services coordination (e.g. linkage support to appointments).

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

Number of Sites: Enter the number of sites.

Total number of legal entities billing DMC-ODS: Enter the total number of legal entities billing.

Estimated billed hours per month: Enter hours.

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

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

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

Comments:

NA

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

Number of sites		2
Total number of legal entities billing DMC-ODS		2
Number of beds		68
Pick 1 or more as applicable and explain below		
1)	Hospitals	
2)	Freestanding	
3)	Within residential treatment center	✓

Comments:

VCBH has two contracted providers who offer WM services, both currently residential (LOC 3.2). Each beneficiary resides at the facility and is monitored during the detoxification process. The components of Withdrawal Management services are: 1. Intake 2. Observation and monitoring (course of withdrawal) 3. Medication services (lawfully authorized medical staff)

4. Discharge services.

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

Total legal entities in county		5
In county NTP		
	Sites	5
	Slots	1790
Out of county NTP sites		
	Sites	
	Slots	
Total estimated billed hours per month		2830
Are all NTPs billing for non-methadone required medications?		No

Comments:

VCBH has five contract providers who provide NTP services.

NTP services are provided in NTP licensed facilities by a licensed physician or prescriber (e.g. nurse practitioner). NTP beneficiaries must receive 50-200 minutes of individual or group counseling per month. Medications authorized for prescription under NTP include, but are not limited to: methadone, buprenorphine, naloxone (aka Narcan), disulfiram, naltrexone.

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

Total legal entities: Enter total number of entities. Number of sites: Enter total number of sites.

Total estimated billed hours per month: Enter number of hours.

Comments:

NA, but already certified and will start offering services by December.

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

Total legal entities	7
Total sites	7
Total number of legal entities billing DMC-ODS	7
Average estimated billed hours per month	1372.11

Comments:

VCBH has eight providers offering LOC 1 services, all of which currently bill to DMC-ODS.

Outpatient Services are provided by an LPHA or certified AOD counselor in a DMC-ODs-certified, County-contracted facility. If Outpatient Services are provided in the community, the provider must be linked to a physical site that is a DMC-certified, County-contracted facility. Based on treatment recommendations, type of service, and preferences of the client, services can be provided in-person, by telephone or via telehealth.
Outpatient includes counseling services and administration of oral naltrexone. Services are not to exceed nine (9) hours a week for adults.

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

Total legal entities	8
Total sites for all legal entities	8
Total number of legal entities billing DMC-ODS	3
Average estimated billed hours per month	154.68

Comments:

VCBH has eight providers certified for LOC 2.1 services, and three that currently bill to DMC-ODS.

Level 2.1 intensive outpatient programs provide 9–19 hours of weekly structured programming for adults or 6–19 hours of weekly structured programming for adolescents. Programs may occur during the day or evening, on the weekend, or after school for adolescents. Intensive outpatient programs are primarily delivered by substance use disorder outpatient specialty providers but may be delivered in any appropriate setting that meets state licensure or certification requirements. These programs have direct affiliation with programs offering more and less intensive levels of care as well as supportive housing services.

Interdisciplinary team of appropriately credentialed addiction treatment professionals including counselors, psychologists, social workers, addiction-credentialed physicians, and program staff, many of whom have cross-training to aid in interpreting mental disorders and deliver intensive outpatient services. At a minimum, this level of care provides a support system including medical, psychological, psychiatric, laboratory, and toxicology services within 24 hours by telephone or within 72 hours in person. Emergency services are available

at all times, and the program should have direct affiliation with more or less intensive care levels and supportive housing.

Level 2.1 intensive outpatient services include individual and group counseling, educational groups, occupational and recreational therapy, psychotherapy, MAT, motivational interviewing, enhancement and engagement strategies, family therapy, or other skilled treatment services.

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

Total sites for all legal entities: Enter total number of all legal entities.
Total number of legal entities billing DMC-ODS: Enter the total number of legal entities billing.
Total number of programs: Enter total number of programs.
Average client capacity per day: Enter average client capacity.

Comments:

NA

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

Total sites for all legal entities	2
Total number of legal entities billing DMC-ODS	2
Number of program sites	2
Total bed capacity	194
Average estimated billed bed days per month	741.22

Comments:

VCBH has two contracted providers offering LOC 3.1 services.

3.1 Residential Treatment Services are 24/7, non-medical, short-term residential services that provide rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or LPHA as medically necessary and in accordance with the individual treatment plan.

Residential Treatment Services are provided to non-perinatal and perinatal beneficiaries. Providers and residents work collaboratively to define barriers, set priorities, establish individualized goals, create treatment plans, and solve problems. Goals may include but are not limited to reducing the harm of alcohol and other drug use, obtaining and sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning,

and engaging in continuing care. Residential Treatment Services may only be provided in a DHCS licensed and certified residential facility that also has been designated by DHCS to meet ASAM Criteria.3.4 There is no bed capacity limit for facilities. Residential Treatment Services can be provided in facilities of any size. Lengths of stay must not exceed 90 days. Beneficiaries are allowed two (2) non-continuous 90-day placements in a one-year period (365 days). If medically necessary, providers may apply for a one-time extension of up to 30 days - beyond the maximum length of stay of 90 days - for one (1) continuous length of stay in a one-year period (365 days).

Residential Treatment Service components include intake; individual and group counseling; patient education; family therapy; safeguarding medications; collateral services; crisis intervention services; treatment planning; transportation services; and discharge services.

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

Total sites for all legal entities	1
Number of program sites	1
Total number of legal entities billing DMC-ODS	1
Total bed capacity	152

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

Comments:

VCBH has one contracted provider offering LOC 3.3 services.

This gradation of residential treatment is specifically designed for the population of adult patients with significant cognitive impairments resulting from substance use or other co-occurring disorders. This level of care is appropriate when an individual's temporary or permanent cognitive limitations make it unlikely for them to benefit from other residential levels of care that offer group therapy and other cognitive-based relapse prevention strategies. These cognitive impairments may be seen in individuals who suffer from an organic brain syndrome as a result of substance use, who suffer from chronic brain syndrome, who have experienced a traumatic brain injury, who have developmental disabilities, or are older adults with age and substance-related cognitive limitations. Individuals with temporary limitations receive slower paced, repetitive treatment until the impairment subsides and s/he is able to progress onto another level of care appropriate for her/his SUD treatment needs.

Services are often provided in a structured, therapeutic rehabilitation facility and traumatic brain injury programs located within a community setting, or in specialty units located within licensed healthcare facilities where high-intensity clinical services are provided in a manner that meets the functional limitations of patients. Such programs have direct affiliation with more or less intensive levels of care as well as supportive services related to employment, literacy training and adult education.

Physicians, physician extenders, and appropriate credentialed mental health professionals lead treatment. On-site 24-hour allied health professional staff supervise the residential

component with access to clinicians competent in SUD treatment. Clinical staff knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions who have specialized training in behavior management support care. Patients have access to additional medical, laboratory, toxicology, psychiatric and psychological services through consultations and referrals.

Specialized services are provided at a slower pace and in a repetitive manner to overcome comprehension and coping challenges. This level of care is appropriate until the cognitive impairment subsides, enabling the patient to engage in motivational relapse prevention strategies delivered in other levels of care.

Services may be provided in a deliberately repetitive fashion to address the special needs of individuals for whom a Level 3.3 program is considered medically necessary. Daily clinical services designed to improve the patient's ability to structure and organize the tasks of daily living and recovery, to stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills are provided. The skilled treatment services include a range of cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; clinical and didactic motivational interventions; and related services directed exclusively toward the benefit of the Medicaid-eligible individual.

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	2
Number of program sites	2
Total number of legal entities billing DMC-ODS	2
Total bed capacity	194

(Can be flexed and combined in some settings with 3.3)

Comments:

VCBH has two contracted providers offering LOC 3.5 services.

This gradation of residential programming is appropriate for individuals in some imminent danger with functional limitations who cannot safely be treated outside of a 24-hour stable living environment that promotes recovery skill development and deters relapse. Patients receiving this level of care have severe social and psychological conditions. This level of care is appropriate for adolescents with patterns of maladaptive behavior, temperament extremes and/or cognitive disability related to mental health disorders.

• Setting: Services are often provided in freestanding, licensed facilities located in a community setting or a specialty unit within a licensed health care facility. Such programs rely on the treatment community as a therapeutic agent.

• Provider Type: Interdisciplinary team is made up of appropriately credentialed clinical staff including addictions counselors, social workers, and licensed professional counselors, and allied health professionals who provide residential oversight. Telephone or in-person consultation with a physician is a required support, but -on-site physicians are not required.
• Treatment Goal: Comprehensive, multifaceted treatment is provided to individuals with psychological problems, and chaotic or unsupportive interpersonal relationships, criminal justice histories, and antisocial value systems. The level of current instability is of such severity that the individual is in imminent danger if not in a 24-hour treatment setting. Treatment promotes abstinence from substance use, arrest, and other negative behaviors to effect change in the patients' lifestyle, attitudes, and values, and focuses on stabilizing current severity and preparation to continue treatment in less intensive levels of care.
• Therapies: Level 3.5 clinically managed residential services are designed to improve the patient's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the individual's substance use disorder symptoms, to help them develop and apply sufficient recovery skills, and to develop and practice prosocial behaviors such that immediate or imminent return to substance use upon transfer to a less intensive level is avoided. The skilled treatment services include a range of cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; random drug screening; planned clinical activities and professional services to develop and apply recovery skills; family therapy; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; and related services directed exclusively toward the benefit of the Medicaid-eligible individual.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??) ____yes _____no

Number of program sites: 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 program sites.
Total bed Capacity: Enter total bed capacity.

Comments:

NA but plan to start

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting. (billing Health Plan/FFS can you access services? _____yes ___no access)

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

Comments:

NA but plan to start

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: Enter the number of sites.
Number of program sites: Enter total number of program sites.
Total bed capacity: Enter total bed capacity.

Comments:

Sober living facilities are available, but not funded or contracted by VCBH at this time.

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

One of our residential contractors is planning to get certified for outpatient perinatal services. Another contractor is working on certification for male residential services.

Attachment F—Acronym List Drug Medi-Cal EQRO Reviews

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

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

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