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

FRESNO DMC-ODS REPORT

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**California Department of
Health Care Services**

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FRESNO DMC-ODS EXECUTIVE SUMMARY

Fresno Threshold Language(s) — Spanish, Hmong

Fresno Size — Large

Fresno Region — Central Valley, California

Fresno Location — Located south of Madera and Mono Counties, west of Inyo County, north of Tulare and Kings Counties and east of San Benito and Monterey Counties

Fresno Seat — Fresno

Fresno Onsite Review Process Barriers — none

Introduction

Located in the Central Valley of California, Fresno County is deemed a large size county by way of its population size as well as an equally large area in square miles. Fresno County sits within the San Joaquin Valley, has agricultural operations covering nearly half of the county's land base and is ranked as one of the top agriculture counties in the country.

Fresno County officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in January 2019 for Medi-Cal recipients as part of California's 1115 DMC Waiver. Fresno was the first to launch in California's Central Region and 22nd county statewide, though it shares this launch date with one other county. In this report, "Fresno" shall be used to identify the Fresno County DMC-ODS program unless otherwise indicated.

Fresno County has a population of 930,450 (US Census Bureau 2010) and a large geographic area of 6,011 square miles. Fresno is west of Monterey County which borders the coast of the Pacific Ocean, is land-locked, and lies within the San Joaquin Valley which is an eight-county region in Central California. The San Joaquin Valley is one of the world's most productive agricultural regions in the world and stretches from the Tehachapi Mountains north of Los Angeles up to Sacramento. Considered some of the most fertile farmland on earth, Fresno County, which is part of this region, produced a record \$7.9 billion worth of agricultural products in 2018. Fresno County's primary employment sectors are health care, social services, agriculture, and retail. Because of its proximity to the Sierra Nevada and National Parks like Yosemite the county employs a larger number of individuals in forestry, fishing and hunting related activities as well.

Fresno County's population makes it the fifth most populous county in California and thirty-fifth largest in the United States. Gender ratios are about equal with 0.17 percent more female inhabitants in its population. The ethnic composition of Fresno County indicates that 53.5 percent of the individuals are Hispanic/Latino and 28.9 percent are White. There is an overall median age of 32, though of those who are native born citizens the average is just 28 years, while for those who are foreign born the median

age jumps to 44 years of age. Foreign born individuals comprise 20.7 percent of all Fresno County residents.

There is an average annual household income of \$52,629 though the per capita income is just \$20,231 consistent with the fact that seven of the ten counties in California with the lowest per capita incomes are located in the Central Valley. Unemployment is at 13.6 percent, well above the State average of 3.9 percent, and there is a poverty rate of 25.4 percent, also much higher than the 13.4 percent rate for California overall. Housing costs contribute to an overall lower cost of living with the median home price listed at \$247,600 compared to the state overall at \$552,800. Vacancy rates are at 3.12 percent just below the state rate of 3.49 percent. However, a recent study published in local news media noted that at least 60 percent of rented households in Fresno County are considered “rent burdened” indicating that residents spend at least 30 percent or more of their income on rent. Analysis showed a recent one-year jump of 6.02 percent in cost to rent which was the second highest increase in all large California cities, just above Oakland which is amongst the highest in the country. The 2019 Fresno County Point in Time Homeless Count noted that 1,152 individuals are homeless an increase of 23 percent from the previous year’s survey.

Fresno County has a high level of health insurance coverage with 92.3 percent of its population insured. Medi-Cal insures 34.8 percent of the overall population. Of those who speaking a language other than English at home, 76.2 percent speak Spanish and 14.8 percent speak an Asian or Pacific Island language. Spanish and Hmong, a language consistent with significant a percentage of individuals who came from Vietnam and China residing in the county, are the threshold languages in Fresno County.

The 2019 report on County Health Rankings indicated multiple lowered rankings for Fresno County on the health factors it measures compared to other the counties in California. For general health factors Fresno County ranked just eighth above the bottom end for counties at 50th for overall health-related outcomes. The report ranked health factors and found in Fresno County, poor or fair health was reported in adult’s 24 percent of the time compared to the state health related quality of life measure level of 18 percent. While specific health factors such as excessive drinking is 16 percent, two points lower than the statewide metric, smoking is at 14 percent, three points above the statewide average. Both sexually transmitted diseases (STD) and teen birth are higher than that found in the state averages at 664 cases per 100,000 for STDs and 37 births per 1,000 teen girls, ages 15-19. Statewide STDs rate per 100,000 is 506 and teen births are 22. In addition to a much higher than state average unemployment noted earlier, county children who live in poverty is elevated at 28 percent compared to the state average of 18 percent. Clinical care access is limited with the ratio of primary care physicians to residents at only 1570:1 compared to the state average of 1,270:1, though access to mental health providers for county residents is close to the state average of 310:1 with one provider for every 320 individuals. More information can be found at: www.countyhealthrankings.org/app/california/2019/overview.

Fresno County has experienced local impacts from the opioid and drug overdose epidemic which has plagued the nation. According to 2017 data, Fresno County had 47 opioid related overdose deaths, 88 opioid overdose emergency department visits and 99 opioid related hospital admissions. According to the California Department of Public Health (CDPH) the 2018 mortality rate in Fresno County was 3.5 per 100,000 residents. However, this does represent a 51 percent decrease from 2016. While opioid addiction may often begin with a prescribed medication, 2018 data shows that there has been a 16 percent reduction in the number of prescriptions for opioids in Fresno County since 2016. At 637,726 prescriptions this rate indicates that an estimated 641.3 opioid prescriptions per 1,000 residents in Fresno County were written in 2018. Total morphine milligram equivalents (MMEs) in the prescribed dosage given to residents has also dropped.

Buprenorphine prescribing has also increased by 13 percent between the first quarter of 2019 and the same time period in 2016. Fresno actively participates in the Central Valley Opioid Safety Coalition, which is a broad, cross-sector coalition that is taking a coordinated and multi-pronged approach to comprehensively address prescription drug abuse and ensure the health, welfare, and safety within the local community. Efforts within this broad-based coalition address the opioid crisis through key initiatives that include education, safe prescribing guidelines, Naloxone distribution and overdose prevention, community education regarding opioid safety awareness campaigns. The Coalition utilizes coordinated resources from three counties and represents a public private partnership. Membership includes representatives of Tulare, Madera and Fresno County, Kaiser Permanente and other private health sector organizations, the Fresno/Madera Medical Society, local law enforcement and elected officials as well as the United States Attorney's Office.

In 2019 there was increased interest in Naloxone distribution when Fresno experienced three overdose fatalities linked to fentanyl the synthetic opioid which is 50 to 100 times more potent than heroin. In addition to a variety of medication assisted treatment (MAT) efforts, Fresno benefits from its contract and partnership with local Narcotic Treatment Program (NTP) provider sites. There has also been improved access through sites funded by the Hub and Spoke grant as part of the California MAT Expansion project. Improving MAT to areas across the county such as in Coalinga which are rural, remote, or otherwise isolated is a priority area for Fresno.

During this FY 2019-20 DMC-ODS Fresno 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 Fresno's DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2018-19.

Access

Fresno's DMC-ODS program has a "no wrong door" approach which means the community has multiple access points across the substance use disorder (SUD)

continuum by which to clients can request services and obtain an ASAM screening to determine the need for SUD treatment and the best level of care. Fresno's system of care contracts with Beacon Health Options to manage and operate its Access Line for beneficiaries, a 24-hour telephone line that is shared for those seeking access to Fresno Mental Health as well. The Access Line has experienced clinical staff who can provide brief SUD screening as well as screen for associated mental health issues. Once a service request is deemed valid and a provisional level of care is determined, Access Line staff will attempt to schedule an appointment with the caller and appropriate service provider. Generally, this contact is a three-way conversation between the client, Access Line operator and SUD Provider.

The receiving service provider will see the client to complete a comprehensive American Society of Addiction Medicine (ASAM) assessment. If results indicate an alternative service level is needed, they will facilitate a transition to the appropriate level of care. Fresno has two threshold languages which are Spanish and Hmong. Incoming callers can select their threshold language through a series of prompts. The Access Line attempts to hire and train multi-lingual staff, and there is also a contract with Language Line interpreter services, at no cost to caller.

Over the course of the first year of DMC-ODS, Fresno has engaged in a variety of promotion initiatives within the community to draw attention to SUD service availability. This includes a contract with a professional marketing firm resulting in a communication plan. Fresno has put information into the community through public service announcements (PSA), branding, placards on city buses and utilization of earned media with national events like Recovery Month in order to promote the Access Line. They have also been using non-traditional partners as ways to disseminate messaging such as advertising in liquor or convenience stores. Targeted promotion in at risk communities such as radio spots and social media directed at Spanish speakers or Hmong radio stations is used as well.

In addition, there are county-run clinic access points with walk-in capability to screen individuals seeking referral to SUD treatment. These include the Urgent Care Wellness Center and Youth Wellness Centers where once a preliminary screening and level of care is determined, staff will attempt to facilitate a client involved contact with providers to obtain an appointment for admission. Finally, clients can self-refer to the SUD programs directly by either calling or walking in for screening and potential assessment and admission. If any of the access points determines that emergency services are needed, they will be connected with an emergency department.

Tracking of incoming calls is facilitated in two distinct data bases. Those that come through the Access Line are entered into Avaya telephonic software. For initial requests for service that occur at either the SUD contract provider or county-run access points, information is recorded on the Access Form within the Avatar electronic health record (EHR). County and provider staff have report capability, and these are often used for review by the program and assigned Contract Analyst staff related to access and monitoring of program adherence to timeliness standards. Quarterly reviews and

analysis of test call data are an agenda topic each quarter at the Quality Improvement Committee (QIC) and Access committee meetings.

Since the implementation of the DMC-ODS Waiver, Fresno has utilized Beacon Health Options as its contract provider to operate the 24/7 toll-free Access Line. The system package that Beacon provides can allow for a very efficient tracking of incoming requests and call dispositions. However, basic data is often either unavailable or incomplete due to persistent inability of this provider to obtain adherence to an agreed upon workflow and protocol by its Access Line employees. Fresno staff assigned to monitor the provision of this critical service to beneficiaries noted that “the current process negatively impacts the administrative process for accessing Substance Use Disorder (SUD) services.”

For example, the Quality Improvement (QI) team conducted seven monthly access line test calls between January and September 2019. Of the total of 62 test calls that were performed 28, or 45 percent were logged and recorded within the Beacon Health Options data base. The contracted standard is set at 100 percent across all Access Line key performance indicators. During the same reporting period, it was identified that only 25 of 62, or 40 percent of beneficiary names were accurately logged and just 22 of the 62, or 35 percent of dispositions were recorded accurately. Despite recurrent discussion and proposed solutions, including training and enhanced protocols, the Access Line for Fresno continues to perform poorly. According to Fresno the Access Line is located in Orange County and there have been no specific staff designated just to Fresno. Other issues include the very long average of 56 minutes for test calls, multiple staff handling a single call episode and an inability of employees at the Access Line to share information on screens. In addition to this impacting an ability to provide an accurate representation of incoming demand for service, there is concern by Fresno on the consumer experience. In addition to other remediation proposals, they have asked to secure a telephonic client satisfaction survey. The Access Line issue is the topic for the non-clinical PIP for Fresno. CalEQRO strongly supports Fresno’s involvement of leadership in discussions with this vendor and that corrective measures and heightened test-call monitoring continue.

Once connected with service providers, incoming clients meet with designated intake Licensed Practitioners of the Healing Arts (LPHA) and qualified substance abuse counselors who conduct an assessment that includes use of ASAM placement criteria. Intake counselors at the county-run access sites can link clients to case management and will keep cases open to ensure appointments are met. Providers are required to have identified staff provide care coordination which is individualized and ongoing. Authorizations for residential services are coordinated between point of assessment and designated Fresno LPHA liaison at Beacon Health Options. Complex or co-occurring cases result in referral and linkage to physical or mental health resources.

Providers enter their initial client access data into a log contained within the EHR. Level of care designations are calculated based on such entries and billing/service codes. Data beyond these initial steps is somewhat limited being accomplished with a manual

review and use of manual entry logs since the file of record is paper. Access to data visualization and analytics software (Sisense) is assigned to each contract monitor and all Fresno Technology and Quality Management Staff, although technological and data entry issues have made the use of Sisense limited to its potential. Fresno is actively working with providers on increasing consistent data entry and ensuring accurate completion of the access data. Currently there is no uniform information system beyond the basic Avatar access providers have. While these areas represent data limitations, it is important to recognize that the full migration of the SUD provider network into this first phase of Avatar implementation was recent, occurring November 2019 to present.

Training on the use of ASAM criteria began as early as 2017 and has continued in Fresno. Fresno has delivered more than 30 trainings for its provider network and these have included not just the ASAM but an array of related topics such as co-occurring disorders, use of evidence-based practices, principles of case management and MAT. Training is reinforced by the expansion of Fresno's Quality Improvement team to include both a substance abuse specialist and an LPHA, who can provide technical assistance and assist providers with documentation and with clinical elements essential to compliance with DMC-ODS Waiver requirements including general inquiries and support, ensuring consistent data entry, and providing feedback on the provider's data. Based on early implementation challenges and patterns, Fresno delivered a mandatory "boot camp" training cycle for its network of providers that ran from June through September 2019. In addition to core clinical and documentation sessions, principles of change management were provided to assist program staff with the major shift in organizational culture under the DMC-ODS Waiver.

Communication with contract providers, who provide 99 percent of SUD services is bi-directional. In late 2019, Fresno formally requested and reviewed information from Providers on the "lessons learned" during the first year of implementation. Providers have held separate monthly meetings in the years prior to the start of the DMC-ODS Waiver. The Provider meeting is led solely by providers where they set the agenda and discuss any relevant issues or topics. Since the start of the waiver, providers have invited Fresno Managed Care, Contracts and Technology and Quality Management staff to be involved as participants. There are also regular cross-divisional meetings occur to facilitate ongoing communication and collaboration across divisions to ensure consistent messaging and processes and to continue to work through issues and improve processes related to DMC-ODS Waiver implementation. In addition, Fresno participates in a multi-county Regional SUD Waiver Workgroup which benefits the system through shared experiences of other counties. Clearly Fresno has a strong commitment to establish the core principles of the DMC-ODS Waiver within its service network and for the community.

Fresno is unable at this time to confirm if an increase in the number of clients served has occurred since the onset of the DMC-ODS Waiver. While Access Line data is known to be incomplete, current incoming call volume for all of Fresno's access points is low for a large county, averaging just 74 calls per month. Of the call data available, Fresno reports that 93 percent of callers to the Access Line are linked to treatment. Admission data from Fiscal Year 2018, the California Outcomes and Measurement

System (CalOMS) indicates 5,813 Fresno County residents accessed SUD treatment. Living status in CalOMS indicated a somewhat lower percent are homeless at 20.3 percent compared to the statewide rate of 26.2 percent. A significantly higher number of individuals report being in dependent living situations at 47 percent compared to the state aggregate which is just 28.6 percent. Of those admitted to Fresno, more than half report not being employed and not looking for work at 54.5 percent compared to the state at 51.1 percent. A lower percentage report no criminal justice involvement at 55.4 percent compared to the state average of 59.8 percent. This is consistent with a slightly higher rate referred through the AB 109 criminal justice program at 33.9 percent compared to the state at 31.4 percent.

Available Fresno claims data indicates an overall penetration rate for treating Medi-Cal beneficiaries with SUD of 1.04 percent, higher than like-sized counties at 1.02 percent and the statewide average of 0.93 percent. For clients who are 65 years of age and older, the rate is more than double the statewide of .70 percent with Fresno at 1.43 percent. Fresno's Hispanic/Latino penetration rate is .68 percent, consistent with the statewide average of .67 percent and somewhat lower than large counties which is .72 percent. Contract providers note a consistent shortage of qualified staff and workforce challenges. According to contract providers there is a need for additional clinician level staff in their programs due to the length of time to conduct an assessment, high no-show rates, and heavy documentation standards linked to licensed clinicians. Many contractors in many counties did not anticipate the impact of the new requirements on staffing and infrastructure needs when negotiating rates for Waiver implementation. Most contractors had little experience with medical documentation and government billing and cost report requirements. They also report that there is a shortage of bi-lingual Spanish speaking staff. While they may offer competitive salaries, many are not certified, and work as interns only to leave when the timeframe for them to certify expires. Fresno notes that all the SUD programs offer use of an alternative language line to assist when a bilingual interpreter is not readily available.

Fresno has taken meaningful steps to increase its continuum of care having experienced significant changes in capacity over the past year. This was due to a loss of one provider in each of the following levels of care: outpatient, withdrawal management (WM), residential and recovery residences. Fortunately, Fresno has been able to add back two WM providers, two recovery residence providers and expanded telehealth to help provide outpatient to additional rural communities. At present, Fresno offers ASAM Level of Care (LOC) 1.0 Outpatient Services at 17 program sites and 2.1 Intensive Outpatient Services at 10 locations in the county. Residential LOC 3.1. has four program sites including capacity for women and perinatal clients. Capacity averages 3,241 bed days billed per month. There are three program sites for LOC 3.5 residential treatment and beds can be allocated to 3.1 or 3.5 depending on current need. Fresno has added a new provider to assure access to Level 3.2 WM after the previous provider was unable to secure DMC certification. This resulted in a gap of service for several months since that provider had the capacity for 577 bed days per month. The new contract has the potential to serve clients with 68 beds including 24 for women and 14 for perinatal clients, albeit in Kern County. It should be noted, this

contract allows for Fresno clients to enter based on bed vacancy availability, not dedicated beds. Fresno is in negotiations with a local provider to secure another 12 beds and hopes to bring on that additional WM capacity in early part of 2020.

Fresno continues to work on network adequacy issues. They have a single alternative access standard (AAS) issue area that is in the western portion of the county which is quite rural and lacks NTP services required by DHCS network adequacy standards for youth and adults. An expansion pilot is being coordinated in Coalinga with a contracted NTP provider. Similarly, Fresno continues to seek an adolescent residential provider, either in or outside the county. Fresno facilitated three sessions to discuss youth needs. These sessions were called a “Youth Convening” with partners and stakeholders, who collaborated on identifying current gaps in service, barriers and other unmet needs related to the youth population. While data on demand was limited, Fresno felt the experience and qualitative data collected with allied providers and agencies who share this population would help to inform next steps for expanding and improving their system. The output from the Youth Convening was a guiding document which was developed to inform future efforts and guide care expansion.

At the time of this CalEQRO review cycle, Fresno did not have any billing for Recovery Services (RS). While seven outpatient providers have expressed an interest, just two are providing RS and of these, just one has started to document and submit bills. CalEQRO strongly encourages Fresno to continue to engage all its service level providers in establishing this much needed level of support for clients.

Though not covered by DMC funding, transitional housing through Recovery Residences (RR) is an essential component for SUD clients who need an alternative to, or step-down from residential treatment. Fresno currently has just two legal entities with a total 63 bed capacity at two program sites, quite a low number for a large county. Housing remains an issue for the SUD population and both line staff and clients in the CalEQRO adult focus group state that any expansion of RR beds is welcomed and needed. Fresno does have plans to open 14 new beds with its existing contract provider Mental Health Systems. These beds will be designated for women including those who have children.

Fresno has noted its commitment to opioid treatment programs offering several locations that clients can access MAT. Fresno contracts with Aegis Medical Systems and MedMark, and Bay Area Addiction Research and Treatment (BAART) their Narcotic Treatment Providers (NTP). NTP clinics currently have five locations in the county with a total of 4,275 treatment slots authorized. While claims data from CalEQRO show minimal non-methadone billing, both NTP providers report that use of non-methadone forms of MAT are increasing. Aegis believes that this is due to suboxone being covered now by fee for service Medi-Cal. Discussions with both NTP providers included what education and decision-making interactions are available to incoming clients. Medical staff provided a tour of their assessment office and materials for buprenorphine including infographics and brochures were visible.

Fresno is currently reviewing requested contract materials to provide non-methadone MAT telehealth with Bright Heart Health. Additionally, two existing MAT providers are in discussion with Fresno to consider establishing DMC certified outpatient sites and two current providers, Kings View Behavioral Health and Fresno New Connections are considering offering MAT services in its outpatient setting. Non NTP providers interviewed by CalEQRO note that there is policy in place for all contractors that clients who present on methadone or other MAT are to be provided access based on clinical need. While this and several trainings have led to movement away from lingering bias and stigma associated with those on MAT, these issues do remain within Fresno's continuum. NTP management staff report that they have an excellent relationship with their assigned Fresno contract analyst and have been asked to provide specifics on any case where a client on MAT is having difficulty in treatment or gaining access.

Fresno County is a Hub and Spoke grant recipient, part of the state-wide DHCS and HHS MAT Expansion project. Facilitated by one of Fresno's NTP providers MedMark, their representative shared her estimate that over 235 individuals have been placed on buprenorphine during this grant cycle. While the funding sunsets in July 2020, there is hope that another round of the grant will be made available to continue this project. Aegis' medical director has worked for decades with the county Public Health Department on a local needle exchange. In addition to syringe replacement Narcan, the overdose reversal agent has been made available to anyone who needs it. The distribution of Narcan also occurs for clients at the NTP sites.

Under its MOU with local health plans (HP), Anthem Blue Cross and CalViva Health, there is a process in place to screen all identified patients for both SUD and MH issues at the FQHC clinics and emergency rooms. Utilizing the SBIRT model after the initial screen for SUD issues, a patient may receive up to three counseling sessions at the clinic and eventually be referred for a full assessment into treatment if indicated. Referrals follow the "warm hand off" strategy of care coordination to insure linkage with providers. HP managers interviewed by CalEQRO relate that this workflow is basically built around a 'no wrong door' policy agreed upon by them and Fresno. While there is no health information exchange (HIE) or integrated EHR, HP manager's report excellent follow-up on referrals.

Access to MAT is enhanced in that clinical staff get MAT training and there is support from Fresno regarding the process for increasing x-waiver prescribers. HPs noted that they favorably view the MedMark led Hub and Spoke grant and that it is increasing local x-waivered capability and MAT demand. Anthem HP has contracted with Bright Heart Health for telehealth MAT services with a start date of January 2020. CalViva HP has an ED Bridge grant to begin doing MAT inductions in the ER and help facilitate SUD counseling referrals. Peer navigators are in place through some HP clinics in order to help to engage clients with both SUD and MH services.

Fresno reports that beneficiaries are accessing transportation supports to SUD appointments through the project linked to the HPs. However, as with the prescribing data in physical health clinics Fresno does not have specific information regarding to

what extent the transportation is being used. In sessions conducted by CalEQRO both Aegis and MedMark report extensive use of this benefit by methadone clients for their NTP outpatient appointments. Transportation remains a significant barrier however, especially for those clients on methadone who enter residential care. This is reportedly due to a reluctance or inability of these programs to insure consistent availability of transport to NTPs. This perception was consistent with client feedback to CalEQRO in focus groups.

Timeliness

Fresno has established all timeliness standards as mandated by the DMC-ODS Waiver and data supplied to CalEQRO dates from January to November 2019. Quality Management staff for Fresno noted that while the establishment and tracking of time to service was an implementation priority, they have continued to progress toward getting a complete data set. These efforts coincided with the implementation of the Avatar electronic health record for SUD providers. While the clinical documentation of the system remains essentially one based on paper charts, certain core elements including billing and CalOMS were part of a system wide transition that included timeliness standards which are coordinated codes in the EHR and hand tabulations. Estimates are that just 30 percent of the required timeliness data was being provided in the initial months of the DMC-ODS Waiver, but now Fresno estimates that 90 percent of these activities are reflected in current reports. Continued attention to pulling this information is an ongoing agenda topic in meetings with both providers and the assigned information technology staff.

CalEQRO interviewed line staff as well as the supervisory staff who oversee the screening and intake workflow during this review cycle. Line staff for both the call center and provider sites were found to be cognizant of the timeliness requirements under the DMC-ODS Waiver. While calls are triaged and expedited for screening, once a disposition has been made, the reported time to initial appointment offered and face-to-face contact are an area that Fresno has been generally successful. The reported overall average wait time for individuals to receive an offered appointment for routine services is just 6.19 days, meeting the 10-day standard 46 percent of the time. For youth the average wait time decreases to just 2.54 days and Fresno meets the 10-day standard on these offered appointments 86 percent of the time. The length of time from initial request to first to face visit has a high percentage that meet the 10-day standard, 53 percent overall. Again, for youth, these first appointment contacts meet the standard a full 85 percent of the time with an average length of time at just 6.29 days. For adults, there is a drop to just 50 percent in meeting this standard as compared to youth. The average number of days adults wait for a first contact well exceeds the 10-day standard at 16.49 days.

BHC notes the ongoing efforts Fresno has taken to provide the necessary data and corrective measures to its providers specific to timely access standards. Fresno

disseminates a SUD Access Form Summary on a quarterly basis that gives each provider a report on the various access and timeliness areas they are to address. The data is culled from Avatar and in addition to summary data, provides details on coding or duplicative entries to assist the provider in making workflow or entry adjustments. This reporting is also reinforced by visits to the providers by Quality Improvement staff and the assigned Contract Analyst. Data is tracked from the onset of the DMC-ODS and trends are reflected in summary analysis. Both challenge areas are noted for improvement opportunities as well as strengths or praise.

Due to data findings early on Fresno conferred with provider network and changes were made to the form and process for completing. In addition to being more streamlined, it is more accurate and complete which has occurred due to strong collaborative communication between Fresno and their providers. CalEQRO notes that while there were general issues with data collection, slow response to making corrections and subsequent billing delays, the oversight now in place is a strong component of Fresno's system management and may well represent a best practice. BHC supports this work as it continues to seek program and system-based improvements.

Fresno acknowledged the ongoing process of improving on these standards and noted that at present they do not have the ability to report on data for this review cycle that pertains to readmission within 30 days to WM. This was due to poor data collection, failure to take steps to correct and a nearly six-month time period where this service level was unavailable. Fresno does have a new WM service provider and notes that the new contractor has the necessary ability to track this appropriately. Data regarding average length of time from initial request to first MAT appointment during the reported time period was unavailable. Fresno reports that between January and November 2019 it was unable to track this due to code and data collection issues. Billing claims data supplied by CalEQRO reports that the three-day standard was met 100 percent of the time, all individuals receiving a first dose of methadone in a day or less.

Fresno has established a timeliness standard of two days regarding requests for urgent appointments. Though the DHCS standard is 48 hours, Fresno does not currently track these requests by hours but does so by days. The average length of time for urgent appointments is reported to be 14.4 days with Fresno meeting the established two-day standard 46 percent of the time. While the number of days drops to just 4.5 for youth, the standard is met only 40 percent of the time. Fresno defines urgent appointment requests as "any beneficiary who faces an imminent and serious threat to their health including but not limited to, the potential loss of life, limb or other major bodily function. The definition notes that a normal timeframe for access or decision-making process would be detrimental to the enrollee's health or life or could jeopardize their ability to regain maximum function". CalEQRO points out to Fresno that this definition appears consistent with emergency health care definitions found in statute and labor codes pertaining to the provision of medical services. Fresno should consider that by defining urgent in this manner, they may well be excluding less emergent situations and that subsequently individuals with urgent needs would not be provided an expedited path to

care. For this reason, CalEQRO strongly encourages Fresno to consider adjusting this definition.

Fresno has set timeliness standards for follow up services after discharge from residential treatment at seven days, commensurate with the HEDIS standard. For the report period of this review cycle, and 156 of the 410 clients or 38 percent of those admitted to residential services had received a follow-up session after discharge within seven days. This represents a relatively high percent of individuals who are moving across the continuum into a lower level of care in a first-year county. It is worth noting that residential providers interviewed by CalEQRO report a strong commitment to peer and internal utilization review processes to assure focused coordination for its clients. Seeking to build on this performance, Fresno has made residential discharge coordination the topic of its clinical PIP. Since the continuation of service is a primary goal of the PIP, CalEQRO strongly supports Fresno's utilization of the Network for Improvement of Addiction Treatment (NIATx) paradigm designed specifically for performance improvement activities pertaining to this objective in behavioral health settings.

At present there is no established no-show standard except as it may exist within the individual programs. However, Fresno developed a process to track beneficiary no-show and cancellations. Program and staff cancellations are also tracked by this process. This requirement has been in place since the implementation of the DMC-ODS Waiver. No-shows and cancellations are entered using non-billable service codes at the network provider level. While efforts to aid providers in the consistent entry of these codes, Fresno's network providers have been challenged by the process and there is inconsistency making the ability to accurately track and trend this data a difficult task. Fresno notes that double entry for some providers that are entering service request data in their own EHR as well as Fresno's on Avatar, can be time consuming and increases the probability of errors in data entry.

Fresno continues to provide ongoing technical assistance and encouragement to its providers with a goal of finding an easier manner so that the routine review and monitoring of this data can occur. Fresno reports that the current incompleteness rate of logging this data by providers is 27 percent. Consistent with this focus, CalEQRO sessions found some individual providers quite involved in addressing daily capacity issues, and the tracking and addressing of cancellations and no-shows. One large provider had set a threshold of three missed visits and once that occurred there was a case review between staff and supervisor to determine how to mitigate the issue.

Quality

Fresno benefits from being part of an integrated department with the Mental Health Plan. The Quality Management (QM) structure, Quality Assurance, and a Quality Improvement Work Plan (QIWP) integrate the efforts of both divisions. Work began on this integration into QM in 2018 and was fully realized in 2019. A significant addition of

both a dedicated SUD counselor and LPHA provides a meaningful bridge from Fresno to its system providers. At present, QM is working to identify objectives, and performance indicators, to establish benchmarks, and standards, regarding this new comprehensive system of care under the DMC-ODS. While performance indicators are outlined in the current Work Plan, Fresno expects to solidify both data and indicators and add them into the revised QIWP in FY 20/2021.

A fundamental premise of the Waiver is that quality of treatment is founded in a client-centered approach that includes matching treatment to a client's situation. Fresno has set forth a system-wide set of guiding principles for care delivery. These provide the clinical framework that influences decision making in order to assure quality care and maximize efficiency. While there is an established expectation that program staff and providers use ASAM criteria for treatment placement decision making, Fresno stresses individualized decision making as a core value in guiding care. Utilization of allied support systems, cultural responsiveness and clinical efficacy are promoted along with program development and adherence to compliance mandates.

Integration of the SUD audit unit into the Managed Care Division occurred in 2019 doubling the size of the unit to oversee DMC-ODS mandates. This integration of effort also assisted the SUD audit team to develop new workflows and processes from their Mental Health counterparts and become more effective. Technical assistance (TA) to network providers from this unit has focused primarily on assessments and treatment planning. In addition to TA, designated QM team members (from QI & Managed Care) are assigned to individual providers and conduct annual site reviews, look for compliance issues and ensure providers are utilizing evidence-based practices. Review of resulting data or reports from these and other QM activities are reviewed at the Quality improvement Committee (QIC) which meets each month. While the focus of the QIWP remains primarily on the regulatory, timeliness and other compliance requirements of the DMC-ODS, ongoing reporting occurs for client satisfaction items such as Treatment Perception Surveys (TPS) and access line test calls.

Fresno SUD system providers have taken on most of the responsibility for initial and ongoing chart reviews as part of their internal quality assurance efforts. These tend to be individual processes specific to the programs themselves. Programs also note some ability to track no-shows, cancellations and productivity, but there are no standards in use to gauge acceptable output. Fresno has continued to give support by training and TA on assessment skill building, the ASAM, CalOMS as well as soliciting training topics from providers regarding any area that could help them improve the quality of care they deliver. Throughout 2019 there has been ongoing TA from Fresno on the technical aspects of documentation, billing submissions and treatment authorizations. This support continues and there are ongoing meetings that include providers on their transition to Avatar. Organizational changes and transitions to a new EHR often result in challenges. Providers shared with CalEQRO that in addition to being "overwhelmed" by the level of paperwork, they are also asked to train staff on use of new forms only to see them change again. Additionally, while they have found the use of EBPs such as the Matrix very helpful, little data has been forthcoming from Fresno on client progress or

outcomes. Feedback is important to maintain enthusiasm for these program interventions.

While service levels defined by the Waiver for client-centered ASAM-based care are currently being delivered by use of contracted treatment providers, Fresno medical director notes that developing local youth services including those for co-occurring disorders continues to be a challenge. There is difficulty in attracting psychiatrists to the Central Valley and Fresno. A desire is expressed to see ASAM scales more tailored to the youth population and they articulate a need exists for increased early intervention through prevention, education and coordination with school-based assistance programs. Fresno is integrated with Mental Health and all incoming clients are screened for both mental health and substance use disorders. At the SUD program level, it was noted by some clients interviewed by CalEQRO that care coordination for those with co-occurring disorders is inconsistent. Some report being part of a warm hand-off while others note just being given a phone number and told to make the connection themselves. Both care coordination and case management are delegated responsibilities to the contracted providers though a subject of Fresno's ongoing monitoring activities. Recovery services have yet to be fully realized and while case management is occurring, billing has been a challenge for some providers.

Performance Improvement projects (PIP) are active and ongoing. The clinical PIP seeks to address issues of client retention with an objective to improve the number of clients who remain engaged in both residential and outpatient treatment. The non-clinical PIP will oversee workflow, protocol and general redesign of the contracted Access Call line. This is due to long-standing poor performance found in test call data analysis. CalEQRO supports both of these projects and it is clear that they benefit from Fresno's strong QM team.

Congruent with DMC Waiver principles, Fresno has worked in strong coordination with physical health services. There are established Memorandum of Understanding (MOU) with the local Health Plans, CalViva and Anthem Blue Cross. Established protocols are in place to identify, screen, and provide brief intervention to individuals determined to require SUD services. For such individuals, Fresno's SUD providers are required to facilitate linkage and assist the beneficiary in ongoing care coordination, including transportation as needed. Similarly, Fresno participates in Whole Person Care (WPC) which by design, helps to facilitate care coordination between medical and behavioral health systems and high-risk vulnerable populations, very often individuals with long-standing mental health or substance abuse issues. CalViva notes that it has just launched a California ED Bridge Model grant project that is designed to provide the necessary medical and SUD screenings allowing them to start suboxone inductions in the emergency room. The ED Bridge project includes funds for peer navigators that will allow them to assist in care coordination with SUD providers.

Like most counties, there has been stigma within Fresno's substance use treatment continuum toward those receiving methadone and other MAT services. Both NTP providers interviewed by CalEQRO note this has diminished somewhat but persists

albeit in less direct ways. There continue to be individual reports of clients being denied services or that arbitrary standards exist. These include limits on the milligrams a client can take or that clients need to demonstrate that they are actively tapering down and/or discontinuing methadone. There are also disincentives such as a program that provides transportation, but this is always with the client having to wait “for hours” to then get a ride back to the program. Clients also state they feel inclined to hide this part of their treatment as others do not recognize their sobriety while on MAT. Fresno has continued to sponsor trainings including one in the last six months from DHCS. A variety of other training opportunities are continuing regarding MAT, and there is a sense of improved acceptance despite the issues that linger.

Outcomes

Fresno has utilized the Treatment Perception Survey (TPS) survey on two occasions in the past year and received analyses of their results from UCLA. Fresno established a baseline by administering the survey in May of 2019 and had providers collect TPS again in October. Fresno has taken the additional step of compiling the TPS results from the Adult and Youth surveys and visually representing this data to both the program and management staff. This has given the Fresno SUD providers an opportunity to not only compare TPS scoring for each time period, but to review the number of program sites who administered it and gauge the percentage of forms that could be utilized as valid responses. Excluded forms were minimal in the October administration of TPS compared to the initial survey cycle in May of 2019. Of note, Fresno’s Quality Improvement, Managed Care and Contracts Management staff were at the annual statewide SUD conference in August 2019 and attended a session on conducting a successful TPS administration. Providing ongoing technical assistance is a priority for Fresno, and they have recently formed a Change Leader Academy. The Academy is designed to advance SUD provider skills on a variety of QI principles and to reinforce the importance of complete, timely and accurate data collection.

TPS survey analysis was shared with leadership noting the variance if any of the different survey administrations. Adult surveys saw improvement in most of the domain areas, but youth results indicated a drop in nearly all the questioned areas between May and October. For youth, agreement ratings on survey questions are now down in 17 of the 18 questions asked compared to previous results. Most significant there is drop noted in questions pertaining to therapeutic alliance between youth and the counselor. CalEQRO has strongly encouraged and Fresno’s Quality Management staff agree to review the youth surveys with its providers and determine what might be possible to rectify this drop in client satisfaction.

As noted earlier, Fresno Quality Improvement Team has provided sharing of outcome and performance data specific to TPS survey when possible. Fresno has reported making the development of data dashboards to enhance data review and monitoring a priority. Data metrics are viewed as an important area to assure both compliance and performance, but Fresno’s launch of a new billing and reporting system has made the

logistics of data retrieval and reporting a challenge. With the move to the Avatar information system, infrastructure support and business adjustments have reduced the current capability to support program analysis pertaining to outcome data. Fresno is currently in its first year of a new electronic health record (EHR) for their DMC-ODS Waiver system of care with Avatar and focus has been primarily on documentation and billing. It is anticipated that as workflow and input challenges are overcome data will become more available to assist Fresno and its contract providers.

CalOMS outcomes are exceedingly low with just 30 percent having a standard discharge, compared to the statewide 49.6 percent. Of this discharge type, just 12.8 percent of Fresno clients completed treatment with a referral, compared to the statewide at 22.9 percent. Administrative discharges for adults are very high at 61.5 percent compared to the statewide metric of 37.9 percent. Within this discharge type, clients who had administrative discharges with unsatisfactory progress was at 36.6 percent compared to the statewide 28.1 percent. CalEQRO strongly suggests that Fresno address this pattern by looking down to the program level and see if targeted performance improvement activities can begin to move this in a more positive direction.

Regarding data collection, Fresno has continued to convey expectations on CalOMS submissions with its provider network though timely and complete outcome data remain a challenge area. While a core area is the adherence to submission requirements by providers, Fresno has had to invoke a variety of quality checks and processes as Avatar was implemented. Some lag in both billing and CalOMS submissions were noted over the course of several months in 2019 as they addressed errors and omissions. Moving from the SUD legacy system to Avatar, which has been in use by Mental Health for several years, migrating CalOMS requires addressing “mistakes” now found in old data. Additionally, tables in Avatar allow for entry despite errors and creates impediments to consistency. Fresno has done multiple provider trainings and given on-site technical assistance specific to its new EHR. BHC has encouraged Fresno to continue to address system issues that make CalOMS data unavailable for analysis and by its provider network.

Client/Family Impressions and Feedback

CalEQRO conducted four diverse client focus groups (FG) during the Fresno onsite review. One FG was held at an adult outpatient program site while a second was at a residential program and included both men and women. A third FG was at another outpatient program though was primarily for clients who were monolingual Spanish speaking adults. A fourth session was at a women’s residential program. The purpose of these focus groups was to obtain perceptions from clients currently receiving treatment services regarding the accessibility, timeliness and quality of those services.

The first FG was held at an outpatient program for adults in need of substance abuse treatment and with Fresno’s largest contract provider. The FG was well attended with six male and two female clients. Participants universally noted most commonly being

referred by the courts or child welfare felt that the intake and entry to treatment was expedient. Clients generally feel they are treated with respect and are supported by staff. The facility offers both day and evening groups which are appreciated by clients who have daytime commitments. Clients report that activities are diverse, engaging and interactive. They note that counseling staff give them the tools needed to be successful in recovery and most report high level of trust and self-confidence. Clients note being treated individually and that this is in contrast to other programs who see them only as “addicts.” Clients did note that they have received little information on the use or benefits of MAT while in treatment. Participants stated that they enjoyed the program the way that it is but recommended the program consider offering more individual counseling.

The second FG held at a residential program and also had good attendance with eight participants, four of whom were men, one transgender and the remainder were women. Clients related that locating the program was easy though timeframe for admission ranged from a day to several weeks and beyond. Assessment focused on gathering their history and all felt that was the main determinant regarding level of care. Clients all feel comfortable with staff, feel the program is structured in a way that lets them think and that they have time to plan for their own recovery. Program participants may have their children and the program is seen as family oriented with scheduled groups for couples and families. Clients related that most had not received information regarding the benefits and use of MAT, though two who reported a history of alcohol dependence said they have been approached on the topic. Bilingual staff are available and there is coordination with mental health services for those who are co-enrolled. All present suggested transportation, vocational assistance, relapse prevention skills and getting them to local 12 Step meetings would be of help.

The third FG was less well attended with just four attendees from the outpatient treatment site that has Spanish speaking clients. Participants all identified as Hispanic/Latino, were all male and two were age 60 years or older. A Spanish interpreter was present, and all the clients reported easy access and quick admission to treatment. All would recommend the program to others and find the staff are supportive in their attempts to achieve recovery. With methamphetamine noted as a primary drug for all but one of the participants, most have received little information on MAT. One client is on Vivitrol through a primary care MD. There was universal agreement that the program would be improved by adding more staff and as an aside the interpreter later shared with CalEQRO that bilingual staff have been hard to keep. Clients noted that groups have been combined due to the recent departure of a Spanish speaking intern.

The fourth FG was at a residential program that offers gender responsive substance abuse treatment for women and has the capacity to take those with co-occurring disorders. Most of the referrals for this program are facilitated in coordination with the local social service agency, child welfare and probation. The session was well attended with nine female clients. Participants noted a range of wait time to get into the program with some entering in a couple of days, others having to wait for a couple of weeks. Most of the delay time was due to Medi-Cal eligibility concerns. Clients generally feel

good about the program but note it is disorganized and communication to clients by staff regarding messages from family or even protective services is not efficient. While access to mental health services was supported, no system-wide approach was described about the use of MAT. One client on methadone who must dose daily says the transportation from the program is unreliable and she often arrives after her scheduled time. Participants stated that the facility was clear on its relapse policy, which they describe as punitive. The policy is if caught using one is exited and there is a 30-day waiting period before readmission is considered. While staff are generally well regarded, all participants have had experience with an employee who is described as inaccessible and not empathic to their needs. Clients stated that they would like to see more for children to do, an expansion of visitation time which is not open on the weekends and an allowance for them to pursue education or vocational goals as they plan their recovery and community re-entry. At present there are restrictions on their ability to work or attend school.

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 Fresno will summarize the actions it took and progress it made regarding each of the recommendations.

Barriers to This Review

None.

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has received 40 implementation and fiscal plans for California counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act. DHCS has approved and contracted thus far with 30 counties, and EQRO has scheduled each of them for review.

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

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

Validation of Performance Measures¹

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

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

Performance Improvement Projects²

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

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

DMC-ODS Information System Capabilities³

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

Validation of State and County Client Satisfaction Surveys

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

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

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

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

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

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

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

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

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

None noted.

Past Year's Initiatives and Accomplishments

- Fresno County began providing DMC-ODS services which included the implementation and fiscal plans submitted and approved by DHCS as reflected in the Intergovernmental Agreement.
- Fresno County transitioned from the previous data system to Avatar and current components include DMC-ODS beneficiary access tracking, CalOMS and billing.
- Fresno County added a decision tree to the toll free 24/7 telephone number that connects callers to the DMC-ODS Access Line, which is operated by a contract provider, Beacon.
- Fresno participated in the development of a department wide Strategic Plan. A process for collecting and incorporating feedback from all departmental supervisors and other staff occurred through 2019. Currently the Strategic Plan is being finalized. Fresno has adopted the Plan's Guiding Principles of Care Delivery.

ACCESS and TIMELINESS OF SERVICE

- Fresno has worked with NTP providers to expand services into rural areas of the county with an initial priority area of Coalinga.
- Fresno expanded services provided by the county run Urgent Care Wellness (adult) and Youth Wellness Centers to provide an integrated access experience where individuals served can be screened and referred for both SUD and Mental Health treatment. Both access points make treatment referrals and perform linkage follow ups.
- Fresno worked to understand service needs of adolescents by conducting a 3-session Youth Convening with community stakeholders. The convenings assisted Fresno in identifying gaps, barriers, and unmet needs of youth related to treatment and prevention of SUD.
- Fresno added Bakersfield Recovery Services to provide Level 3.2 WM to 30 men, 24 women and 14 perinatal WM beds totaling 68 potential beds.
- Fresno added Turning Point to its Recovery Residence Master Agreement adding another 25 beds.

- Fresno's SUD provider, Mental Health Systems began providing Level 3.2 to women and perinatal beneficiaries adding 12 beds.
- Many of Fresno's SUD providers have expanded the number of support staff positions to address expanded administrative requirements of the DMC-ODS Waiver.

QUALITY OF CARE

- Fresno has delivered a total of 34 trainings that covered topics such as Evidence Based Practices, Co-Occurring Services, Telehealth, Recovery Services, Case Management, MAT Implementation, Physician Consultation, DSM 5, Rate Setting, and ASAM across a two-year span of time.
- Fresno formally integrated substance abuse into the Quality Improvement Committee (QIC). The current QI work plan has both mental health and substance abuse component.
- Fresno hosts the Provider Q & A sessions to provide technical assistance and clarifications on all aspects of the DMC-ODS Waiver. This began as a monthly meeting but is now quarterly.
- QIC began work on an integrated QI Work Plan which was approved December 2019.
- Fresno has provided quality improvement trainings and established a Change Leader Academy. The purpose of this initiative is to promote and build QI capacity within each network provider's workforce. Dates for this academy are scheduled into the next year.
- Fresno has integrated the SUD audit unit into its Managed Care Division. Positions added have doubled the size of the audit team to support the additional site, program monitoring and credentialing required to comply with the DMC-ODS Waiver.
- Fresno has continued to provide training for all offices of the court and criminal justice system to enhance adoption by this significant referral source of key elements of the DMC-ODS Waiver including ASAM criteria and medical necessity.

OUTCOMES

- Fresno has continued with ASAM trainings as well as refresher courses to enhance practitioner's skills across its system of care.
- Fresno provided peer professional training to provide an opportunity for persons with lived experience and parent partners to receive an 80-hour training preparing them for future state certification.
- Fresno's IT staff began creating dashboards to support data review and monitoring of outcomes.
- CalOMS on-site technical assistance given to the network providers throughout the year by Contracts Management and IT staff.

MANAGEMENT

- Fresno County was chosen as an Opioid Transitions in Care grantee. Fresno assisted Health Management Associates (HMA) in organizing and facilitating a process improvement event where interest regarding solutions related to opioid use was noted. Additionally, individual TA sessions related to MAT expansion by community-based organizations was requested.
- Fresno issued a Request for Application (RFA) for Capacity Building and Capital Improvements with the goal of assisting providers cover necessary but un-reimbursable ramp up and improvements costs. Allowable expenses included facility improvements, technology upgrades, staff training, etc. Total amount awarded \$57,956.74.
- Fresno IT and Contract Management teams collaborated and organized the transition from the previous data system to Avatar. IT team provided several trainings and visited network providers on site to provide technical assistance in support of the system's transition to Avatar. Current challenges include a technical issue on initial transition file and consistent data entry such as CalOMS discharges and service requests.
- Fresno's Finance Division added four new positions and are in the process of adding eight additional positions to the DMC-ODS claiming, budgeting, rate setting, accounting and invoice review.
- Fresno provides an avenue for clarification by setting up a series of meetings for providers. This includes a biweekly SUD Billing and Invoicing meeting to work through challenges with billing functions in Avatar. There is also a monthly QI, IT and Contract Management internal meeting with a focus on increasing internal collaboration and communication across divisions and to better support network providers. There are also regularly scheduled Contract Management and Managed Care-UR team meetings to increase internal collaboration and communication across divisions and to better support network providers.
- Fresno has administered the TPS twice in 2019 including during the first week of the month to establish baseline measurements. Administration meets the standards set by DHCS and the results are forwarded to UCLA for analysis.
- Fresno also submitted ASAM data to UCLA and a high level of congruence was noted for assessment results and placement.
- Fresno notes effort at monitoring and training with system providers in order to improve CalOMS submissions and Medi-Cal documentation skills. References for each of these data sets are notes below.

Data References:

1. CalOMS Treatment Data Collection Guide:
http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

2. TPS:
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Note_17-026_TPS_Instructions.pdf
3. ASAM Level of Care Data Collection System:
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Note_17-035_ASAM_Data_Submission.pdf

Fresno Goals for the Coming Year

- Fresno will continue to participate in the Regional Waiver Workgroup meetings in order to learn and benefit from other Central Valley counties that have implemented the DMC-ODS Waiver.
- Fresno is working to expand the system of care to address network adequacy and include NTP services in rural parts of Fresno County, specifically Coalinga.
- Fresno will continue to improve and make available data for providers and the system through the dashboard for Key Performance Indicators (KPI).
- Fresno will continue the development of Avatar, the EHR for use by the SUD system providers including contract agencies.
- Fresno's Quality Improvement (QI) staff will continue with onsite visits and provider targeted training for consistent recording of service requests and No Shows/Cancellations to address timely, complete and accurate data issues.
- QI will expand staff classifications to include a peer support specialist with lived experience and two additional LPHAs (non-physician) familiar with substance use disorders.
- Fresno's IT division will continue to build its capacity with the addition of staff including one Business Systems Analyst and one Sr. Business Systems Analyst. Work will be done to add two additional Business Systems Analysts as well.
- Fresno has approval by DHCS to develop a Peer Support Training Plan that will benefit the SUD beneficiary.
- Fresno will continue to seek a provider for substance use treatment residential services for adolescents through the procurement processes. While Fresno is discussing a regional approach to share resources and identify potential providers, they are also working to identify an out-of-county provider if the regional effort is unsuccessful.
- Fresno will be adding 14 new Recovery Residence beds through its SUD provider, Mental Health Systems. The new beds will be for women and perinatal beneficiaries.
- Fresno is working with WestCare California to secure an additional 15 WM beds for both men and women.
- Fresno is working to develop clear guidelines/protocols for new waiver services and activities, such as Recovery Services, Case Management and Field Based Services.
- Fresno is currently developing the FY 2020/21 Fiscal Plan using actual data from year one of DMC-ODS services. The Fiscal Plan will be submitted to DHCS for approval by February 2020.

- Fresno is working to develop additional MAT resources in Fresno County with the goal of bringing on one new MAT telehealth provider and one new MAT outpatient provider.
- Fresno is working with Health Management Associates (HMA) in the development of a community stakeholder event focusing on perinatal MAT.
- Fresno is engaged with the Division of Public Behavioral Health to develop more community messaging through a marketing campaign of the DMC-ODS Waiver.
- Fresno continues to solicit feedback from its providers to plan and prioritize their concerns in the next fiscal year. This currently includes continuing to expand by moving to new locations, hiring additional staff specifically in LPHA and case manager positions, continuing in training staff in ASAM and evidence-based practices, expand recovery support services, and participate in quality improvement activities.
- Fresno is working to enhance its in-house training by having the Managed Care SUD monitoring team trained to provide ASAM trainings.

PERFORMANCE MEASURES

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

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

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

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

- Percentage of clients with three or more 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 public 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 One of Waiver Services

This is the first year that Fresno has been 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 (October 2019) and CalOMS data from CY 2018. ASAM data was not available at the time of the review because Fresno had started submitting in January 2020. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may be a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 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 2018-19 Table 1 shows Fresno's number of Medi-Cal 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 (1.16 percent vs. 1.12 percent). The penetration rate for youth ages 12-17 is also slightly higher than the statewide rate (0.33 percent vs. 0.26 percent). For adults ages 65 and older, the penetration rate is twice as high as the state (1.43 percent vs. 0.70 percent). Fresno has been successful in their implementation year at engaging youth and older adults in substance use services which are slightly higher than statewide and other large counties.

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

Table 1: Penetration Rates by Age FY 2018-19					
Fresno				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	61,523	200	0.33%	0.28%	0.26%
Ages 18-64	247,839	2,868	1.16%	1.24%	1.12%
Ages 65+	34,154	490	1.43%	0.79%	0.70%
TOTAL	343,515	3,558	1.04%	1.02%	0.93%

Table 2 below shows Fresno's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. The average approved claims overall for Fresno was \$2,112, which was lower the statewide average of \$3,868. 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			
Fresno			Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	\$299,839	\$1,499	\$1,750
Ages 18-64	\$6,108,308	\$2,130	\$3,898
Ages 65+	\$1,106,083	\$2,257	\$4,560
TOTAL	\$7,514,230	\$2,112	\$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.

Those covered by Medi-Cal who are Hispanic/Latino comprise 54.2 percent of Drug Medi-Cal (DMC) eligibles and 35.5 percent of DMC-ODS clients served. Individuals who identify as White comprise 13.6 percent of the DMC eligible population and disproportionately comprise 28.1 percent of clients served. Clients who fall into the race/ethnicity category of “Other” are also more likely to be served—18.5 percent of the eligible population and 26.2 percent of clients served fall into this category

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

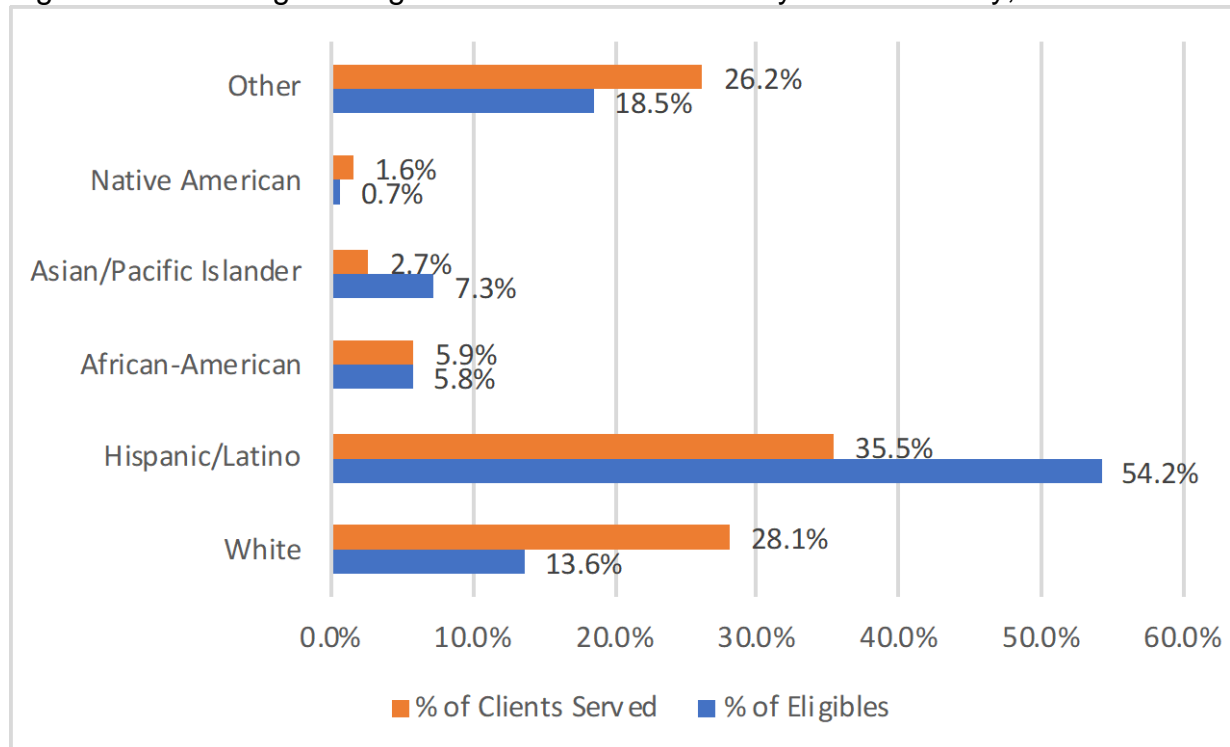


Table 3 shows the penetration rates by race/ethnicity. The penetration rates reflect the trends noted above, with rates for clients who are “White”, “Asian/Pacific Islander,” “Native American,” and “Other” higher in Fresno than statewide. The penetration rate for clients who are “Hispanic/Latino” was on par with the statewide rate, and those who are “African-American” was lower than the statewide rate.

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

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19					
Fresno				Large Counties	Statewide
Race/Ethnicity	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	46,715	1,000	2.14%	2.11%	1.76%
Latino/Hispanic	186,120	1,262	0.68%	0.72%	0.67%
African American	19,844	209	1.05%	1.33%	1.28%
Asian/Pacific Islander	24,947	96	0.38%	0.17%	0.16%
Native American	2,309	58	2.51%	2.44%	1.55%
Other	63,581	933	1.47%	1.11%	1.05%
TOTAL	343,516	3,558	1.04%	1.02%	0.93%

Table 4 below shows Fresno penetration rates by eligibility type. The rates are compared with statewide averages for all DMC-ODS counties. ACA eligible clients represent the largest number of those served (47 percent), followed by “Family Adult” (24.2 percent), and “Disabled” (20.3 percent). Penetration rates for those categories were on par or higher than statewide rates. While the numbers served are small, the penetration rate for youth 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				
Fresno				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	36,025	739	2.05%	1.62%
Foster Care	1,133	14	1.24%	1.72%
Other Child	42,648	151	0.35%	0.28%
Family Adult	90,260	881	0.98%	0.95%
Other Adult	38,512	89	0.23%	0.10%
MCHIP	18,431	51	0.28%	0.20%
ACA	115,925	1,708	1.47%	1.46%

Table 5 below shows Fresno'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 "Other Adult" was the highest across eligibility categories (\$2,299) and lower than statewide.

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

Table 5: Average Approved Claims by Eligibility Category, FY 2018-19				
Fresno				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	36,025	739	\$2,285	\$4,207
Foster Care	1,133	14	\$1,493	\$1,117
Other Child	42,648	151	\$1,379	\$1,690
Family Adult	90,260	881	\$2,051	\$3,255
Other Adult	38,512	89	\$2,299	\$4,269
MCHIP	18,431	51	\$1,535	\$1,810
ACA	115,925	1,708	\$2,053	\$3,867

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. Most clients in Fresno are served in NTPs (52.9 percent). 36.2 percent were served in outpatient services and 10.35 in residential according to the claims data represented here. Residential treatment was the service category with the highest average approved claims amount (\$5,263).

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

Table 6: % of Clients Served and Average Approved Claims by Service Categories, FY 2018-19			
Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	1,975	52.95%	\$2,149
Residential Treatment	386	10.35%	\$5,263
Res. Withdrawal Mgmt.	*	n/a	\$3,154
Ambulatory Withdrawal Mgmt.	-	-	\$0
Non-Methadone MAT	*	n/a	\$210
Recovery Support Services	-	-	\$0
Partial Hospitalization	-	-	\$0
Intensive Outpatient Tx.	15	0.40%	\$688
Outpatient Drug Free	1,351	36.2%	\$904
TOTAL	3,730	100.0%	\$2,112

Asterisks 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. It is important to have timely access to treatment, 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 was less than one day after assessment for NTP treatment.

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						
Fresno				Statewide		
Age Groups	Clients	%	Avg. Days	Clients	%	Avg. Days
Age Group 12-17	*	n/a	n/a	*	n/a	n/a
Age Group 18-64	1,514	77.0%	<1	28,929	80.04%	<1
Age Group 65+	*	n/a	n/a	*	n/a	n/a
Total Count	1,965	100%	<1	36,144	100%	<1

Asterisks 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, private physician practices, and DMC-ODS certified outpatient clinics. For those seeking an alternative to methadone for opiate addiction or MAT for another type of addiction such as alcoholism, these alternatives are important options. The DMC-ODS Waiver encourages delivery of MATs in other settings additional to their delivery in NTPs

Non-methadone MAT access has continued to expand in Fresno County with a variety of alternate access points. Noted earlier in this report Fresno has actively engaged to increase training and expand the pool of x-waivered prescribers. Fresno participates in grant funded efforts such as the State MAT Expansion Project and California ED Bridge Program. These programs allow Fresno to address rural or remote areas that have traditionally no access to MAT as well as work collaboratively with health plans, emergency departments and FQHC primary care access points.

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

Table 8 shows the number and percentage of clients receiving three or more non-methadone MAT visits per year provided through Fresno DMC-ODS providers and statewide. 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. They are very

low and are likely linked to NTP prescribing which has been slow to adopt non-methadone MATs.

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

Asterisks 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

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

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

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

Of the 385 clients who discharged from residential treatment, only 60 were transitioned to a lower level of care. Timely transition is very low with just 19 or 4.9 percent of the discharged clients moving to another level of treatment within seven days. Fresno claims data indicated that just 15.6 percent of all discharged clients received a lower level of care within any days of discharge. Compared to statewide, Fresno's transitions

in care following residential treatment is lower suggesting room for improvement. This is one the measures CMS and HEDIS link to better outcomes in SUD treatment.

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

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2018-19				
Fresno (n= 385)			Statewide (n= 17,046)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	19	4.9%	2,034	8.3%
Within 14 Days	34	8.8%	2,728	11.1%
Within 30 Days	53	13.8%	3,383	13.8%
Any days (TOTAL)	60	15.6%	4,607	18.7%

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are ambivalent about engaging in treatment for their addictions 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, dropped calls, etc. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

-Table 10: Access Line Critical Indicators, January 2019 – September 2019

Table 10: Fresno Access Line Critical Indicators 1/1/19 through 9/30/19	
Average Volume	74 calls per month
% Dropped Calls	2.42%
Time to answer calls	15 seconds
Monthly authorizations for residential treatment	162
% of calls referred to a treatment program for care, including residential authorizations	93% of callers are linked to treatment through the Access Line
Non-English capacity	Callers can select threshold language prompts that transfer to a language queue. We hire and train multi-lingual staff and contract with Voiance interpreter services.

As stated elsewhere in the report findings Fresno staff believe the data is not complete and they are having performance issues with the contractor Beacon who is using Avaya Software.

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 Fresno. 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 Fresno 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-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.

Less than 2 percent of all clients served in Fresno met the threshold to be designated a high cost beneficiary. Overall, the average approved claims for high cost beneficiaries in Fresno is \$14,219. Both these statistics are lower than the statewide average.

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

Table 11a: Fresno High Cost Beneficiaries by Age, FY 2018-19						
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages 12-17	200	-	-	-	-	-
Ages 18-64	2,868	*	n/a	n/a	n/a	n/a
Ages 65+	490	*	n/a	n/a	n/a	n/a
TOTAL	3,558	51	1.4%	\$14,219	\$725,169	9.7%

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

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

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

Residential Withdrawal Management with No Other Treatment

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

Fresno billing claims data indicates that they had a small number of WM clients, though as noted earlier in this report certification, data and billing was an issue at the time of throughout the DMC-ODS Waiver implementation. None of them had three or more episodes with no other treatment.

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

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

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

Use of ASAM Criteria for Level of Care Referrals

The clinical cornerstone of the DMC-ODS 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 findings, the reason is documented. For Fresno assessments,

there was a 64.87 percent congruence rate with “Actual Referral Missing” the most common reason for the difference (19.9 percent), followed by “Clinical Judgement (14.87 percent). Training and review of data submitted may be needed for this function.

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

Table 13: Congruence of Level of Care Referrals with ASAM Findings, FY 2018-19						
Fresno ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	229	24.18%	1,169	64.87%	415	94.75%
Patient Preference	*	n/a	-	-	-	-
Level of Care Not Available	-	-	-	-	-	-
Clinical Judgement	*	n/a	268	14.87%	-	-
Geographic Accessibility	*	n/a	*	n/a	-	-
Family Responsibility	-	-	-	-	-	-
Legal Issues	-	-	-	-	-	-
Lack of Insurance/Payment Source	*	n/a	-	-	-	-
Other	-	-	*	n/a	*	n/a
Actual Referral Missing	703	74.23%	359	19.92%	21	4.79%
TOTAL	947	100.0%	1802	100.0%	438	100.0%

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

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the Fresno 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 Fresno (56.1 percent), a higher percentage than statewide (46.9 percent).” Other Stimulant Abuse”, most likely methamphetamine, was the next most common diagnosis (22.8 percent), followed by “Cannabis Use (11.1 percent). It is notable that a higher percentage of clients in Fresno are in treatment for Cannabis Use compared to statewide (11.1 percent compared to 8.7 percent). Also notable is that fewer clients in Fresno are served for Alcohol Use Disorder compared to the state (8.6 percent vs. 15.8).

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

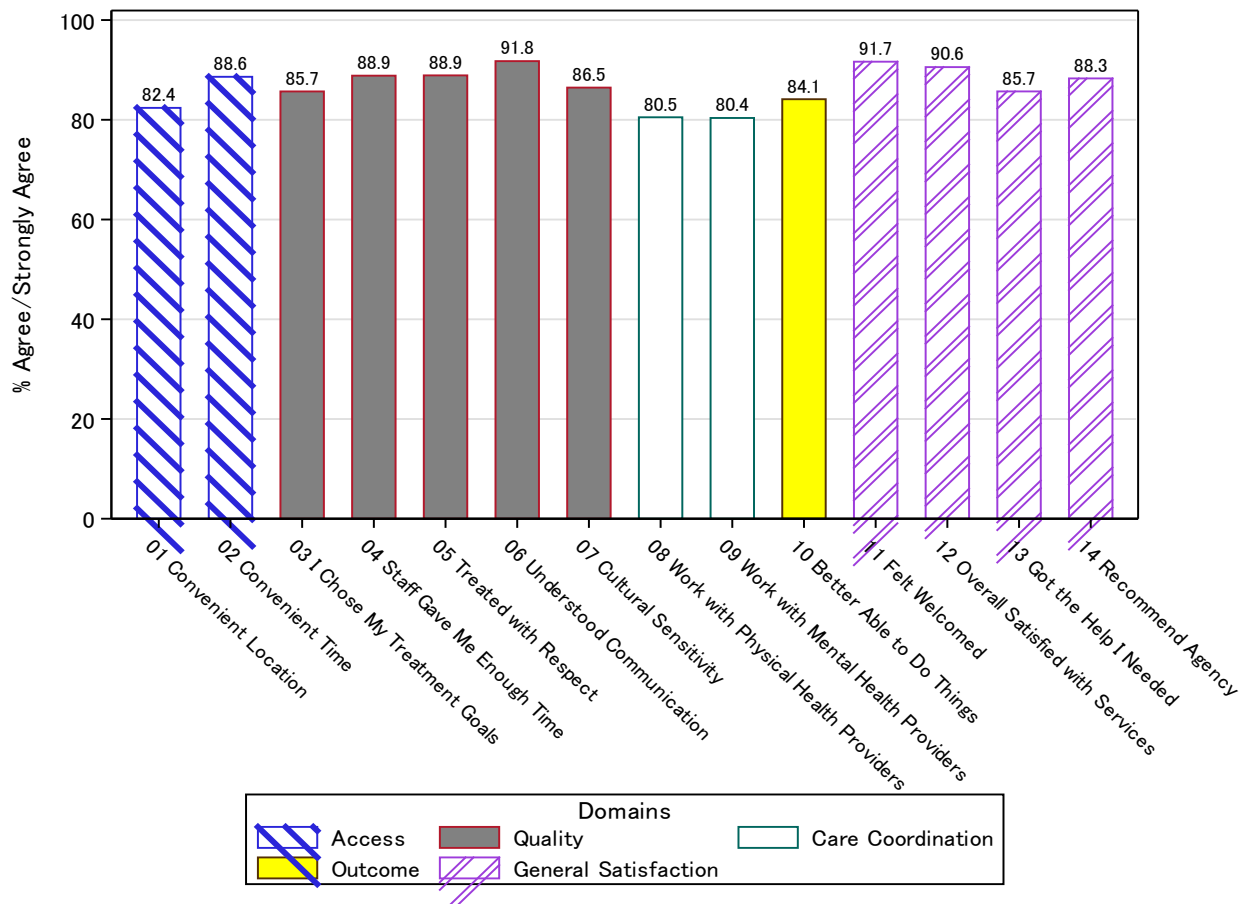
Table 14: Percentage Served and Average Cost by Diagnosis Code, FY 2018-19				
Diagnosis Codes	Fresno		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	8.6%	\$2,176	15.8%	\$4,232
Cannabis Use	11.1%	\$1,278	8.7%	\$1,953
Cocaine Abuse or Dependence	0.6%	\$1,197	2.1%	\$4,593
Hallucinogen Dependence	0.3%	\$900	0.2%	\$3,847
Inhalant Abuse	0.0%	\$0	0.02%	\$3,119
Opioid	56.1%	\$2,284	46.9%	\$4,286
Other Stimulant Abuse	22.8%	\$2,103	24.4%	\$3,736
Other Psychoactive Substance	0.1%	\$10,397	0.4%	\$5,521
Sedative, Hypnotic Abuse	0.1%	\$492	0.5%	\$4,033
Other	0.2%	\$1,950	0.9%	\$2,586
Total	100%	\$2,112	100%	\$3,868

Client Perceptions of 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.

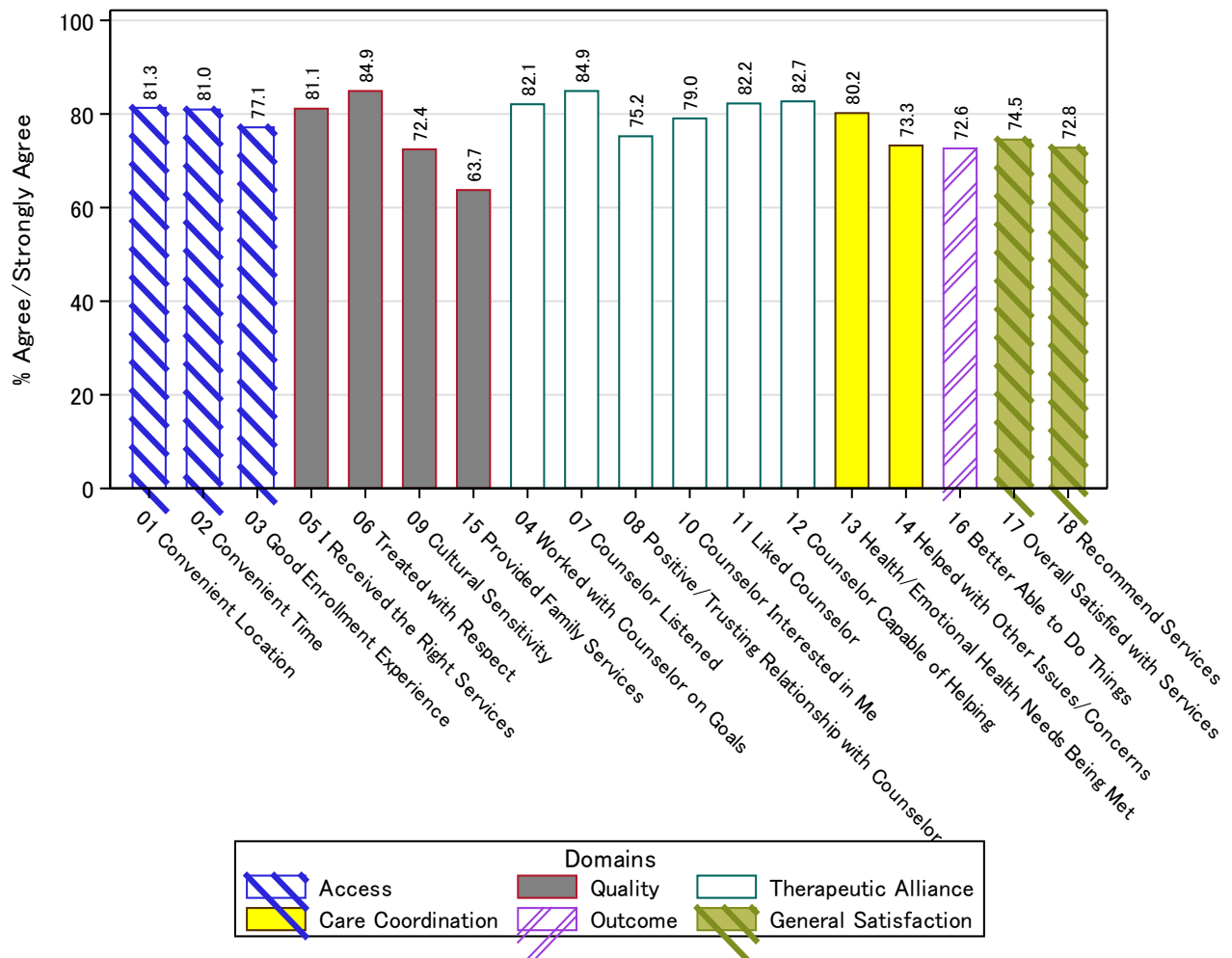
Fresno received surveys from 598 adults and the results are positive across all domains. As with most counties, the ratings were slightly lower for coordination with physical health care services and with mental health care services, but still rated high at 80.5 and 80.4 percent, respectively. Almost 90 percent of respondents would recommend the agency from which they receive services.

Figure 2a: Percentage of Adult Participants with Positive Perceptions of Care, Fresno, TPS Results from UCLA (n = 598)



Fresno also surveyed youth ages 12-17 and had 107 responses. The results are more varied than the adult responses, with “Provided Family Services” rated the lowest of all items. This was a very positive number of youth surveys for a first-year county and results appear similar to many other counties.

Figure 2b: Fresno: Percentage of Youth Participants with Positive Perceptions of Care, Fresno, TPS Results from UCLA (n = 107)



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 provides 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 Fresno will need to consider and with which agencies they will need to coordinate. Fresno had a lower percentage of clients who were homeless at admission compared to statewide (20.3 percent compared to 26.2 percent), but more clients whose status was “Dependent Living” compared to statewide (47.1 percent vs. 28.6 percent).

Table 15: CalOMS Living Status at Admission, CY 2018

Table 15: CalOMS Living Status at Admission, CY 2018				
Admission Living Status	Fresno		Statewide	
	#	%	#	%
Homeless	1,182	20.3%	24,020	26.2%
Dependent Living	2,736	47.1%	26,296	28.6%
Independent Living	1,895	32.6%	41,472	45.2%
TOTAL	5,813	100.0%	91,788	100.0%

Overall, more than half of the clients in Fresno (55.4 percent) have a legal status of no criminal justice involvement at admission, which is similar to the 59.9 percent statewide, though 33.9 percent of Fresno's clients are under post-release supervision (AB 109).

Table 16: CalOMS Legal Status at Admission, CY 2018

Table 16: CalOMS Legal Status at Admission, CY 2018				
Admission Legal Status	Fresno		Statewide	
	#	%	#	%
No Criminal Justice Involvement	3,222	55.4%	54,930	59.8%
Under Parole Supervision by CDCR	316	5.4%	2,288	2.5%
On Parole from any other jurisdiction	70	1.2%	890	1.0%
Post release supervision - AB 109	1,972	33.9%	28,801	31.4%
Court Diversion CA Penal Code 1000	23	0.4%	1,259	1.4%
Incarcerated	81	1.4%	389	0.4%
Awaiting Trial	129	2.2%	3,221	3.5%
TOTAL	5,813	100.0%	91,788	100.0%

Employment status at admission is similar for Fresno clients compared to statewide, across all statuses, though there is a slightly higher level of unemployed, not in the labor force and not seeking work at 54.5 percent over the statewide rate of 51.1 percent.

Table 17: CalOMS Employment Status at Admission, CY 2018

Table 17: CalOMS Employment Status at Admission, CY 2018				
Current Employment Status	Fresno		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	635	10.9%	12,134	13.2%
Employed Part Time - Less than 35 hours	388	6.7%	7,259	7.9%
Unemployed - Looking for work	1,617	27.8%	25,522	27.8%
Unemployed - not in the labor force and not seeking	3,173	54.5%	46,873	51.1%
TOTAL	5,813	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 CalOMS Discharge Types for Fresno reflect a very high level of administrative discharge rate at 61.5 percent, compared to 37.9 percent statewide. The standard adult discharge rate is 30.0 percent, significantly lower than statewide of 49.6 percent. Improvement in the administrative discharge rate would make the outcome and discharge data from CalOMS more reliable as a tool for program assessment.

Table 18: CalOMS Types of Discharges, CY 2018

Table 18: CalOMS Types of Discharges, CY 2018				
Discharge Types	Fresno		Statewide	
	#	%	#	%
Standard Adult Discharges	2,023	30.0%	43,654	49.6%
Administrative Adult Discharges	4,133	61.5%	33,344	37.9%
Detox Discharges	84	1.2%	8,470	9.6%
Youth Discharges	484	7.2%	2,609	3.0%
TOTAL	6,724	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.

While Fresno’s overall percentage of clients with a satisfactory discharge status is 48 percent, just below the statewide of 52 percent, just 12.8 percent of clients completing treatment have completed treatment with a referral.

Table 19: CalOMS Discharge Status Ratings, CY 2018

Table 19: CalOMS Discharge Status Ratings, CY 2018				
Discharge Status	Fresno		Statewide	
	#	%	#	%
Completed Treatment - Referred	864	12.8%	20,190	22.9%
Completed Treatment - Not Referred	444	6.6%	6,070	6.9%
Left Before Completion with Satisfactory Progress - Standard Questions	343	5.1%	12,220	13.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,599	23.8%	7,259	8.2%
<i>Subtotal</i>	<i>3,250</i>	<i>48%</i>	<i>45,739</i>	<i>52%</i>
Left Before Completion with Unsatisfactory Progress - Standard Questions	940	14.0%	16,253	18.4%
Left Before Completion with Unsatisfactory Progress - Administrative	2,464	36.6%	24,781	28.1%
Death	*	n/a	96	0.1%
Incarceration	*	n/a	1,208	1.4%
<i>Subtotal</i>	<i>3,474</i>	<i>52%</i>	<i>42,338</i>	<i>48%</i>
TOTAL	6,724	100.0%	88,077	100.0%

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

Performance Measures Findings: Impact and Implications

Access to Care PM Issues

- In the first year of implementing the Waiver, Fresno delivered services to individuals of all ages, successfully engaging youth and older adults.
- Penetration rates by race/ethnicity were mostly on par with or higher than other large counties or statewide; the one exception was African American eligibles. The penetration rate for this group was 1.05 percent in Fresno, compared to 1.33 percent in other large counties and 1.28 percent statewide.

Timeliness of Services PM Issues

- Fresno is tracking the time from initial request to first offered and first face-to-face appointment. For each of these measures, the DHCS standard is ten days, and for both, Fresno is meeting the standard about half of the time (46 percent for first offered appointment and 53 percent for first face-to-face appointment).
- Fresno is not currently tracking time from initial MAT request to NTP appointment. However, dosing data shows prompt services are available.
- Fresno has a definition of “urgent requests” and is able to meet the standard of seeing clients within 48 hours of the initial request 46 percent of the time.
- According to claims data from FY 2018-19, Fresno had 385 clients discharge from residential treatment. Of those, 15.6 percent had a transition to a lower level of care within any days including non-Medi-Cal clients.
- Fresno only had a small number of clients receiving WM and was not tracking readmission within 30 days.

Quality of Care PM Issues

- Fresno has a county-run Intensive Outpatient Treatment program, but there were only 15 clients who received this service in FY 2018-19. Many clients received outpatient services (1,351) so the low IOT number is puzzling given its value for treatment of more serious SUD disorders reflected in the diagnoses.
- Fresno was in the process of expanding their WM capacity during the site visit. This expanded capacity addresses a need in the county, and it is anticipated that these WM slots will be widely used and soon will be billed and tracked as part of the PMs.

- Follow-up after residential treatment is an important quality issue and the focus of one of the county PIPS which seems appropriate given the linkage to other levels of Medi-Cal care is low.

Client Outcomes PM Issues

- Responses from both adults and youth on the TPS were positive, overall. Rating from youth were lower than the adults, with the lowest rated item from youth being “Provided Family Services.” The lower youth ratings are similar to other counties.
- Coordination of care on TPS was lower than other TPS ratings, which is similar to other counties and can be an area for future improvement.
- Fresno is collecting CalOMS at intake and discharge. As of CY 2018, the administrative discharge rate for Fresno was 61.5 percent, almost twice the statewide rate of 37.9 percent. This should be improved to make the quality of the data more reliable.

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	1%
Contract providers	99%
Total	100%

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 1 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
6	5	0	3

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
0	0	0	0

The following should be noted regarding the above information:

- IS staff being all counted in Table 2 with no distinction between technology and data/analytic staff.

Current Operations

Fresno currently uses Netsmart's myAvatar as its EHR, with the system hosted at Netsmart. The county is in the process of exploring whether a different EHR would better fit their needs but are not yet in an RFP stage. Use of Avatar with SUD and its providers is relatively new and has added to year one launch challenges of the DMC-ODS.

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
MyAvatar CalPM	Billing	Netsmart	9	Netsmart
MyAvatar CWS	EHR	Netsmart	9	Netsmart
MyAvatar OrderConnect	ePrescribing and Labs	Netsmart	9	Netsmart
MyAvatar - MSO / Provider Connect	Managed Care Auth/Billing	Netsmart	0	Netsmart

Priorities for the Coming Year

- EHR overhaul and re-assessment
- Expand Sisense Dashboards to line staff
- Finish Human Resources position tracking system
- Implement Project Portfolio system

Major Changes since Prior Year

- Started submitting DMC-ODS Medi-Cal claims and CalOMS data
- Added contracted support to assist with claiming and managed care related projects
- Expanded to unlimited licenses for Sisense
- Netsmart contract amendment

Other Significant Issues

- None noted

Plans for Information Systems Change

- Actively searching for a new system options, project plan in place and project team assigned and active.

- While Fresno may not ultimately decide to change information systems, the County is exploring the landscape of options and comparing against myAvatar. The County received 15 responses to a Letter of Interest solicitation indicating that they would response to an RFP. At this point, Fresno is not committed to doing an RFP process.

Current Electronic Health Record Status

ISCA Table 5: EHR Functionality

ISCA Table 5: EHR Functionality					
Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	myAvatar	X			
Assessments				X	
Care Coordination	myAvatar	X			
Document imaging/storage	myAvatar	X			
Electronic signature— client				X	
Laboratory results (eLab)				X	
Level of Care/Level of Service	myAvatar	X			
Outcomes	myAvatar	X			
Prescriptions (eRx)				X	
Progress notes				X	
Referral Management	myAvatar	X			
Treatment plans				X	
Summary Totals for EHR Functionality:		6	0	6	0

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

- Fresno has implemented ProviderConnect to allow contract providers access to the EHR. Contract providers with their own individual EHRs are providing electronic batch uploads of their data.

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.			61.5
TPS being administered in all Medi-Cal Programs.	X		

Highlights of use of outcome tools above or challenges:

- TPS data was analyzed and presented to leadership and a plan was in place to present at the monthly SUD Provider meeting.
- There were issues with CalOMS in terms of transitioning from a legacy system to myAvatar and importing in old data and getting it into the system.

Drug Medi-Cal Claims Processing

- In switching over the old billing system to myAvatar, the county has a six-month lag in billing DHCS.
- Fresno's billing department has worked diligently during the first year of the Waiver implementation to make sure claims data is accurate before submitting to the state. Prior to the Waiver, more providers had permissions in Avatar that allowed them to do the quality checks for data accuracy; now, permissions have been scaled back so that county staff are responsible for the accuracy checks. The county is getting more efficient and plan to be caught up with billing by the end of this calendar year.

Special Issues Related to Contract Agencies

- Fresno conducted site visits at 14 of the 27 provider sites during the summer of 2019 primarily to provide technical assistance for the Waiver and how to

track client and residential requests, capture timeliness and request data and determine correct billing codes, and report timeliness by type.

- Contract providers are currently sending electronic batch file transfer or doing direct data entry into the EHR for beneficiary and service data. Fresno is not sure when providers will be able to input service data directly into myAvatar.

Overview and Key Findings

Access to Care

- None noted from an IS standpoint.

Timeliness of Services

- The current EHR allows Fresno to track various timeliness measures, including time from first request to first offered appointment, first face-to-face, and first face-to face after an urgent request.
- Fresno does not currently have the capacity to track first request for MAT to first NTP appointment and is working on developing a process to do so.

Quality of Care

- The billing department added additional staff to be able to meet all of the claims/billing requirements of the Waiver and are in the process of catching up with claims submission as stated by the end of this calendar year.
- The former system for billing and data entry would not let providers submit data if there were errors; in the new system, data is able to be submitted with errors, so the County billing department had to restructure to be able to meet the demand for checking data accuracy and getting the data clean prior to submission to the state.
- Fresno uses Sisense Dashboards on the mental health side for managers and supervisors and is in the process of the use and pushing out relevant dashboards to line staff at contract agencies so that they can see their performance metrics. It would be beneficial for this to be available to SUD providers as well.
- In the process of transitioning data management systems, Fresno experienced some challenges with CalOMS. There is work to be done yet to get CalOMS up to date and to improve administrative discharges.

Client Outcomes

- The TPS is administered annually and the results are analyzed and presented to county leadership and contract provider staff. Coordination of care is an area of potential improvement and more detailed review of outlier programs by site using TPS in future years compared to baseline year.
- CalOMS has the potential for showing improvement from treatment but to consider the data reliable the percent of administrative discharges needs to be reduced and the data needs to be up to date.

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 Fresno, the time and distance requirements are 90 minutes or 60 miles for outpatient services and 75 minutes or 45 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 (AAS) for that area with details of how many individuals are impacted, and access to any alternative providers who might become Medi-Cal certified for DMC-ODS or are in a surrounding county who might be contracted with. 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 to discuss access, 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 Fresno County staff all documents and maps submitted to DHCS. CalEQRO also reviewed the special form created by CalEQRO for AAS zip codes and efforts to resolve these access issues. There was one zip code with an AAS standards in Fresno County. This was in the rural northern area of the county and were for both youth and adult NTP services. All youth and adult outpatient services met time and distance standards as required by DHCS.

In the single zip code with an approved AAS (93210) as well as the rest of Fresno County, Fresno has and will continue to contract with SUD contract providers outside of its network for expanding client service opportunities. Additionally, Fresno has encouraged its existing providers to expand their programs and locations, especially in rural areas of the County.

Fresno notes that subcontractors are required to have policies and procedures in place that address disabled populations, including but not limited to service accessibility, ADA compliant facilities and CLAS standards. At least annually, Fresno monitors to ensure compliance through a review of the subcontractor's physical facilities, policies and procedures.

Regarding access and transportation, Fresno requires its subcontractors to provide care coordination and case management services, which includes providing transportation to MAT/NTP, outpatient or any other services the client may need particularly if the Health Plan is not available or able to. DMC providers have access information for the MCPs transportation benefit to assist beneficiaries with arranging transportation when needed.

Plan of Correction to Meet NA Standards

At present there is an NTP provider that has expressed interest in expanding services to the AAS zip code. Fresno also has had initial discussions with out of network providers seeking to expand into Fresno County to provide MAT services. Fresno continues to research viable youth residential providers and has been working with other counties in the region to create a cooperative agreement, but that remains in the discussion phase at this time. Fresno has been working with an existing NTP provider to open a medication unit (MU) to dispense methadone in the city of Coalinga. Fresno is working via these expanded efforts to resolve that part of the NACT deficiency and not need an AAS.

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.

Fresno 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 Fresno and then reviewed by CalEQRO as required by the PIP Protocol Validation of PIPs.⁴

Clinical PIP: Client Engagement: Residential and Outpatient Continuation

Date PIP Began: December 2019

Status of PIP: Active and ongoing

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

Fresno contracted provider agencies identified engagement and retention as a high priority, in terms of improving client outcomes. Fresno then developed a dashboard of continuation measures to assess current levels of engagement. Fresno stated that continuation (or retention) in services is considered to be a good indicator of engagement and so is useful in determining the rates of successful engagement. By looking at the data on the number of clients admitted to residential and comparing that to the number that persisted in treatment to successful completion, Fresno determined that improvement was indicated. The same analysis was conducted with data on clients who were admitted into outpatient, including those who should be transitioning from residential. In both cases, it was clear that the level of performance was below expectation. The baseline information that Fresno looked at for both levels of treatment dates from January to July 2019. The critical role of engagement and continuation in care linked to achieving positive client outcomes is well-established in the SUD field,

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.

and Fresno determined that the NIATx model, which is a well-developed resource for performance improvement methods (especially in the SUD arena), emphasizes the focus on engagement and continuation in treatment across the continuum of care. Research on NIATx indicates that clients who persist in treatment (with high retention rates) are more likely to complete treatment, improve and thereby have better clinical outcomes, and reduced risks of relapse.

PIP Question:

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

“Can NIATx recommended system and practice changes(interventions) to improve client engagement and continuation increase the percentage of clients who initiate and remain in outpatient services for at least 4 visits to 55 percent (from 38 percent) and clients who initiate and remain in residential services for at least four weeks to 55 percent (from 32 percent)?“

Indicators:

Fresno listed the following PIP indicators:

Outpatient Engagement Indicators

Percent of continuation from first service request to first day of service

Percent continuation from first service to second day of service

Percent continuation from second day of service to third day of service

Percent continuation from third day of service to fourth day of service

Percent continuation from the service request to fourth days within 30 days

Residential Engagement Indicators

Percent continuation from first service request to admission

Percent of residents who have seven consecutive days of room and board following admission

Percent of residents who have seven consecutive days of room and board following their first week (seven days) of residential services

Percent of residents who have seven consecutive days of room and board following their second week (14 days) of residential services

Percent of residents who have seven consecutive days of room and board following their third week (21 days) of residential services

Timely Access Indicator

Timely Access: Initiating Services within three business Days

Timely Access: Average days to initial services/admission

Interventions:

Fresno cited the following interventions:

Adjust Staff Schedules to Meet Client Demand

Use the Spirit of Motivational Interviewing during the First Contact

Use Motivational Interviewing during Treatment

Build Community Among Clients:

Results/Impact upon Clients:

Fresno cited the following client outcomes:

No client outcomes were cited as this PIP has just been implemented and no data is available for analysis.

Technical Assistance Provided:

Technical assistance was provided to Fresno on several occasions leading up to the onsite review. These discussions occurred on August and December of 2019 as well as the month leading up to the review in January 2020. There were also several email interactions and written feedback was provided by CalEQRO prior to the review on Fresno's PIP validation drafts.

Specific technical assistance was provided by CalEQRO on several points to either enhance or clarify terminology or design. It was suggested that Fresno modify the terms used to outline the residential indicators. At present clients are referred to as "residents" implying that residential care is a placement, not treatment.

Also, retention in treatment is described as consecutive days of "room and board," again inferring that clients are in housing not treatment. Client engagement skills and strategies outlined in the model chosen by Fresno implies a strong predictor of clinical benefit. It was suggested that there be some consideration (as the project progresses) to look at an additional marker on how persistence in treatment contributes to clinical benefit. Such markers might include reduced cravings or symptoms related to withdrawal, improved coping skills and other areas linked to improved health status. It was noted that Fresno has active participation by consumers and stakeholders in determining not only the development of this project but also helping them to understand the root causes of these rather steep drop rates amongst its newly enrolled clients.

Utilization of the NIATx framework could assist Fresno to enhance the description of their interventions which should be more behaviorally specific, and they are encouraged

to provide that specificity in a revised draft. This could include the introduction of scripted intervention, frequency of contacts, prompting through use of reminder calls to clients, or access to transportation, willingness to be contacted when client needs extra support, etc. The NIATx paradigm that will allow for structured measurable improvements in client engagement and retention is strongly supported by CalEQRO.

PIP Score: 90.6%

Non-Clinical PIP: Substance Use Disorder 24/7 Access Line

Date PIP Began: February 2020
active (not rated)

Status of PIP: Concept only, not yet

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

Fresno conducted monthly monitoring of the Access Line which revealed problems in the collection and reporting of incoming calls for service. These activities are key deliverables that are part of Fresno's contract with their vendor and impact client care and their experiences. With this analysis it was clear that lacking this information Fresno did not have accurate data and that there was presumed to be a negative impact on timely access to program services by clients in need of substance abuse treatment. Beacon Health Services is the contractor used by Fresno to provide this service.

Test calls were reviewed January through September 2019 and of 62 calls, only 28 or 45 percent were properly logged in the call log database. While discussions with Beacon, review of the specific issues revealed in the call data and an examination of workflow protocols have revealed certain opportunities for improvement, attempts to correct these issues administratively have not been successful to date. Fresno determined that a formal PIP was indicated due to the pervasive and negative impact this has on its ability to properly serve and support the needs of incoming clients. By instituting a PIP hopefully these important issues will be addressed and information on client requests, needs, and dispositions will be comprehensive and accurate.

The decision to make this a PIP was supported by the Fresno's Quality Improvement Committee (QIC). The overarching goal of the PIP is to make the Access Line functional for tracking all client requests and screening them appropriately for services, and thus achieve a general consumer satisfaction level of at least 90 percent. It should be noted at the time of the onset review, some of the indicators and data targets were incomplete. In no small part this is because Beacon Health Services has a corporate structure that does not allow for local, expedient determinations or adjustments to their processes. More work is needed to finalize interventions, indicators and launch the PIP to make it active.

PIP Question:

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

“By July 30, 2020, will the redesign of the 24/7 toll-free Access Line improve the experience of stakeholders (consumer/family); increasing key performance indicators (test call score) by 30%, decrease the length of call (minutes) to service by 27%, increase caller volume by 30%, achieve a general caller satisfaction of 70%, and increase the percent of callers matched by Level of Care by (5%)?”

Indicators:

Fresno listed the following PIP indicators:

The average percent of accurate number of *calls logged* that are captured within the *Written Access Line Call Log*

The average percent of accurate *names* logged that are captured within the *Written Access Line Call Log*

The average percent of accurate *dates of calls* logged that are captured within the *Written Access Line Call Log*

The average percent of accurate *dispositions* of calls logged that are captured within the *Written Access Line Call Log*

The average percent of accurate *grievance* calls logged that are captured within the *Written Access Line Call Log*

The average percent *length of call*; in minutes for those seeking request for SUD services (from initial request to referral/Linkage):

Percentage of number of calls for service answered within 30 minutes

The average percent of overall *callers satisfied* with the SUD Access Line Adult population Treatment Perception Survey

The average percent of *Consumer Level of Care (LOC) Matched* to appropriate SUD program (using ASAM screening).

Interventions:

Fresno is proposing the following interventions:

Beacon will) develop a County Specialist whose telephone profile will be set with priority for County business and receive inbound member calls related to the Fresno DMC benefit

County Specialist Team will be training on workflows and county protocols specific to (Fresno) County benefits and services.

Increase staffing levels by two (2) FTEs to support daytime operating hours and contractual telephone performance requirements for prompt service to callers.

Increase oversight by hiring a supervisor specifically for the Fresno County Specialist Team to monitor performance, data, and assist in complex clinical cases.

Member Service and Clinical departments will maintain training guides to support ongoing staff training and new hire onboarding.

Results/Impact upon Clients:

Fresno cited the following client outcomes:

This PIP remains in the latter stage of development and no results are available as it is still concept only.

Technical Assistance Provided:

Technical assistance was provided to Fresno on several occasions leading up to the onsite review. These discussions occurred on August and December of 2019 as well as the month leading up to the review in January 2020. There were also several email interactions and written feedback on draft concepts was provided by CalEQRO prior to the review on Fresno's PIP validation drafts.

Technical assistance was also provided while CalEQRO was on site with Fresno. There is a basic need to provide more clarifying language on areas such as "operational redesign" and to adjust interventions if Fresno determines that these are too numerous and sweeping for a project that aims to make workflow and service protocols adjustments. While there is some understanding of baseline based on test calls and monitoring of call logs by Fresno, it had yet to establish a clear measurable starting point from which to measure improvements for all indicators and linked to all interventions. This is critical to the PIP process and it is expected that Fresno will have this solidified soon.

Indicators that clearly denote benefit to the client might be included as this project proceeds more clearly specifically those that measure the client experience, or that follow through on treatment referrals. There might be a TPS indicator question added and used to imply client satisfaction with the Access Call Center if used, an increase in matching ASAM designations, and phone software with a yes or no rating of satisfaction question as the call ends. A significant barrier to achieving the changes that had been attempted throughout 2019 is the complex administrative realities of working with an outside contractor, having the actual service site be located in a distant county, and the corporate bureaucracy that must weigh in on any changes. However, CalEQRO strongly supports Fresno's determination to assert corrective action on this extremely vital access portal for clients in need of SUD services and competent direction.

PIP Score: Not Rated

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

PIP Table 1: PIP Validation Review

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

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

PIP Table 2: PIP Validation Review Summary

PIP Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-clinical PIP
Number Met	13	NR
Number Partially Met	3	NR
Number Not Met	0	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	16	NR
Overall PIP Rating Clinical: $((13M*2) + (3PM))/(16AP*2)$ Non-clinical: $((\#M*2) + (\#PM))/(\#AP*2)$	90.6%	NR

PIP Findings: Impact and Implications

Overview

Fresno has both a clinical and non-clinical PIP, though the non-clinical is not active and deemed concept only at the time of this review. Both PIPs were selected to focus upon problem areas that are clearly evident within the SUD system of care, and typical of counties in early phases of implementation of the Waiver. The need to initiate PIP activities was identified by a review of local data and analysis. Fresno has involved consumers and stakeholders in both PIPs and that may benefit these projects by providing additional input, allowing them to better understand causal factors as they developed their proposed interventions.

The Clinical PIP focuses on addressing the low level of client retention and continuation in both outpatient and residential services. Utilizing the NIATx paradigm, necessary changes will likely lead to practical solutions and ultimately improved clinical outcomes for beneficiaries who stay in treatment. The Non-Clinical PIP which remains in a late stage of development seeks to address well documented problems in the beneficiary access line. These workflow and accountability problems have led to an incomplete representation of how many clients are seeking services, where demand or service gaps need to be addressed. Lacking that more complete representation of client requests and needs has hampered Fresno's ability to make timely or informed course corrections to address identified issues, ultimately impacting client care.

Access to Care Issues related to PIPs

Both PIPs are designed to improve access to and engagement in treatment. By more uniformly coordinating the use of retention and motivational skills, barriers to clients remaining in treatment will be addressed. Since the clinical PIP involves both outpatient and residential care it should improve client retention and completion rates, an area well documented by current CalOMS data to be in need. Clients who are new to treatment will have a meaningful adjunct to their treatment through trained staff whose schedules have been adjusted to better suit their clinical needs at the vulnerable time of admission. Other interventions should enhance the therapeutic alliance and engagement of clients in their care.

The non-clinical PIP seeks to overcome a basic barrier to access by obtaining complete, accurate and timely data on all incoming calls for service. Fresno has worked diligently to obtain Beacon cooperation on designated staff, training and re-establishing specific workflows in order to assure proper care coordination from the initial point of access to improve this important gateway into treatment.

Timeliness of Services Related to PIPs

Reducing client withdrawals from care and potential relapse of clients newly entering service sites will likely impact outcomes as well as the whole system. Ensuring that clients who utilize staff time to facilitate a lengthy assessment and intake process stay in treatment is going to free up time expended trying to locate them when they withdraw from care and also help to identify earlier in the treatment process key issues to address to keep the client feeling engaged and committed to recovery. Up front efforts to retain the clients that Fresno has admitted by effectively engaging them in the treatment process will hopefully make room for new clients to be seen more expediently as well.

Similarly, addressing the lack of complete or accurate call log data from the access line will allow Fresno to better manage and deploy resources including the value of knowing how many new clients are being scheduled for appointments and thereby be able to make more informed adjustments to the system to maximize appointment time available for others in need. Also, it will allow for anticipation of capacity needs at different levels of care depending on the type of treatment the client is requesting and the outcomes of their screenings and assessments.

Quality of Care Related to PIPs

The clinical PIP will provide assigned staff with the client retention tools necessary to address issues of motivation and establishing key elements of the therapeutic alliance that are characteristic of substance abuse treatment and can lead to withdrawal from

care and relapse. By providing the needed skill set to staff to improve continuation in treatment, the PIP is designed to reduce barriers and improve commitment levels in clients and to enhance recovery. Clients that remain in treatment, and attend sessions as scheduled, are much more likely to complete treatment which will lead to improved clinical outcomes overall.

The non-clinical PIP will address an intake system that at present limits Fresno's ability to understand the incoming client base and their needs and how they were or were not met. Literature suggest that benefits from a functional call center can lead to improved access, better engagement and consumer satisfaction. Fresno's PIP is designed to not just streamline the operational system process but increase positive perception of the consumer experience.

Client Outcomes Related to PIPs

The interventions for the clinical PIP have just begun and no client outcome data is yet available. The clinical PIP hopes to improve client engagement in outpatient from 23 percent to 50 percent and in residential care from 58 percent to 65 percent. This higher rate of engagement and continuation in treatment can only be accomplished through the Fresno system by the plan it has set forth and close monitoring of the impact of these interventions. This plan involves both its outpatient and residential providers as they launch a uniform set of motivational and retention strategies, reaching the maximum number of newly enrolled clients.

The interventions of the non-clinical PIP are scheduled to begin in February 2020. It is anticipated the interventions proposed will lead to an increased level of accuracy in calls that are logged into the system. Additionally, data will be complete, and inaccuracies diminished. Both client satisfaction and level of care designations will be improved as measured by review of test calls. Fresno has set a goal for 90 percent satisfaction rate and 100 percent accurate LOC match to the appropriate program.

CLIENT FOCUS GROUPS

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

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

Focus Group One: **Adult Outpatient**

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

The group met on February 4, 2020 at the Central California Recovery program which provides adult outpatient treatment for both men and women in Fresno, CA. There were eight participants all of whom were adults 18 years of age or over. All but one of the participants were admitted new into treatment within the last 12 months. They all spoke English, and therefore no interpreter was needed. Six of the clients were male, with three of the clients being White, three were Hispanic/Latino, one Native American and one African American/Black.

Number of participants: 8

Participants were first facilitated through a group process to rate each of items on a structured 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.	4.6	4-5
2. I got my assessment appointment at a time and date I wanted.	4.6	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.6	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.6	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.7	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.7	4-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.9	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.7	4-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.9	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:

- Clients noted that they were treated respectfully and as individuals.
- Clients stated that while each counselor appeared to have their own method the different styles all were effective.

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

- Clients reported experiencing an expedient intake process.
- One client noted that alternative programs they had experienced were not as effective in treatment and counseling as this one, saying “this is the best program I have ever been to.”

Recommendations for improving SUD care included the following:

- Several of the clients described the program as “perfect” and offered no suggestions for change.
- Given the diverse approach by staff, clients suggested that the program could help them by giving them options to work with counselors who specialize in different approaches and areas of recovery.
- Clients stated that increased individual counseling time with their counselor would be of helpful for their recovery.

Interpreter used for focus group 1: No

Focus Group Two: Adult Residential

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

The group met on February 4, 2020 at WestCare Martin Luther King Campus which provides residential treatment service for men, women and either gender of client with children and is in Fresno, CA.

There were eight participants all of whom were adults 18 years of age or over. All the participants were admitted new into treatment within the last 12 months. They all spoke English, and therefore no interpreter was needed. Seven of the clients were 25-59 years of age, with one older client who reported being over 60. Four of the clients were male and one stated they were transgender. Three of the clients were Hispanic/Latino, three were African American/Black, one was White, and one was Native American.

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.	4.4	3-5
2. I got my assessment appointment at a time and date I wanted.	4.0	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.5	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.4	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	2.8	1-5
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.	4.5	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.1	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.4	3-5

It should be noted on surveys clients are stating they are not being told about the benefits of MAT by staff or most of the clients are not being informed.

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:

- Clients reported that securing a referral to the program was expedient however many noted having to enter interim services due to lag time in admissions.
- Clients state that for those with children the program is family friendly.
- All participants felt that access to groups for both couples and families was a benefit.
- Bilingual Spanish speaking staff are available.

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

- Clients noted that they felt comfortable with their assigned counselor.
- Program schedule allows them to think about and plan for their own individual recovery, which they find beneficial.
- There are active efforts to coordinate their care with mental health
- Most of the clients noted that no information had been shared by the program about the use and benefits of MAT.

Recommendations for improving care included the following:

- Clients felt that more time with their counselors individually would be of benefit.
- Clients stated that the program spends too much time focused on their past or history. They believe they could benefit more by addressing their current status and looking forward including helping with jobs, housing, relationships, and family supports.
- The program needs money to upgrade its food menu and supply clients with more recreational activities.

- Clients noted that they would like to have more access to community support systems like AA and NA.
- Clients stated that Medi-Cal should allow for a longer length of stay in residential.
- Clients noted that the program needs to provide them with more guidance on how to obtain disability, employment and housing. These were critical for community success.

Interpreter used for focus group two: No

Focus Group Three: Outpatient Spanish Speaking

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

The group met on February 5, 2020 at Fresno New Connections which provides outpatient treatment service and is located in Fresno, CA.

There were four participants all of whom were adults 18 years of age or over. All the participants entered services within the last 12 months. The participants spoke Spanish, though one of the four was bilingual, and an interpreter was provided. Two of the clients were 25-59 years of age, and two were older clients who reported being over the age of 60. All four of the clients were male and stated they were of Hispanic/Latino descent.

Number of participants: 4

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.	4.5	4-5
3. It did not take long to begin treatment soon after my first appointment.	5.0	5-5

Question	Average	Range
4. I feel comfortable calling my program for help with an urgent problem.	4.5	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.7	4-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	5.0	5-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.5	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.5	4-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	5.0	5-5

The following comments were made by some of the 4 participants who entered services within the past year and who described their experiences as follows:

- Clients all reported that finding the program and obtaining an intake was not difficult.
- All the clients stated that the program staff were supportive, and they would recommend services at this site to others.

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

- Clients state the counseling staff are helpful and involved in their individual care.
- Clients state the program is effective for them and that the staff are able to share tools that assist them in their recovery.
- Clients reported that little information was shared on the indication or benefits of MAT. They indicated that most clients in the program are dependent on methamphetamines, not opioids or alcohol.

Recommendations for improving care included the following:

- Clients state they could benefit from more access to literature on how to retain sobriety.
- Clients state that while the curriculum is good, they think having a workbook to help them guide their thoughts or organize recovery skills would be of assistance.
- Clients noted recent Spanish speaking staff shortage has resulted in groups being combined. Need more Spanish speaking counselors and staff.
- Clients feel that homework would help to reinforce recovery skills learned in group.

Interpreter used for focus group three: Yes

Focus Group Four: Women's Residential

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

The group met on February 5, 2020 at Fresno First CalWORKs part of the Mental Health Systems agency that has 85 treatment programs across California. Fresno First provides residential treatment service for women, women with children and women who have co-occurring psychiatric disorders. The program is located in Fresno, CA.

There were nine participants all of whom were adult females that were 25-59 years of age. All the participants entered treatment within the last 12 months. All of them spoke English, and therefore no interpreter was needed. Five of the clients were White, three were Hispanic/Latina, and one was Native American.

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.	4.3	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.9	4-5
4. I feel comfortable calling my program for help with an urgent problem.	4.0	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.4	3-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.2	3-5

Question	Average	Range
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.5	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.3	2-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	5.0	5-5

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

- Clients generally reported access and intake process took a few days or up to more than a few weeks.
- Clients related that delays in access were due to the time it took to move Medi-Cal and other cross-county eligibility complexities.
- Some clients noted that staff can be unprofessional and that the format of the program was disorganized. Not making a difference to do things better.

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

- Clients noted that most staff are easy to address and work with, but all had incidents with one employee in particular who was not empathic.
- Clients noted that rules and consequences regarding relapse and other program infractions are punitive in nature.
- Clients who have NTP appointments often have to wait to be transported and sit at the NTP site for hours before staff swing back around to pick them up.

Recommendations for improving care included the following:

- Clients stated that basic assistance in helping them with child welfare and court documents would be of benefit.
- Access to counselors and licensed therapists are seen as insufficient.
- Clients noted that the facility is not family or kid friendly.
- Clients related the program would be improved by better organization.
- The clients stated there should be greater allowance for spending time on after-care activities such as employment and housing especially as they prepare to be discharged, need to connect with community more.

Interpreter used for focus group four: No

Client Focus Group Findings and Experience of Care

Overview

A total of four adult focus groups were conducted with both outpatient and residential treatment programs. Two of the focus groups were well attended with eight and nine clients present in each respectively. The outpatient program with Spanish speakers provided just four clients for the group. Three of the groups were facilitated with English speaking clients, but there was one outpatient group that required use of an interpreter.

Access Feedback from Client Focus Groups

- Clients all reported that locating an intake at programs was generally easy.
- Clients who were in residential did note that there were lag times on entry though this mostly pertained to securing local eligibility for Medi-Cal, not program capacity. Transfer of Medi-Cal from other counties continues to be a problem and getting new Medi-Cal started.

Timeliness of Services Feedback from Client Focus Groups

- More time with their assigned counselor for individual counseling and case management was a universal request by clients.
- For one program, clients had to move their group schedule due to activities being adjusted because the program was short staffed.
- Some clients felt that more should be done to assist them in working with allied services and needs relevant to their discharge planning, such as housing, employment and appointments. Preparation for community discharge is important for success and more time is needed with this as its focus.

Quality of Care Issues from Client Focus Groups

- Clients seek enhanced coordination and support in working with child welfare, probation and mental health.
- Clients at one site noted that some staff were unprofessional and that the program itself was disorganized and utilized punitive measures in dealing with relapse. There were some performance issues at this contract site requiring following up to improve quality.
- Clients report inconsistent availability of information on the use and benefits of MAT from staff and programs.

Client Outcomes Feedback from Client Focus Groups

- Some clients in each group praised the staff, the program and assistance they have received in gaining sobriety.
- Clients in some programs are asking for more homework, guidance, and structure to assist them in their recovery.
- Clients noted that more could be done to help them establish community support systems such as 12-Step programs and other positive community engagement activities as part of the treatment process.
- Clients requested more help in preparing for community re-entry in housing, jobs, family relations, and support in general. Many of these activities could be part of case management and recovery services.
- Clients felt their success would be enhanced by more individual case management activities.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
Component		Quality Rating
1A	Service Access are Reflective of Cultural Competence Principles and Practices	M
<p>Taking a no wrong door approach, Fresno has three distinct access points. First there is the Access Call Line which is operated by Beacon Health Services under contract with Fresno. This toll-free number is available 24 hours a day, seven days per week. Access Line staff are reported to have participated in the culture competence training and Beacon attempts to hire individuals who are multi-lingual. Language translation capability is also available for incoming callers who have specific linguistic needs. A second point of access are the county-run Urgent Care and Youth Wellness Centers that Fresno has to provide preliminary screening and linkage with system treatment providers. Finally, incoming clients can self-refer and walk or call into those system contract provider program sites. Sites that interact with individuals seeking treatment have some Spanish or Asian language capability and as with the Access Line an agreement exists to access translation services should that be necessary. Sessions that involved beneficiaries and staff stated to CalEQRO that there are not enough Spanish speaking staff and thought Fresno continues to seek individuals who have alternate language capability. Information and postings at sites visited by CalEQRO were noted to have both Spanish and English translations. Issues regarding workflow and data tracking existing within the Access Line and</p>		

KC Table 1: Access to Care Components

Component		Quality Rating
<p>shifts in protocol, staffing and contract discussions have yet to yield the results that Fresno would like to see.</p> <p>CalEQRO strongly supports Fresno's ongoing efforts including making the problems being experienced at this critical access point for beneficiaries seeking care the topic of a PIP.</p> <p>Claims data does indicate a Hispanic/Latino penetration rate of .68 percent which is in line with the rate of .67 percent found in the statewide average, though lower than that of other large counties which is .72 percent. The Culturally Responsive Plan (CRP) for Fresno was updated for FY 2018-19 and there are regular scheduled meetings of the Cultural Humility Committee (CHC). The CRP includes local access and disparity data analysis along with the Cultural and Linguistically Appropriate Services (CLAS) framework. This framework includes the CLAS 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities and is promoted as a national standard by Health and Human Services (HHS). Fresno shares its CRP with Mental Health and while all core areas have distinct information about SUD and some data, there are several areas that are yet to retrieve or pull data given the recent launch of the DMC-ODS Waiver. A revision of the CRP was scheduled for December 2019, but only the FY 2018-19 was available for this review cycle. Fresno participated and helped to facilitate a November 2019 Mental Health Empowerment Conference that focused on the Asian Pacific Islander population. The conference was designed to provide staff and other attendees professional and cultural learning opportunities with the goal of improving culturally responsive care and reduce disparities.</p>		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	PM
<p>Fresno system of care for SUD utilizes contracted services to provide an array of services required by the DMC-ODS Waiver. Programs often have multiple sites and network adequacy appears to be an issue in just a single rural portion of the county. While that area which includes the town of Coalinga was found lacking NTP services, Fresno has created a pilot effort to address this access issue. In addition to the concerns noted above regarding the client Access Line, Fresno was unable to secure a licensed WM program for several months of 2019. Working with an existing provider over several months it was clear that that they were having issues meeting the standards for certification. Fresno notes that while the WM provider was not DMC-certified. DHCS "waived" that requirement temporarily, pending DMC certification. That provider contract was ultimately terminated. Fresno worked hard to secure an alternate WM program and was able to immediately contract with a Kern County provider. Fresno sees this as an interim solution and is seeking local access to WM for its clients as well. Affordable and drug and alcohol-free housing options are a challenge area. While not reimbursed under the DMC-ODS Waiver, Fresno currently has just 63 beds at two program sites for Recovery Residences (RR). CalEQRO strongly encourages Fresno to continue to find transitional housing options</p>		

KC Table 1: Access to Care Components

Component	Quality Rating
<p>for clients as the current number is low for a large county. FG participants along with staff reiterated this concern regarding very few RR beds.</p> <p>Fresno acknowledges workforce challenges, both for bilingual and qualified substance abuse counselors. Fresno helped to initiate a cohort at Fresno City College along with the Fresno Regional Workforce Development Board to help increase the number of SUD counselors. This effort to develop workforce is critical for meeting local needs.</p> <p>Fresno conducts regular surveys of staff, families and clients in English, Spanish and Hmong. Surveys are designed to garner information and data regarding impressions of treatment and client satisfaction and uses this information to gauge the need for further professional development within its system. In a 2019 workforce survey that included both Fresno and contract staff, 43 percent of the 460 respondents reported that they are bilingual. A full 93 percent of staff report that they occasionally or frequently take advantage of opportunities to learn more about cultural differences to improve their behavioral health skills. Fresno surmised that services for youth may be insufficient. Lacking a full understanding of the nature of how this service gap may be impacting the community, Fresno facilitated a multi-session Youth Convening for county stakeholders. Multiple segments of the community participated including social services, mental health, public health, courts, SUD system providers, law enforcement, and educators. These sessions were designed to give Fresno a clearer understanding of barriers to treatment, gaps in service, along with other unmet needs for the adolescent population who have issues with substance abuse. A guiding document was developed from the Youth Convening to help Fresno target specific initiatives and inform future efforts related to education, prevention and treatment for adolescents. Service utilization data reports are available to Fresno leadership to assess accessibility of service levels for beneficiaries.</p>	
1C Collaboration with Community-Based Services to Improve SUD Treatment Access	M
<p>Fresno has established levels of collaborative in order to improve treatment access with many community-based organizations. This includes entering into a MOU with the Managed Care Plans, CalViva and Anthem. The MOU ensures Medi-Cal beneficiaries have access to the full continuum of care through established protocols for identification and referral to Fresno. As part of an integrated department with Mental Health, Fresno's Access Line and county-run screening portals provide an integrated access point for incoming clients by referring them to presumed levels of care and performing linkage follow-ups. Fresno screening staff are trained in the ASAM criteria and understand LOC parameters and SUD clients can access specialty MH services as clinically indicated.</p> <p>Criminal justice is a significant referral source for the Fresno system of care. Since the onset of the DMC-ODS Waiver, Fresno notes a shift in the relationship between them and probation as well as other parts of the justice system. Probation now has its own set of assessment tools and staff are trained in evidence-based practices. Fresno County Probation staff work in tandem with SUD providers to assure clinically</p>	

KC Table 1: Access to Care Components	
Component	Quality Rating
<p>indicated LOC placement and acceptance of the ASAM criteria. Fresno has provided training to probation for each of its assigned divisions on a variety of topics pertaining to addiction treatment. Ongoing training has also been provided to judges and other offices of the court system. Fresno facilitated these training sessions on a variety of topics including use of ASAM and medical necessity in order to help address attitudes and beliefs and increase support for inter-agency adoption of standards. Formal agreements between the courts and Fresno have also come from the Community Corrections Partnership (CCP) which is the county steering committee for AB 109. Fresno receives \$1.8 million dollars along with Mental Health to serve that population and their Director is a voting member of the CCP. There is a history of Fresno working with Fresno Police Department and other law enforcement and they anticipate being involved in the mobile outreach team to address the local homeless problem. Fresno also has been working on the provision of SUD services within the county jail. At present there is limited visibility or formal reentry processes in place which Fresno hopes to address as a formal proposal is being discussed. Fresno also facilitates training efforts along with a schedule of routine cross-system meetings that include Mental Health and the county department of Social Services. Fresno's DMC-ODS system of SUD care is entirely provided by community-based contractors, and they have scheduled meetings regarding access, timeliness issues, documentation, billing and information technology. In interviews conducted by CalEQRO with contract managers it was noted that while communication with assigned contract liaisons and system staff is strong, there are ongoing areas of frustration regarding various elements of DMC-ODS Waiver. These include, but are not limited to, training on protocols that eventually are changed or reversed, pressures pertaining to clinical and billing documentation, shortage of qualified workforce to fulfill new advanced roles, lack of transitional housing options for clients, no uniform electronic health record (EHR) and delays in approvals by the State Provider Enrollment Division (PED). Recent PED time delays described including a 16-month process to secure a suite for a program with an existing license and nearly 12 months to secure approval for additional bed capacity for another provider with an existing license.</p>	

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components

Component		Quality Rating
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
<p>Fresno has instituted protocols and workflow agreements with its providers in order to compile, track and report timeliness metrics for access across the system. Fresno reports that between January to November 2019 the average length of time from first request for service to first face to face appointment was 15.64 days. Utilizing the 10-day standard from DHCS for routine appointments the percentage of clients seen in a timely fashion was 53 percent overall. This dropped to 50 percent for adults seeking initial contact but rose to 85 percent for youth. Adolescent first appointments had an average of 6.29 days. The adult client participants in focus groups conducted by CalEQRO reported that it was generally easy for them to schedule assessment appointments and start services, though lag times were noted by some of the residential clients requesting services.</p>		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	PM
<p>Fresno notes that billing and claims data is available to track timeliness from first contact to first appointment at the contracted NTP sites. Fresno reporting indicates that of the 618 requests for NTP services, just 517 received that initial appointment in the required three-day time frame. Fresno notes this may be due to a coding error in claims as well as just a handful of outliers. At present Fresno data shows that only 85 percent of NTP initial contacts begin dosing the first day of contact. Claims data provided by CalEQRO for FY 2018-19 indicates that all incoming clients meet the standard and are seen in less than a day. CalEQRO suggests that Fresno follow its data to determine cause of the inconsistency.</p>		
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment:	M
<p>While Fresno has taken meaningful steps to improve access to non-methadone MAT there is currently no integrated system wide mechanism to track initial contact to first non-methadone MAT appointment. Non-methadone MAT is provided through a Hub and Spoke Grant and involves MedMark, one of Fresno's contracted NTP providers. The project has five Spokes which are specifically located in regions of the county so as to increase MAT access in rural or remote areas. Fresno also participates in an ED Bridge Grant in coordination with local Health Plan providers. Prescribing patterns that can be gleaned from the claims data provided by CalEQRO indicated that Fresno NTPs have yet to fully utilize alternatives to methadone. Discussion with the Aegis medical director indicates that he has been actively screening clients for buprenorphine. His presentation included taking CalEQRO through the steps of his clinical interview as well as showing the written and visual materials in place that would help to educate incoming clients on their choices. Anecdotal information is that the number of clients at the Aegis clinic visited has gone from a few patients to over 30 since the onset of the DMC-ODS Waiver. The NTP regional manager did note that there are complex DHCS rules regarding non-methadone billing that may</p>		

KC Table 2: Timeliness to Care Components

Component		Quality Rating
impede obtaining a full representation of the efforts in the NTP clinics with alternate MAT.		
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	PM
Fresno has established a timeliness standard for urgent appointments of two days, not 48 hours and is therefore only able to track the data for these requests in days, not hours. The urgent requests across its system report that an average time to initial face to face is 14.4 days. For individuals seeking youth services the average time to initial urgent appointment is just 4.5 days, though the urgent standard of two days is met just 40 percent of the time. For adults, the standard is met 46 percent of the time. CalEQRO questioned Fresno on the definition it is utilizing which tracks very closely with medical definition of an emergency. The question would be is the emergent wording leaving out a whole pool of clients who may have an urgent need. In other words, does the definition go beyond urgent (not routine but not an emergency). It is unclear how many individuals have called and made a service request deemed to be urgent. CalEQRO suggests Fresno review of the urgent request definition to determine it is inclusive of all individuals calling who need an expedited service contact.		
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	PM
Fresno has adopted the post residential discharge standard by which an appointment should occur within seven days. Data provided by Fresno indicates that of the 410 admissions, just 156 clients who left residential treatment received a timely appointment within that 7-day standard. The average length of time for the first follow up session after residential discharge was 42.7 days and Fresno was adherent to the timeliness standard just 38 percent of the time. CalEQRO supports the performance improvement strategies outlined in the PIP that Fresno has initiated to improve the number of clients who are seen in a timely fashion after leaving residential treatment as well as measure client retention once that linkage has been assured.		
2F	Tracks Data and Trends No Shows	PM
Fresno has not required that providers establish no-show standards. There are some providers that are very attentive to tracking no-shows and cancellations, and this is something that Fresno hopes to build on in their second year. CalEQRO heard from one large outpatient provider who has established a threshold for loss of contact. This provider has their clinical manager review each of these cases with staff in order to identify ways to re-engage clients before they need to be closed.		

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	PM
<p>Fresno has a QI Work Plan (QIWP) which is combined with Mental Health. While there are some specific measurable QI goals and objectives related to DMC-ODS Waiver quality, these revolve around areas of compliance such as timely access, charting and final rule requirements. QM staff noted that meeting the core elements required after implementation has been priority one and they expect to add clinical and quality initiatives in the coming year. Structurally Fresno Quality Management has taken active steps to integrate and include SUD personnel into the division and enhance capability specific to the DMC-ODS Waiver requirements. While a full revision of the work plan is in development, Fresno relates that the document is updated each time changes are made. CalEQRO noted however that most of the SUD designated areas within the workplan currently are incomplete with placeholder language that notes “data for this indicator is still being formulated.” Fresno is encouraged to complete these areas for the SUD system of care in order to organize and facilitate its otherwise well-articulated QIWP.</p> <p>Fresno has a long tradition of group observation. With the requirement to use evidence-based practices (EBP), they have worked to develop a form that monitors group activities rank use and fidelity to specified EBPs. Providers interviewed by CalEQRO note that there has been a shift in culture when it comes to site monitoring. They universally praise Fresno QM staff as providing assistance. “We feel like we can now ask for help without it raising a red flag, which is a real change.” Fresno worked with its providers to develop a manual that outlines expectations and communicate changes that are necessary to meet regulatory mandates. This was a change for the QM team since involvement with Mental Health has primarily been with county-run programs and staff. Fresno QM staff interviewed by CalEQRO noted the need to partner with long-standing SUD providers who already had a cohesiveness that benefits the standardizing of essential elements of DMC-ODS Waiver. Fresno developed its QI Academy in order to build on these relationships and give providers the tools and framework to build their understanding of core QI principles.</p>		

KC Table 3: Quality of Care Components

Component		Quality Rating
The QI committee (QIC) meets monthly and minutes have recorded quality management activities pertaining to both SUD and MH related areas. The structure of Fresno's QIC reporting includes direct communication with top leadership including the Director. Providers are noted to be present at some meetings and are often reporting out of QIC subcommittees. Fresno has active participation of stakeholders such as attendance to specific meetings by members of its behavioral health advisory board. Tracking of training and other related in-service activities is done using the Reliance application. Fresno PIP project submission notes that it has convened an active committee that meets each month to work on the development of targeted performance improvement activities. However, just one of the two required PIPs are active and ongoing for this review cycle. Providers are subject to site monitoring though the majority of file-based utilization review activities occur at the individual program level.		
3B	Data is used to inform management and guide decisions	PM
As noted previously, Fresno has utilized the first year of the DMC-ODS Waiver to work with its provider network on the collection, input and reporting of program level data. Fresno has provided a myriad of helpful training and technical assistance in order to advance the system's processes and workflow in order to secure improved adherence. Fresno continues to work with programs in order to address incomplete or incorrect data. An annual summary on Fresno's efforts to address the inconsistency of timely and complete data includes percentages of incompleteness pertaining to CalOMS within its system. There are also definite attempts by Fresno to reinforce the value of clinical outcomes and noted the high level of administrative discharges in the CalOMS data for 2019. At present Fresno does produce reports to look at service delivery numbers, errors and census. QM staff interviewed during this review cycle noted that once billing and CalOMS data is timely and complete they will begin to provide more quality data to the system so that it can help inform any system changes. CalEQRO encourages Fresno to continue its work in securing timely and valid data from SUD providers, but should also expedite extraction of more quality data that can be shared in meaningful reports that both leadership and providers can utilize.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
Fresno participates in regular meetings, with a variety of stakeholders including probation, child welfare, mental health and schools. QI Committee Minutes reflect minimal presence of consumers or providers, but Fresno is hoping to expand that involvement in the coming year. Input from clients and staff is actively sought by Fresno through its cycle of surveys. Data from these surveys provide the system with valuable input and feedback regarding several areas including service delivery, and meeting learning objectives in trainings that are provided. Fresno also benefits by participating in a cross-county Regional Waiver Workgroup Meeting that has		

KC Table 3: Quality of Care Components

Component	Quality Rating
<p>provided valuable input and discussion on system planning under the DMC-ODS Waiver. Strategic priorities and system development plans are clearly outlined in the Youth Convening guiding document and are based on community and stakeholder input. These prioritized initiatives will assist Fresno as it further develops its adolescent prevention and treatment efforts based on its community forum to secure meaningful and local direction and feedback.</p> <p>Service providers do meet each month both in a county-run and self-run format. In interviews held with CalEQRO, service providers note that they are often asked to provide input or participate in system issues by Fresno. There are assigned Fresno contract analysts to each service provider, and they have found the communication to be supportive and generally consistent. Examples are shared however where billing information or other directives have had to be revised or reversed, causing frustration and confusion with line staff. Providers note that they receive data indicating how many clients are entering the system. Their concerns are not admissions but retention, “how do we address all the clients who self-discharge.” Some providers note that they have no-show rates at or above 50 percent. All acknowledged that training has been available on a variety of topics. Workforce concerns were noted given that most counselors want to spend their time working with clients. As one provider stated, “we were told care needs to be client centered, but we spend more than half our time on documentation. That isn’t client centered care.” Several providers noted that they have lost staff who can make the same wage working somewhere else that doesn’t have the same burden of documentation. Concern was expressed over the eventual roll out of Avatar where a “heavy lift” is “again” anticipated. Fresno took an unusual and transparent step in preparation for the CalEQRO visit by asking its providers to give direct written input to some of the required documents. This reinforces a stated sense of having a partnership between community providers and county staff.</p> <p>Fresno has continued to provide quality assurance training as well as ongoing technical assistance to its network of SUD providers. Nearly three dozen training opportunities regarding skill and capacity building strategies were offered leading up to implementation. Additionally, providers have been able to attend ten trainings in 2019 on topics ranging from the EHR, quality improvement capacity building, the use of EBP and ASAM. Fresno as well as contract providers have added support staff to assist them in meeting the requirements of the DMC-ODS Waiver. There are ongoing interactions with providers and Fresno quality management and contracts staff. A Quality Improvement academy was instituted to give providers the tools to better address those issues in house.</p>	
3D Evidence of an ASAM continuum of care	PM
<p>Fresno has been able to establish the required continuum of ASAM required treatment levels. With several levels of care the implementation year has seen loss of an adult outpatient provider, residential WM provider, a residential treatment provider and loss of one of its recovery residence providers. Fresno has been able to replace</p>	

KC Table 3: Quality of Care Components

Component	Quality Rating
<p>many of these programs with more than one addition. WM has been replaced by one out of county provider and there are strong indicators that a second provider located in Fresno County will be available for clients very soon. Despite being a large county, Fresno has just two sites that offer recovery residences with just 63 beds which is a small number for a large county. Fresno has also been unable to determine the causes for its under-utilization of IOT services. At present just one of the ten sites certified to provide IOT is billing for it at an average of 32 hours per month and demand for that level of service is low. Fresno has yet to fully implement Recovery Services across its continuum. Of the seven providers that have indicated “an interest in providing” these services, there is just one provider who is doing so and billing for it. A second site has begun to provide these services but has yet to bill. Fresno does report that they are actively looking for a youth residential provider and additional recovery residence beds. In order to address network adequacy issues, Fresno has to expand NTP services into the very rural area of Coalinga. While Fresno seeks to clarify and expand services for youth in need of treatment, it benefits from a strong prevention and early intervention effort that addresses areas such as underage drinking, marijuana and prescription drug abuse. Survey data, progress on outcomes both short term and long term along with a reporting process that clearly denotes ongoing progress using data driven decision making. The prevention efforts have an overarching goal of reducing substance abuse among youth ages ten-25 though the initiatives demonstrate a creative array of reaching both young people and those who interact with that population.</p>	
<p>3E MAT services (both outpatient and NTP) exist to enhance wellness and recovery:</p>	M
<p>Fresno contracts with three legal entities who have five NTP program sites and a treatment capacity of 2,815 slots. Two of the NTP providers are administering and billing for non-methadone MAT services, though the billing for these medications is not yet evident on their claims. Alternate MAT access points also include services provided through a Hub and Spoke Grant, part of the California MAT Expansion Project. This grant involves MedMark, located in Fairfield, one of Fresno’s contracted NTP, as the Hub. Five Spokes are in FQHC and other primary care clinics with a goal to increase MAT access in rural or remote areas. Fresno also participates in an ED Bridge Grant in coordination with local hospital Health Plan providers, specifically the Central California Faculty Medical Group. These efforts assist in the identification, referral and ongoing coordination of care for medical patients identified as needing MAT and SUD treatment. The model utilized by the ED Bridge grants include utilization of a system navigator and very active acceleration of MAT induction by x-waivered prescribers. As an active participant in the Central Valley Opioid Safety Coalition (CVOSC), Fresno has helped to facilitate a significant amount of educational training to physicians, pharmacists and healthcare leaders in the Central Valley. These included a series of continuing medical education (CME) trainings to fill educational gaps around the opioid epidemic, training physicians on topics such as</p>	

KC Table 3: Quality of Care Components

Component	Quality Rating
<p>understanding pain, safe prescribing and how best to help patients that are experiencing addiction. The series has been well supported over the past two years and each event had attendance that reached well over 100 participants. Fresno has also participated in a broad range of communication efforts including public service announcements (PSA) that have been utilized on social media, radio and television outlets. As part of the CVOSC Opioid Awareness campaign, more than 3600 spots have been run in both English and Spanish. Taglines and branding drove listeners and viewers to the Fresno website to learn more about services and programs.</p> <p>To increase adoption of Naloxone and overdose reversal efforts with local law enforcement agencies (LEA), CVOSC gave a presentation requesting support from the local Law Enforcement Chiefs Association Meeting in 2017. As of end of March 2019, a total of 19 LEAs, along with local fire departments, and two non-first responder agencies (Tulare County HHSA and Kings County Probation Officers) have been trained or waiting to be trained on the use of naloxone. Fresno also benefits from the CVOSC utilization of local overdose and fatality data to measure the impact of its various committees and initiatives. CVOSC review of recent data notes that its broad and comprehensive community engagement, utilization of harm reduction with naloxone carried by LEAs and first responders, quality educational support to health providers, use of CURES, and outreach programs has resulted in a decrease in age-adjusted opioid related deaths was in Fresno (35.6%), Madera (37.7%), and Tulare (13.9%) in 2017 compared to 2016.</p>	
<p>3F ASAM training and fidelity to core principles is evident in programs within the continuum of care</p>	<p>M</p>
<p>Fresno's orientation to ASAM criteria has been system-wide and includes both provider LPHA and SUD staff as well at the two county-run screening sites. Once screened, full assessments may be provided to or conducted by the SUD provider. Fresno's training on adoption of ASAM anticipated the launch of the DMC-ODS Waiver and continues with ongoing training cycles. Fresno has good adoption, fidelity and tracking of all levels of ASAM. Training has been and continues to be provided to system providers. Clinical staff interviewed by CalEQRO revealed a good understanding and that implementation of the ASAM criteria is evident throughout access and the admission process. While level of care (LOC) designations are adherent to the ASAM placement criteria, the focus on client centered care means that they will honor patient preference, so clients often don't start in the ASAM indicated LOC. Providers note that while Fresno trains on use of client centered care, insufficient staff time for client interactions can limit complete adherence to it. If contractors did not add staff for Waiver services, they often feel their staff are just doing too much paperwork. Many contractors did not build sufficient staffing for new services and new documentation into their rates for Waiver services. Interviews with staff and providers by CalEQRO revealed that awareness of transitions of care beyond the initial LOC designation is not high and may limit</p>	

KC Table 3: Quality of Care Components

Component		Quality Rating
such movement. Formal monitoring reports at the program site level provide data on referrals, screening activity, access data and designation. These forms also include a written summary, strengths and opportunities so that providers have documented feedback from Fresno QM staff.		
3G	Measures clinical and/or functional outcomes of clients served	PM
<p>Fresno can record the ASAM screening and placement dispositions data along with LOC designation and CalOMS outcome data set in Avatar. While these are recorded by individual SUD contract providers, there are at present no aggregate reports or analysis available. As noted earlier, accurate and timely completion of data has been the primary focus by Fresno along with addressing gaps in billing and other documentation. CalEQRO shared CalOMS data from CY 2018 noting that standard discharges in Fresno are at just 30 percent, well below the state average of 49.6 percent. Fresno also has quite a high level of administrative discharges at 61.5 percent compared to statewide rate of 37.9 percent. CalEQRO heard from system providers that they would very much like to have current CalOMS data to assist them in judging their own performance. CalEQRO strongly encourages Fresno to take steps to issue reports and analysis of CalOMS outcome data with contract providers. As noted above, CalEQRO also recommends that Fresno continue to take active steps to address client retention and completion rates, which it has begun through the clinical PIP project.</p>		
3H	Utilizes information from client perception of care (TPS) surveys to improve care	PM
<p>Fresno has actively participated in the administration of the Treatment Perception Survey (TPS) which is forwarded to UCLA for analysis. As noted earlier, Fresno conducted the TPS two times leading up to this review cycle. The first time was done optionally as Fresno wanted to establish a baseline in May 2019. These surveys were administered again as required in October 2019. Fresno took the UCLA analysis and created a visual representation for both the youth and adult results which were shared with leadership noting the variance if any of the different survey time periods. Essentially the adult surveys saw improvement in most of the domain areas, but youth results indicated a drop in nearly all the questioned areas between May and October.</p> <p>In the October survey period, the UCLA analysis reports that a total of 29 adult and youth program sites participated, and that 705 TPS forms were returned. All the 107 youth forms were in English and just 20 of the 598 adult TPS were in Spanish, though they were collected from three different LOC sites. For adults, outpatient/intensive outpatient, residential and NTPs participated representing 17 program sites. Overall results within each of the domains surveyed were quite positive. The scores included the domains of access (4.2), outcomes (4.3), care coordination (4.2), quality of care (4.4) and general satisfaction (4.4). Of the adult clients, 91.7 percent agreed or strongly agreed that they felt welcomed though slightly lower percent were overall satisfied with services at 90.6 percent. Just 86.5</p>		

KC Table 3: Quality of Care Components

Component	Quality Rating
<p>percent agreed that the program was sensitive to their cultural needs. Care coordination with physical or mental health were rated at 80.5 percent and 80.4 percent, respectively. This is consistent with the client focus groups (FG) conducted by CalEQRO where clients related difficulty or lack of consistency by their program in working with allied care providers on their needs. County analysis indicated that nine of the 14 domains saw overall improvement in October compared to their baseline TPS in May 2019.</p> <p>The analysis for youth TPS indicates that 96 of the 107 surveys collected were from responses at 11 outpatient/intensive outpatient program sites. Overall results in the measured domains were rated high. Average ratings were reported for access (4.1), outcomes (4.0), care coordination (4.1), quality of care (4.2) and general satisfaction (4.1). Of the youth population surveyed the majority were male at 75 compared to just 26 female, one transgender and 5 individuals declining to state. The largest identified ethnicity group was Hispanic/Latino at 63 percent and 87 percent were 15 years of age or older. Respondents indicated high level of satisfaction with staff indicating that they were treated with respect and that their counselor listened at 84.9 percent. While there is general satisfaction in some of the six domains, just 72.4 percent agree that the program has culturally sensitivity and provision of family services is 63.8 percent. County data provided indicates that agreement ratings on survey questions are now down in 17 of the 18 questions asked comparing October and May 2019 results. Most significant there is drop noted in questions pertaining to therapeutic alliance between youth and the counselor. The question regarding counselor listening dropped from 95 percent in agreement in May to just 84.9 percent in October. The counselor showed an interest in them individually also saw a steep drop from 94.1 percent in agreement in May to just 79 percent in the October survey cycle.</p> <p>CalEQRO has strongly encouraged and Fresno's Quality Management staff agree to review the youth surveys with its providers and determine what might be possible to rectify this drop in client satisfaction. There is also a need to review and address any variances that may exist within the other individual program TPS scores.</p>	

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Fresno is utilizing data from test calls to formulate performance improvement activities for its beneficiary access line.
- Congruence of level of care referrals with ASAM findings is 94.75 percent consistent with findings of the follow-up assessment visit.
- Fresno has established an operational definition for urgent appointment requests and a standard timeframe of two days and is meeting 46 percent of the time which is rare for first year counties in the Waiver.
- Fresno has established a variety of efforts to expand the use of MAT including non-methadone forms.
- Fresno is working to address network adequacy issues specifically those pertaining to lack of NTP services and a local provider has opened a MU in the rural part of the county.

Opportunities:

- ASAM data submitted for congruence noted 19.2 percent referrals were missing from the initial assessment data.
- Performance indicator results from test calls to the beneficiary access line are extremely poor in areas of basic documentation, data collection and input into the required call logs.
- Fresno is offering intensive outpatient at the ten sites which are DMC-ODS certified, but billing for this level of service remains very low at an average of just 32 hours per month.
- Fresno continues to be without a provider for youth residential services though is looking at possibly joining with other counties to obtain on a regional approach.
- Fresno is just starting to provide access to Recovery Services and physician consultation which are a required service under the Waiver.
- Fresno does not have a WM provider within the county but is working on identifying one.

Timeliness of DMC-ODS Services

Strengths:

- Fresno continues to look for ways to increase the number of service providers in its system of care.
- Fresno is entering into an agreement with Bright Heart in order to provide access to telehealth MAT and expand both access and timeliness.
- Fresno gives its providers a quarterly summary of timely access information and data on the SUD Access Form.
- Fresno estimates a 90 percent completion rate of data entry by providers that is required to determine its timeliness standards up from just 30 percent at the time of its launch.

Opportunities:

- Percentage of clients who obtain an offered appointment in ten days is just 46 percent and the first face to face contact within ten days meets standard 53 percent of the time.
- Fresno reports that just 38 percent of the 410 clients discharged from residential services received an appointment within seven days, while Medi-Cal claims data provided by CalEQRO indicates this occurred just 4.9 percent of the time for FY 18-19.
- Requests for urgent appointments average 14.4 days and meet the two-day standard just 46 percent of the time overall, 40 percent for youth.

Quality of Care in DMC-ODS

Strengths:

- Fresno is utilizing performance improvement activities within its clinical PIP to improve client retention in outpatient and residential services.
- Fresno is a recipient of both an ED Bridge Grant and a Hub and Spoke grant that focus on expanding MAT treatment access.
- Fresno has introduced a form to log results of group monitoring which checks for adherence of provider and staff use of EBPs in treatment.
- Fresno has added new SUD designated staff and incorporated existing SUD monitoring and quality staff into the larger QM structure.

- Fresno has transitioned the SUD billing to the reporting information system, Avatar which has been utilized for Mental Health services for several years.
- Fresno has mandated provider attendance to its training “bootcamp” to improve the knowledge base of program staff on documentation and billing areas. They want to support their contract providers in being successful with billing and documentation.
- Fresno implemented a QI Academy to help providers develop their own QI activities.

Opportunities:

- Fresno providers have a steep drop out rate amongst newly admitted clients soon after admission with just 23 percent of clients persisting in treatment after admission for four or more visits.
- Fresno has yet to launch its non-clinical PIP to work on the Access Call Center issues impacting clients.
- Fresno has limited data reporting and analysis capability as there is not a uniform EHR and the chart of record for all SUD programs which are contract agencies is currently paper based.

Client Outcomes for DMC-ODS

Strengths:

- Fresno is working to obtain consistent adherence to data submission requirements from its providers facilitating both training and on-site technical assistance.
- Fresno has administered the TPS survey twice since the launch of the DMC-ODS Waiver including an optional survey cycle in May 2019.
- Fresno QM staff created excellent visual comparative representation of the two TPS survey cycles for its leadership and providers for use in quality improvement efforts.
- Fresno has recurrent opportunities for stakeholder, consumer and staff input including the use of surveys designed for each group and that have shown a high response rate and informative data.
- Fresno has staff surveys on cultural sensitivity, awareness and humility.
- Fresno has strong commitment to address the opioid overdose epidemic. They fully participate in a well formulated, data driven task force called the Central Valley Opioid Safety Coalition.

Opportunities:

- Fresno notes that providers are not completing requested data the county needs to fully track timeliness standards.
- CalOMS data indicates a low standard discharge rate and high level of administrative discharges.
- TPS scores for youth in October 2019 are markedly down across most domains from the prior survey cycle in May 2019.
- Client focus groups and interviews with program staff indicate that some level of stigma persists that impacts clients on methadone even as programs have come to be more accepting of MAT overall.

Recommendations for DMC-ODS for FY 2019-20

1. As required, fully implement both the clinical and non-clinical performance improvement projects focused on the Access Call Center enhancements and the engagement and retention of clients in outpatient and residential care to enhance quality.
2. Fresno should ensure completion of the Quality Improvement Work Plan and specifically the areas pertaining to SUD and add the necessary data and information to set meaningful initiatives and goals for improvement linked to SUD treatment.
3. Fresno should continue to solicit providers in order to expand services in critical areas of need such as Withdrawal Management, non-methadone MAT access, NTP services in the remote areas of the county, reliable transportation options for those clients on methadone who are in residential services and residential treatment options for youth.
4. Fresno should continue to work with local providers to assist them in resolving remaining certification issues with PED and billing capacity in order to maximize the use of the Medi-Cal benefit and obtain essential data necessary to drive decision making and enhance resources for other critical client needs.
5. Fresno should improve care coordination capability to support enhanced continuity of care in order to assist clients discharged from residential link to lower levels of care such as outpatient, recovery support, case management, medication assisted treatment and/or transitional housing.
6. Fresno should continue efforts to add transitional housing options such as Recovery Residences for clients in need, especially for women who have children to its SUD continuum of care.

7. Fresno should determine the root cause for extremely low utilization of IOT in order to formulate informed solutions.
8. Fresno's efforts to enhance their CalOMS capacity and reports should continue and. they should share reports as soon as possible with providers. If needed get assistance from DHCS in their efforts to secure needed reports and technical assistance.
9. Fresno should identify strategies to improve the time frame for urgent appointment requests.
10. Fresno should continue provider training and set expectations with programs and line staff on the need to accept MAT, provide universal education to individual clients on availability and efficacy along with taking steps to reduce bias toward those clients receiving it.

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

- D.1 Opioid Safety Ads
- D.2 Monitoring to assure fidelity
- D.3 Fresno and data driven initiatives
- D.4 Fresno and local task force on opioids
- D.5 Interactive web page on opioid use in Fresno County and the State

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 - Fresno DMC-ODS
Opening session – Changes in the past year, current initiatives, status of previous year’s recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of performance measures
Quality Improvement Plan, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments (MATs)
MHP coordination with DMC-ODS
Criminal justice coordination with DMC-ODS
Clinic managers group interview – contracted
Clinical supervisors group interview – county and contracted
Clinical line staff group interview – county and contracted
Recovery support services group interview including staff with lived experience – county and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family
Site visits such as residential treatment (youth, perinatal, or general adult), WM, access center, MAT induction center, and/or innovative program
Exit interview: questions and next steps

Attachment B: Review Participants

CalEQRO Reviewers

Patrick Zarate, Lead Quality Reviewer
Rod Libbey, Quality Reviewer
Rob Walton, Quality Reviewer
Melissa Martin-Mollard, Information Systems Reviewer
Diane Mintz, 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 Fresno's DMC-ODS Review

DMC-ODS Sites

Fresno County Department of Behavioral Health
Health and Wellness Center (HAWC)
1925 East Dakota Avenue, Fresno CA 93726

Contract Provider Sites

Central California Recovery
1204 W. Shaw Ave, Suite 102
Fresno, CA 93711

WestCare Martin Luther King Campus
2772 Martin Luther King
Fresno, CA 93706

Aegis Treatment Centers
3707 East Shields Ave.
Fresno, CA 93726

Fresno New Connections
4411 N. Cedar Ave.
Fresno, CA 93726

Mental Health Systems
2550 W. Clinton Ave.
Fresno, CA 93705

LAST NAME	FIRST NAME	POSITION	AGENCY
Acle	Ralph	Staff Analyst	Fresno County Department of Behavioral Health (DBH): Substance Use Disorder (SUD) Contracts
Aguilar	Lucia	Clinical Supervisor	Housing Program
Anderson	Kathy	Principal Analyst	DBH: Contracts (SUD)
Apperson	Julie	Clinical Supervisor	DBH: Pathways Recovery
Arkelian	Brian	Clinical Supervisor	DBH: Clinical Team
Armistead	Natalie	Clinical Supervisor	DBH: Intensive Outpatient
Arrevalo	Milagro	Senior Licensed Mental Health Clinician	DBH: QI (Quality Improvement)/IT (Information Technology)
Avery	Jeffery	Clinical Supervisor	DBH: First On-Set
Bahrami	Admad	Division Manager/Ethnic Services Coordinator	DBH: Public Behavioral Health (PBH)
Balto	Adam	Senior Substance Abuse Specialist	DBH: Managed Care (SUD)
Banks	Ryan	Deputy Regional Director	Turning Point of Central California
Barragan	Angelica	Administrative Bookkeeper	Turning Point First Street (AB-109)
Bejarano	Vidal	Substance Abuse Counselor	Mental Health Systems
Betancourt	Alexander	Clinical Supervisor	DBH: Children's Outpatient
Birkholz	Trevor	Clinical Supervisor	DBH: Older Adult Mental Health
Bishop	Brian	Staff Analyst	DBH: Public Behavioral Health

LAST NAME	FIRST NAME	POSITION	AGENCY
Black	Marcelia	Clinical Supervisor	DBH: Managed Care (SUD)
Boyd	Karla	Clinical Supervisor	DBH: School Based Team (SBT)- Central
Brandon	Loretta	Staff Analyst	DBH: Contracts (SUD)
Breitzman	Shannon	Principal	Health Management Associates
Bressel	Derrick	Program Director	Westcare: Day Reporting Center
Brown	Betty	Division Manager	DBH: Managed Care
Castro	Gleyra	Clinical Supervisor	DBH: Children's Mental Health-Outpatient
Collins	Neil	Director of Account Partnership/Care Management	Beacon Health Options
Curtis	Marissa	Staff Analyst	Contracts (Mental Health AB-109)
Davis	Keegan	Substance Use Counselor	Transitions Children's Services
Delgado	Nick	Senior Substance Abuse Specialist	DBH: QI/IT
Dhanda	Jagdip	Director	Prodigy
DuPlessis	Helen	Principal	Health Management Associates
Elisalde	Peggy	Program Technician	DBH: QI/IT
Elliott	Jeffrey	Epidemiologist	DBH: QI/IT
Ennis	Keith	Program Director	Turning Point First Street (AB-109)
Enunwa	Felix	Director	Delta Care
Erwin	Sharon	Senior Staff Analyst	DBH: Contracts (SUD)
Escobar	Selina	Program Manager	Anthem Blue Cross
Escobedo	Francisco	Senior Staff Analyst	DBH: QI/IT
Evans	Ron	Supervising Clinical Case Manager	Turning Point First Street (AB-109)

LAST NAME	FIRST NAME	POSITION	AGENCY
Evans	Terry	Clinical Supervisor	Turning Point Quest House
Ewert	Sue	Director	ART Cartwright and E Street
Flores	Lesby	Division Manager	DBH: Children's Mental Health
Garcia	Gabriela	Substance Use Counselor	Fresno New Connections
Garrett	Sylvia	Substance Abuse Counselor	Fresno New Connections
Gomez	Gabriel	Senior Licensed Mental Health Clinician	DBH: QI/IT
Gonzalez	Daniel	Program Manager	California Health Collaborative
Gordon-Browar	Jolie	Division Manager	DBH: Adult Services
Hager	Cynthia	Clinical Supervisor	DBH: Collaborative Courts
Hailmariam	Taylor	Senior Staff Analyst	DBH: Billing and Admitting
Hamilton	Darrell	Director of SUD Services	Kingsview
Hart	David	Staff Analyst	DBH: Contracts (SUD)
Hart	Courtney	Licensed Practitioner of the Healing Arts	Promesa
Hayden	Kathy	Clinical Director	Westcare, Inc.
Herrera	Helen	Division Manager	DBH: Administration
Herrera	Merina	Substance Abuse Counselor	Mental Health Systems
Holland	Sandra	Licensed Practitioner of the Healing Arts	Turning Point Quest House
Holt	Susan	Deputy Director, Clinical Operations	DBH
James	Lori	Clinical Supervisor	DBH: Perinatal Wellness Center
Jimenez	Dalila	Licensed Mental Health Clinician	DBH: QI/IT
Jones	Susan	Medical Biller	Turning Point First Street (AB-109)

LAST NAME	FIRST NAME	POSITION	AGENCY
Kalk	Karen	Consultant	BHS consulting
Korettoff	Jennifer	Compliance Specialist/ Substance Abuse Counselor	Mental Health Systems
Kuoch-Seng	Jefferson	Business Systems Analyst	DBH: IT
Langroodi	Matin	Clinical Supervisor	Children's Outpatient
Le	Mary Ann	Deputy Director, Administrative Operations	DBH
Leanhart	Mark	Admissions and Outpatient Services Director	WestCare
Lewis	Okie	Staff Analyst	DBH: Contracts (SUD)
Lewis	Robin	Sr. Manager	Mental Health Network
Lopez	Daisy	Director of Program Services	California Health Collaborative
Loyd	Caitlin	Associate	Health Management Associates
Lujan	Joe	Clinical Director	Transitions Children's Services
Luna	Laura	Program Manager	DBH: Staff Development
Magdaleno	Jenny	Director of Residential Services	WestCare
Mala	Mac	Staff Analyst	DBH: Compliance
Martin	Rob	Director	Fresno New Connections
Martinez	Tiffany	Clinic Manager	Aegis
Medina	Sandra	Clinical Supervisor	DBH: Supporting Psychiatry only clients with Advocacy, Resources and Kindness (SPARK) Team
Mehia	Rita	Clinical Supervisor	DBH: Recovery with Inspiration, Support & Empowerment (RISE)

LAST NAME	FIRST NAME	POSITION	AGENCY
Miller	Michael	Supervising Senior Business Systems Analyst	DBH: IT
Mirelez	Dolores	Hub & Spoke Coordinator	Medmark
Moench	Ryan	Substance Abuse Counselor	DBH: Youth Wellness Center (YWC)
Montano	Stephane	Senior Staff Analyst	DBH: Billing and Admitting
Moreno	Javier	Regional Director	Aegis
Murdock	Susan	Clinical Director	Mental Health Systems, Inc
Nelson	Ciera	Clinical Supervisor	MHS
Newsome	Patricia	Licensed Practitioner of the Healing Arts	DBH: Pathways
Nguyen	Sue Ann	Program Technician	DBH: QI/IT
Obong	Daizell	Clinical Supervisor	Fresno New Connections
Parra-Sanchez	Luisa	Clinical Supervisor	DBH: SBT - West
Patterson	Sean	Business Manager	DBH: Finance Office
Perez	Ray	Regional Director	Turning Point of Central California
Pinuelas	David	Clinical Supervisor	Kingsview
Prichard	Michael	Staff Analyst	Public Behavioral Health
Puente	Tanimara	Senior Staff Analyst	DBH: Billing and Admitting
Rangel	Joseph	Division Manager	DBH: Contracts Services
Reed	Mandi	Director	Promesa
Reyes	Analinda	Administrative Assistant	DBH: QI/IT
Robbins	Charles	Principal	Health Management Associates
Robinson	Jeffery	Clinical Supervisor	DBH: Urgent Care Wellness Center (UCWC)

LAST NAME	FIRST NAME	POSITION	AGENCY
Rodriguez-Perez	Cesar	Senior Staff Analyst	DBH: Contracts (SUD)
Rojas	Aimie	Clinical Supervisor	DBH: Youth Wellness Center (YWC)
Ross	Sharon	Regional Director	Turning Point of Central California
Ross	Kateri	Behavioral Health Case Manger	Anthem Blue Cross
Ruiz	Lisa	Program Technician	DBH: Contracts (SUD)
Ryals	Amy	Staff Analyst	DBH: Contracts (SUD)
Sahai-Bains	Sonia	Clinical Supervisor	DBH: UCWC Mobile Access, CIT, Multi-Agency Access Point (MAP): Poverello House, and Housing
Schreiber	Chris	Senior Licensed Mental Health Clinician/ UR Specialist	DBH: Managed Care (SUD)
Shaw	Vernell	Manager of Service Coordination	Health Net
Shelton	M.K.	Director	ART Van Ness
Sorondo	Lindsey	Staff Analyst	DBH: Contracts (MH)
Taylor-Salery	April	Licensed Practitioner of the Healing Arts	DBH: Urgent Care Wellness Center
Tombs	Karen	Nurse Manager	DBH: Adult and Children's System of Care
Toonachat	Kannika	Division Manager	DBH: QI/IT and Medical Records
Tran	John	Medical Director	Central California Faculty Medical Group: Medical Services
Turk	Michelle	Licensed Practitioner of the Healing Arts	Turning Point First Street (AB-109)
Utecht	Dawan	Director	DBH
Valencia	Andrea	Substance Use Counselor	MedMark

LAST NAME	FIRST NAME	POSITION	AGENCY
Vanbruggen	Stacy	Division Manager	DBH: Adult Services
Vang	Cha La	ED Bridge Navigator	MedMark
Vasquez	Elizabeth	Compliance Officer	DBH: Compliance
Vasquez	Joyce	Clinical Supervisor	DBH: SBT - East
Villegas	Mercedes	Office Assistant	DBH: QI/IT
Vue	Bee	Director	MedMark
Weaver	Lisa	Staff Analyst	DBH: Contracts (SUD)
White	Dale	President/Director	Central California Recovery
Williams	Cary	Clinical Supervisor	DBH: SEES (Supported Employment and Education Services)
Winnett	Herb	Program Director	Turning Point Quest House
Winslow	Mark	Business Systems Analyst	DBH: IT
Winter	Kerry	Senior Substance Abuse Counselor	DBH: Pathways
Wongsing	Greg	Program Technician	DBH: Compliance
Xiong	Pa Ge	Staff Analyst	DBH: QI/IT
Zahtz	Jessica	Regional Operations Director	Beacon Health Options
Zapata	Domingo	Executive Director	Fresno Hispanic Commission Nuestra Casa

Attachment C: PIP Validation Tools

GENERAL INFORMATION	
DMC-ODS: Fresno <input checked="" type="checkbox"/> Clinical PIP <input type="checkbox"/> Non-Clinical PIP	
PIP Title: Client Engagement: Residential and Outpatient Continuation	
Start Date (MM/DD/YY): 12/19 Completion Date (MM/DD/YY): 11/20 Projected Study Period (#of Months): 12 Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Date(s) of On-Site Review (MM/DD/YY): 02/05/20 Name of Reviewer: Patrick Zarate	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input checked="" type="checkbox"/> Active and ongoing (baseline established, and interventions started)
	<input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
<input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP	
Brief Description of PIP (including goal and what PIP is attempting to accomplish): <p>Fresno asked its SUD providers to participate in a survey to determine potential performance improvement topics utilizing the Delphi Method. Survey results revealed strong interest and consensus by providers to look at the area of client engagement into treatment. Fresno constructed a data review dashboard to assess current levels of engagement across the system of care. Both outpatient and residential levels of care were reviewed, and a baseline was established that looked at persistence in care of at least four weeks between January to July 2019. Fresno noted that with each passing week the percentage of clients that continued in both residential and outpatient dropped. By the fourth week just 38 percent continued in care. Literature notes the clinical implications that would well play a factor in this drop and need to advance and build motivation and engagement skills. These skills and principles are embedded in the NIATx model, which is designed to address issues of barriers, enhance motivation, and make service delivery adjustments to facilitate both engagement and retention of clients. While not noted by Fresno, the extremely high level of administrative discharges</p>	

(over 65 percent) and low level of successfully completed discharges (12.8 percent, nearly half the state average) noted in the clinical outcomes data set, CalOMS, certainly indicates the need for advancing clinical engagement skills amongst system providers. The overarching goal is to see if the introduction of NIATx principles can increase the percentage of clients that remain in services for four weeks or visits (in outpatient) to 55 percent.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Fresno utilized a multi-disciplinary set of individuals and staff to develop the PIP. This included clinical staff, providers and along with quality management and staff from mental health. Heavy involvement and data from the SUD provider survey using the Delphi Model is a positive.</p> <p>BHC supports the planned addition of consumers during the implementation process of this PIP.</p>
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The time period and data reviewed was appropriate to the problem under review.</p> <p>BHC recommends that Fresno consider looking at the impact regarding those clients who do not link to continue in services.</p>
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input checked="" type="checkbox"/> High volume services <input checked="" type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input type="checkbox"/> Process of accessing or delivering care

<p>1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?</p> <p><i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP infers benefit to client condition and that it is adversely impacted by drop off in client participation in both residential and outpatient levels of care.</p> <p>BHC recommends that Fresno consider additional language to the clinical aspect of this PIP, i.e. expanding on "improve engagement" in order to more clearly differentiate it as a clinical project.</p>
<p>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)?</p> <p><i>Demographics:</i></p> <p><input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Fresno collected baseline data relevant to the specific study population as defined from service data input from contracted residential programs and outpatient clinic sites.</p>
Totals		3 Met 1 Partially Met 0 Not Met 0 UTD

STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing?</p> <p>Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i></p> <p>"Can NIATx recommended system and practice changes to improve client engagement and continuation increase the percentage of clients who initiate and remain in outpatient services by at least 4 visits to 55% (from 38%) and clients who initiate and remain in residential services for at least 4 weeks to 55% (from 32%)?"</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>BHC notes that adherence to the NIATx model will assist them to demonstrate root causes and that information will be useful in having the most effective change activities. The percentage of change noted is consistent as well with the levels recommended by NIATx.</p> <p>BHC would recommend that Fresno consider noting more clearly the clinical benefit this improvement will yield, i.e. "and that clients who persist in treatment will have improved clinical outcomes as measured by CalOMS."</p>
Totals		0 Met 1 Partially Met 0 Not Met 0 UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Fresno collected baseline data relevant to the specific study population as defined.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? <i>Methods of identifying participants:</i> <input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: <Text if checked>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	All adult returning or new admissions to outpatient and residential care specific to designated providers in the PIP tool submission.
Totals		2 Met 0 Partially Met 0 Not Met 0 UTD
STEP 4: Review Selected Study Indicators		

<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <p>Outpatient:</p> <ol style="list-style-type: none"> 1. Percentage of continuation from 1st service request to 1st day of service 2. Percentage of continuation from 1st service to 2nd day of service 3. Percentage of continuation from 2nd day of service to 3rd day of service 4. Percentage of continuation from 3rd day of service to 4th day of service 5. Percentage of continuation from the service request to 4th days within 30 days <p>Residential:</p> <ol style="list-style-type: none"> 1. Percentage of continuation from 1st service request to admission 2. Percentage of residents who have 7 consecutive days of room and board following admission 3. Percentage of residents who have 7 consecutive days of room and board following their first week (7 days) of residential services 4. Percentage of residents who have 7 consecutive days of room and board following their second week (14 days) of residential services 5. Percentage of residents who have 7 consecutive days of room and board following their third week (21 days) of residential services <p>Timely Access: Initiating Services within 3 Days</p> <ol style="list-style-type: none"> 1. Percentage of clients who receive initial services within 3 days following request 	<p><input checked="" type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>BHC recommends that Fresno consider changing the verbiage from “residents” to “clients”. It is also recommended that Fresno change “7 consecutive days of room and board” to “7 consecutive days of receiving residential services”. “Residents” and “room and board” imply that this is a placement in housing for clients and not treatment.</p> <p>Client engagement skills and strategies outlined in the model chosen by Fresno implies a strong predictor of clinical benefit. There should be some consideration (as the project progresses) to look at an additional marker on how persistence in treatment contributes to clinical benefit.</p>
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<p>2. Average days to initial services/admission; Average days to first services/admission for clients who request services</p> <p>•</p>		
<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused.</p> <p><input type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status</p> <p><input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>See 4.1</p>
<p>Totals</p>		<p>0 Met 2 Partially Met 0 Not Met 0 UTD</p>
<p>STEP 5: Review Sampling Methods</p>		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used.</p> <p>c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The above indicators apply to all clients in the study population and no sampling is required.</p>
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p> <p><Text></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	

<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____N of enrollees in sampling frame</p> <p>_____N of sample</p> <p>_____N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	NO APPLICABLE
Totals		Met Partially Met Not Met UTD

STEP 6: Review Data Collection Procedures

<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Initial request, admission and intake (initiation of treatment), dates of service, client activity.
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member <input checked="" type="checkbox"/> Claims <input checked="" type="checkbox"/> Provider</p> <p><input type="checkbox"/> Other: Access forms, Avatar, billing, TPS surveys</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Yes
<p>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?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>A systematic method of how these data sources will be adherent to input and tracking is noted.</p> <p>Information is listed regarding the timing of reporting, analysis of this data. Identification of who and what committee will be overseeing the fidelity, collection, reporting and analysis of this data is present.</p>

<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools</p> <p><input checked="" type="checkbox"/> Other: Access forms, Avatar, claims for billing, TPS surveys</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Yes, See 6.3. Data dashboard and graphs depicting this data was provided by Fresno in establishing the baseline.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan?</p> <p>Did the plan include contingencies for untoward results?</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Yes, regular monitoring and review will address any concerns revealed. Senior management involvement and QIC reporting will assure completion of the data set.</p>
<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name: Kathy Anderson</p> <p>Title: Principal Analyst</p> <p>Role: Sponsor</p> <p><i>Other team members:</i></p> <p>Names: Lisa Weaver, Contract Analyst /Project Lead</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Full listing of qualified personnel included program level lead, project manager, QI system leads, service providers and data / county support staff.</p>
<p>Totals</p>		<p>6 Met 0 Partially Met 0 Not Met 0 UTD</p>

STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ol style="list-style-type: none"> 1. Adjust Staff Schedules to Meet Client Demand 2. Use of Motivational Interviewing during First Contact 3. Use Motivational Interviewing during Treatment 4. Build community among clients 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>BHC notes that Fresno has noted specifics with each intervention to guide staff usage. A method to assure what is working and showing most improvement for the stated goals should be considered.</p> <p>BHC notes that during the onsite review it remained unclear due to lack of data which were fully implemented. The date of January 2020 allowed for a month and Fresno should provide some additional information to determine if this is active across the system defined by the project.</p>
Totals		1 Met 0 Partially Met 0 Not Met 0 NA 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	No data or findings provided for this PIP
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 8.1

<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 8.1
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> NO DATA AVAILABLE YET</p> <p><i>Conclusions regarding the success of the interpretation:</i> <Text></p> <p><i>Recommendations for follow-up:</i> <Text></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 8.1
Totals		0 Met 0 Partially Met 0 Not Met 4 NA 0 UTD
STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used? QUARTERLY</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	Too early in the development or launch and no measures or data were available on this PIP project.

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
Totals		0 Met 0 Partially Met 0 Not Met 5 NA 0 UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

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

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

This project remains in its initial implementation stage. Some clarifications and focus are needed on how this project will result in measurable changes and benefit to the beneficiary. No data, analysis or findings were available and therefore no conclusions about the PIP are possible at this time.

Recommendations:

Fresno should continue to address the issues that it has with client engagement, persistence in treatment and retention. It is likely that such efforts will result in more favorable clinical outcomes for the clients in both outpatient and residential. Structural or clinical adjustments are part of the NIATx framework that Fresno has chosen, and the indicators listed will demonstrate any improvements for client engagement or retention. Some metric to show improved care should be considered, though that can be as the project progresses. While this project has just launched, the current time frame is sufficient under the NIATx to show the desired improvements.

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**13 Met****3 Partially Met****0 Not Met****12 Not Applicable****PIP overall scoring** **$((13M \times 2) + 3PM) / (16 \text{ applicable} \times 2) = 90.6\%$**

GENERAL INFORMATION	
DMC-ODS: Fresno <input type="checkbox"/> Clinical PIP <input checked="" type="checkbox"/> Non-Clinical PIP	
PIP Title: Substance Use Disorder 24/7 Access Line	
Start Date (MM/DD/YY): 08/01/19 Completion Date (MM/DD/YY): 07/31/20 Projected Study Period (#of Months): 12 Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Date(s) of On-Site Review (MM/DD/YY): 02/05/20 Name of Reviewer: Patrick Zarate	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input type="checkbox"/> Active and ongoing (baseline established, and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
<input checked="" type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP	
Brief Description of PIP (including goal and what PIP is attempting to accomplish): <p>Monthly monitoring of the Access Line revealed problems in the collection and reporting of incoming calls for service. These activities are key deliverables in assuring accurate and timely access to program services by clients in need of substance abuse treatment. Beacon Health Services is the contractor used by Fresno to provide this service. Test calls were reviewed January through September 2019 and of 62 calls, only 28 or 45 percent were properly logged in the call line database. In discussions with Beacon, review of the specific issues revealed in the call data and an examination of workflow protocols have revealed certain opportunities attempts to correct these issues administratively have not been successful. Fresno determined that a formal performance improvement project was indicated due to the pervasive and negative impact this has on its ability to properly service incoming clients, the resulting inability to have complete and full data regarding who is calling and by instituting a PIP hopefully address areas where information that was taken is either incomplete or incorrect. The decision to make this a PIP was supported by the Fresno's Quality Improvement Committee (QIC). The overarching goal of the PIP is to make the Access Line functional and</p>	

achieve a general consumer satisfaction level of at least 90 percent. It should be noted at the time of the onset review, some of the indicators and data targets were incomplete. In no small part this has been due to the fact that Beacon Health Services has a corporate structure that does not allow for expedient determinations or adjustments without going through its own processes for approval. It should also be noted that the Access Line is actually staffed at a Beacon call center in Orange County. Many of the staff assigned to take Fresno calls have little or no familiarity with local resources. Such administrative hurdles have hampered Fresno's progress on this PIP but since this is the same line utilized by Fresno MHP there is heightened desire to see effective corrective measures being taken.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the DMC-ODS develop a multi-functional team compiled of stakeholders invested in this issue?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Fresno utilized a multi-disciplinary set of individuals and staff to develop the PIP. This included clinical staff, providers and along with quality management and staff from both SUD and mental health.</p> <p>BHC noted and supports utilization of two consumers or family members during the development process of this PIP.</p>
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The time period and data reviewed was appropriate to the problem under review. System and client impact regarding the lack of efficient call center processes are likely impacting client needs and service delivery.</p>
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input checked="" type="checkbox"/> Process of accessing or delivering care

<p>1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?</p> <p><i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP infers benefit to client condition which is currently impacted in a negative way by the lack of timely and complete data.</p>
<p>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)?</p> <p><i>Demographics:</i></p> <p><input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Fresno collected baseline data relevant to the specific study population which is all incoming callers for SUD services to the 24/7 Access Line.</p>
Totals		<p>Met Partially Met Not Met UTD</p>

STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing?</p> <p>Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative</i></p> <p>“By April 1, 2020, will the redesign of the 24/7 toll-free Access Line improve the challenges experienced by stakeholders (consumer/family); increasing key performance indicators (test call score) by 30%, decrease the length of call (minutes) to service by 27%, increase caller volume by 30%, achieve a general caller satisfaction of 70%, and increase the percent of callers matched by Level of Care by (5%)?” (revised 2/24/20)</p> <p>:</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>BHC requests that Fresno consider eliminating the sentence “increase the percent of callers matched by Level of Care by (xx%) and decrease the number of incomplete calls by xx%” if they are unable to finalize their baseline estimates. (see revised Study Question)</p> <p>BHC would recommend Fresno consider adding these in later if they are able, but in the interim, removing that would finalize the study question.</p> <p>The time frame of “by July 31, 2020” is a good target, but unnecessary and clouds the question. “will the redesign of the ...” is sufficient.</p>
Totals		<p>Met Partially Met Not Met UTD</p>

STEP 3: Review the Identified Study Population					
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i></p> <p><input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Fresno collected baseline data relevant to the specific study population as defined.</p>			
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i></p> <p><input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification</p> <p><input checked="" type="checkbox"/> Other: Test call data, Beacon call log, levels of care designation</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>All incoming calls for service as represented by call data and test calls.</p>			
Totals		Met	Partially Met	Not Met	UTD

STEP 4: Review Selected Study Indicators

4.1 Did the study use objective, clearly defined, measurable indicators?

List indicators:

6. The average percent of accurate **Calls Logged** that are captured within the *Written Access Line Call Log*
7. The average percent of accurate **Names** Logged that are captured within the *Written Access Line Call Log*
8. The average percent of accurate **Dates** Logged that are captured within the *Written Access Line Call Log*
9. The average percent of accurate **Dispositions** Logged that are captured within the *Written Access Line Call Log*
10. The average percent of accurate **Grievances** Logged that are captured within the *Written Access Line Call Log*
11. The average percent **Length of Call**; in minutes for those seeking request for SUD services (from initial request to referral/Linkage):
12. % Number of Calls for service within 30 minutes
13. Average percent of Incomplete Calls
14. The average percent of overall **Callers Satisfied** with the SUD Access Line Adult population Treatment Perception Survey
15. The average percent of overall **Callers Satisfied** with the SUD Access Line Adult population Treatment Perception Survey
16. The average percent of **Consumer Level of Care (LOC) Matched** to appropriate SUD program

- ☐ Met
- ☐ Partially Met
- ☐ Not Met
- ☐ Unable to Determine

Fresno may want to revisit these indicators which are sweeping but numerous. If they determine they have the ability to track and report these it remains ambitious. That the PIP incorporates clinical elements such as level of care designation, disposition and client satisfaction are positives.

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client focused.</p> <p> <input type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status <input checked="" type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction </p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	See 4.1
Totals		Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used.</p> <p>c) Margin of error that will be acceptable?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i> <Text></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	

<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____N of enrollees in sampling frame</p> <p>_____N of sample</p> <p>_____N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		Met Partially Met Not Met UTD

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Yes
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Claims <input checked="" type="checkbox"/> Provider</p> <p><input type="checkbox"/> Other: Via the EHR, LOC designations, Beacon call log, test call data, caller satisfaction surveys</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Yes
<p>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?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>A myriad of data sources is noted. The primary issue revolves around poor adherence in data collection and reporting. The systematic method of how these data sources will be adherent to input and tracking may need to be enhanced if monthly reviews finds gaps.</p>

<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input checked="" type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other: EHR, LOC designations, Beacon call log, test call data, caller satisfaction surveys</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>See 6.3</p>
<p>6.5 Did the study design prospectively specify a data analysis plan?</p> <p>Did the plan include contingencies for untoward results?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>See 6.3</p>
<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name: Kathy Anderson</p> <p>Title: Principle Analyst</p> <p>Role: Project Sponsor</p> <p><i>Other team members:</i></p> <p>Names: Francisco Escobido, Sr Staff Analyst</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>BHC notes as a strong positive the participation of the Beacon Health Services director of operations and other assigned staff. Beacon was also present for the PIP discussion having traveled up from southern California.</p>
<p>Totals</p>		<p>Met Partially Met Not Met UTD</p>

STEP 7: Assess Improvement Strategies					
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ul style="list-style-type: none"> • (Beacon will) develop a County Specialist whose telephone profile will be set with priority for County business and receive inbound member calls related to Fresno DMC benefit • County Specialist Team will be training on workflows and county protocols specific to (Fresno) County benefits and services • Increase staffing levels by two (2) FTEs to support daytime operating hours and contractual telephone performance requirements • Increase oversight by hiring a supervisor specifically for the County Specialist Team • Member Service and Clinical departments will maintain guides to support ongoing staff training and new hire onboarding <p>Note: Additional interventions will be studied for continuous quality improvement. PIP Team will make recommendations to (Fresno) leadership team to re-evaluate the SUD Access Process Map</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>BHC notes clarifying language as to the role of Beacon pertaining to these interventions should be more clearly defined. “Workflows” and “protocols” imply documentation and tracking standards, but those should be noted where appropriate since most indicators clearly require “accurate” and complete data.</p> <p>BHC notes the level of effort to obtain coordinated assistance from Fresno’s provider. Having a functional and available Access Line for beneficiaries is a DMC-ODS Waiver requirement that Fresno acknowledges.</p>			
Totals		Met Partially Met Not Met NA UTD			

STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	No data or findings provided yet for this PIP
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 8.1
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 8.1

<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> <Text></p> <p><i>Conclusions regarding the success of the interpretation:</i> <Text></p> <p><i>Recommendations for follow-up:</i> <Text></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 8.1
Totals		Met Partially Met Not Met NA UTD
STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	Too early in the development or launch and no measures or data were available on this PIP project.
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i> <input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? <input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 9.1
Totals		Met Partially Met Not Met NA UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

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

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

Conclusions:

This project remains in its initial implementation stage. Some clarifications and focus are needed on how this project will track adherence to data collection, a primary source of the identified problem.

This PIP is deemed *concept only* due to its stage of development and stage of implementation. There are areas within the PIP submission tool that need enhancement or clarification.

No data, analysis or findings were available at the time of this review.

Recommendations:

The outward facing door to the community is often the beneficiary access line. Fresno is encouraged to hold its provider accountable for providing ready access, accurate data and seamless transfer of incoming callers to the care that they need. There are some areas that Fresno could refine and enhance within the outline of this PIP project, but the stated performance indicators and interventions should continue through completion.

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

This PIP deemed “concept only” and Not Rated

PIP item scoring

Met

Partially Met

Not Met

Not Applicable

PIP overall scoring

$((\#M \times 2) + \#PM) / (\# \text{ applicable} \times 2) = \text{<\#>\%}$

Attachment D: County Highlights

D.1 Opioid safety ads in Fresno

In conjunction with Public Health and the Central Valley Opioid Safety Coalition Fresno participated in a local messaging campaign designed to give the community essential information on the nature and risks of opioids and raise awareness regarding the drug overdose epidemic. URL links to a variety of PSAs that ran on television, radio, Spanish language radio and in print are listed below.



Patty Havard :30 second Spot which ran on all major Broadcast stations
<https://drive.google.com/file/d/1gcLmqWb7DCdulerTTtGLsT4Br1LdfxoR/view?usp=sharing>

Michael Prichard :30 Second Spot which ran on all major Broadcast stations
<https://drive.google.com/file/d/12X6jPtCy47YloDAca5Cdp9QpFsWVmGma/view?usp=sharing>

Marisol Zamora :30 Second Spot which ran on Spanish Broadcast stations
https://drive.google.com/file/d/1EK0n1_JOwERwhLM-m1S5qPRc7wyX1Bj/view?usp=sharing

Series of 5 Radio Spots :30 Each
https://drive.google.com/drive/folders/1bcopNoFr6FP5r-islIT_JSvVuUM9Fvjr?usp=sharing

Opioid Safety Pamphlet
<https://drive.google.com/file/d/1Avbo9ulkmXy5WV3Rj3ySQDgAqiQr24aE/view?usp=sharing>

D.2 Monitoring to assure fidelity

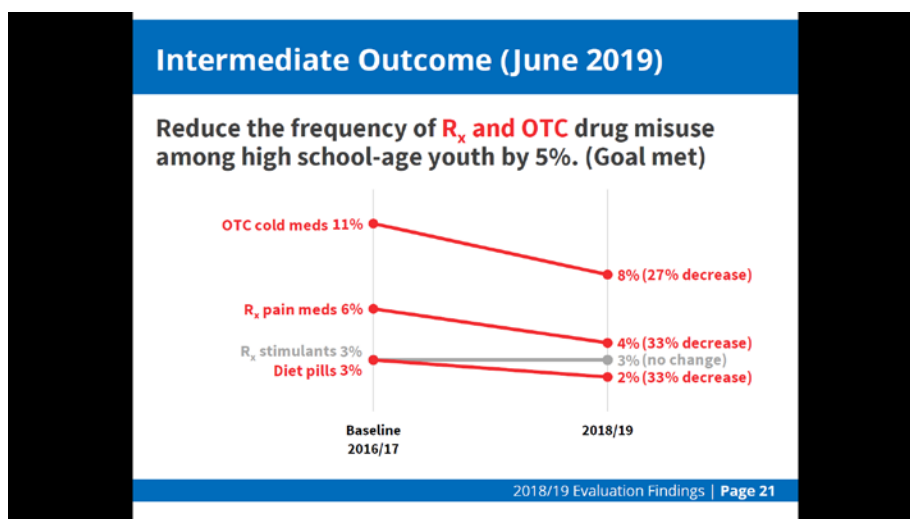
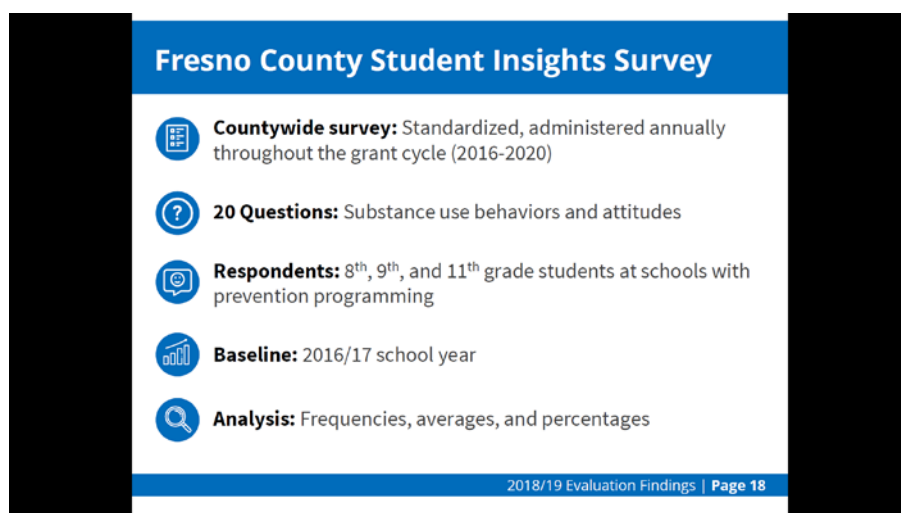
Fresno has provided dozens of trainings in anticipation of the DMC-ODS Waiver. Development of a tool to check on adherence to the use of Evidence Based Practices which is used while a monitor sits in on group sessions, helps to identify gaps in learning and target areas for improvement at the program and staff level.

COUNTY OF FRESNO DBH-MANAGED CARE DIVISION-SUD SERVICES SUBSTANCE USE DISORDER PROGRAM GROUP OBSERVATION		
Agency Name:	Program Name:	Modality:
Site Address:	Provider Representative(s):	County Reviewer(s):
		Date:
Review each item on the checklist and indicate "Y" for Yes, "N" for No or "NA" for Not Applicable. Please complete a separate checklist for each activity observed. Use the "Comments" section to provide additional information, as needed. Not all items on the checklist are applicable to all programs.		
Is the group facilitated in accordance with evidence-based practices? (CBT, MI, Wellness and Recovery model) <u>Intergovernmental Agreement Exhibit A, Attachment I Program Specifications (AA)(3)(iii)</u>	Group matched (length, start, end, etc.)? Beneficiary participation/engagement? Staff engagement? Staff is knowledgeable about topic? Staff is able to articulate <u>concepts</u> ?	
Is the curriculum evidence-based? (Hazelden, Covington)	Activities are accessible to the disabled? Were there enough materials and resources available? The quality of the materials and resources is adequate?	
Is the group held in a confidential setting?	Cultural sensitivity and ethnic diversity in staff, services, activities and materials is evident and appropriate for the target population?	
Are there 2 - 12 beneficiaries? IA (III)(PP)(13)(i)	Other:	

Version 9/10/19

D.3 Fresno and data driven initiatives

Fresno has a strong commitment to its use of data in measuring impacts of local prevention initiatives. In addition to a year over year comparison, a high response rate of 63 percent or over 5,375 surveys collected. Results of local prevention efforts are noted below. Noting that the majority of adult substance abuse disorders begin before age 25, the need for focused education and intervention is clear for this at-risk population. Other prevention initiatives focus on alcohol and marijuana use by underage youth and can be seen by following the URL link below.



Use this URL to learn more about Fresno's alcohol and other drug prevention efforts.

<https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services/substance-use-disorder-prevention/substance-use-disorder-information-for-parents-caregivers>

D. 4 Fresno and local task force on opioids

Strong participation and leadership are noted in Fresno's collaborative work within the Central Valley Opioid Safety Coalition. Key initiatives are clearly mapped out and data is utilized to gauge progress. More can be learned by following the URL link below

<https://centralvalleyopioidsafety.org/>

centralvalleyopioidsafety.org



Department of Public Health
<http://fcdph.org>



Central Valley Opioid Safety Coalition
Hospitals • Health Plans • Providers • Public Health • Community



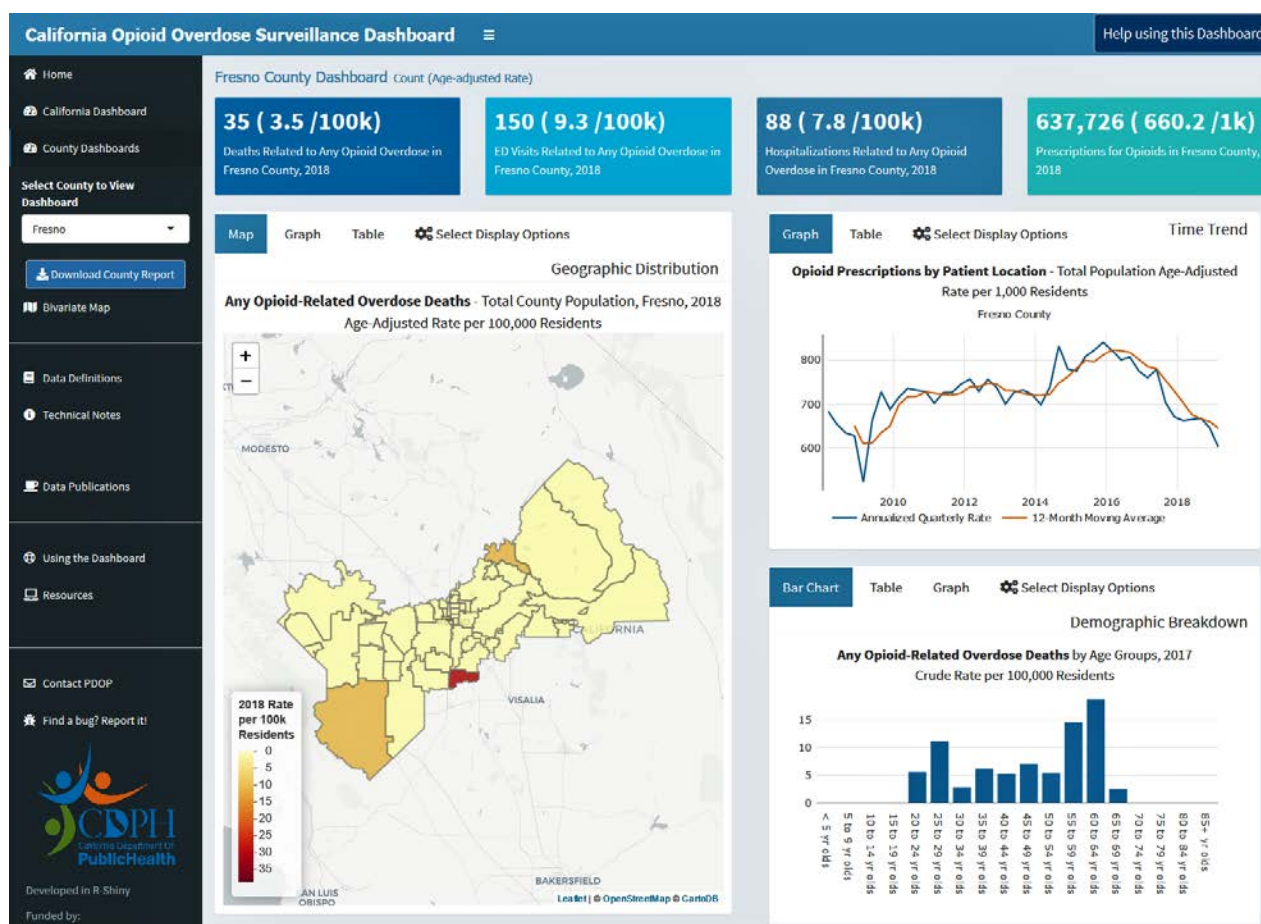
**DEPARTMENT of
BEHAVIORAL
HEALTH**

This work was funded by the California Department of Public Health (CDPH) and was supported by Grant Number 6NU17 CE002747, funded by the Centers for Disease Control and Prevention.

D.5 Interactive web page on opioid use in Fresno County and the State

The link below provides an array of data, graphs and trends in Fresno County pertaining to opioid prescribing, use and overdoses.

<https://discovery.cdph.ca.gov/CDIC/ODdash/>



Attachment E: Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: **Fresno** Review date(s): **February 4-6, 2020**

Person completing form: **Lisa Weaver**

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

Percent of all treatment services that are contracted: 94%

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:

Access: The Fresno County SUD system of care (SOC) has a no wrong door approach for beneficiaries to access care. Beneficiaries can: (1) call the 24/7 SUD Access Line; (2) walk into the county-operated Urgent Care Wellness Center (adults) or the Youth Wellness Center; and (3) self-refer by calling or walking into a SUD System of Care contracted provider. Persons making contact with the SUD SOC receive a brief screening to determine a provisional level of care (if applicable) and are connected to an appropriate provider. The Access Line and the county-operated access points will attempt to schedule an initial appointment with the provider on behalf of the beneficiary. If an access point determines that emergency services are needed the beneficiary will be connected to an emergency department. The 24/7 Access Line for the SUD SOC is operated by an Administrative Services Organization, Beacon Health Options of California, Inc.

Coordination of Care: Care coordination activities are delegated to the SUD provider network. The County monitors these activities through site visits and provides technical assistance when gaps are identified between beneficiary needs and services delivered. Providers are required to identify the person within their program who is formally designated to provide coordination of care to each beneficiary and ensure the beneficiary is provided with contact information for the designated person. Providers must have a policy describing how they will ensure that each beneficiary has an ongoing source of care appropriate to their needs.

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: **1,686**

Comments:

Case management activities have been delegated to the contracted DMC certified programs. Providers are required to offer case management throughout the course of the treatment episode as appropriate. Case management services are monitored during annual site reviews which are conducted by the Managed Care Division. Case Management, as a newly eligible service, continues to increase in usage as providers are working to build their programs by increasing AOD counselors.

Methodology used to capture monthly estimated billed hours of Case

Management: Billing data for services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system. Billing, which is entered on a per minute basis, was converted to hours and then averaged across the seven-month range.

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: **7**

Total number of legal entities billing DMC-ODS: **1**

Choices: **Included with outpatient sites as step-down**

Comments:

There are seven (7) outpatient providers that have indicated an interest in offering recovery services as a step down after beneficiaries complete their course of treatment. Of the seven, one is currently providing and billing for recovery services. Another provider is providing recovery services but has not yet billed for them.

Fresno County Department of Behavioral Health is working with the provider network to expand the number of programs offering Recovery Services by providing training and technical assistance to increase knowledge and capacity. Providers are expected to continue to work on expanding capacity or establish a relationship with other network providers to refer beneficiaries for these new services.

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

Number of Sites: **0**

Total number of legal entities billing DMC-ODS: **0**

Estimated billed hours per month: **0**

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

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

Choice(s): N/A

Comments:

DBH is working toward contracting with providers that offer this service.

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: 80 as of December 6, 2019

Estimated billed hours per month: 577 billed bed days

Pick 1 or more as applicable and explain below:

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

Choice(s): Within residential treatment center

Comments:

Fresno County's primary 3.2-WM provider, Comprehensive Addiction Program (CAP), was not able to obtain DMC certification prior to ODS implementation. The County was provided a waiver to allow CAP to serve DMC eligible beneficiaries until CAP was able to complete the certification process and then bill DMC retroactively. CAP provided an average of 577 bed days per month prior to ceasing operations as a treatment provider in August 2019. Effective August 2019, the County contracted with an out-of-county provider, Bakersfield Recovery Services, Inc., to fill a portion of the need for 3.2-WM. Bakersfield Recovery Services makes beds available to Fresno County beneficiaries based on vacancies in their facility rather than a specific number of beds. As of November 2019, Mental Health Systems (MHS) was added to the contract to provide these services. MHS adds 12 women's beds to these services.

Neither Bakersfield Recovery Services or MHS have billed for any 3.2-WM services provided; however, Bakersfield Recovery has provided 38 bed days since August. The County is in the process of adding WestCare California as another in-county operator of 3.2-WM. WestCare anticipates becoming operational in early 2020 which will increase capacity by an additional 12 beds.

Methodology used to capture monthly estimated billed bed days for Level 3.2 Withdrawal Management Residential: Billing data for services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system and then averaged across the seven month range.

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: 3

In county NTP: Sites 5 Slots: 2815

Out of county NTP: Sites 0 Slots: 0

Total estimated billed hours per month: 4,275

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

Comments:

Two contracted NTP providers, Aegis and MedMark, are administering and billing for additional MAT services.

Methodology used to capture monthly estimated billed hours: Billing data for counseling services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system. Billing for NTP counseling services is done on a per unit basis. Each unit is equivalent to a 10-minute increment. Therefore, the units were converted to hours and then averaged across the seven-month range.

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

Total legal entities: 0 Number of sites: 0

Total estimated billed hours per month: 0

Comments:

Fresno County has received interest from Bright Heart Health to provide MAT telehealth services. Bright Heart Health has already submitted much of the required materials needed to contract with Fresno County, and we are currently reviewing that submission. Fresno County has had discussions with Kings View Behavioral Health, a contracted outpatient provider, to begin offering MAT services. And finally, there are two additional MAT providers that have shown an interest in establishing DMC certified treatment sites in Fresno County to expand the availability of MAT services.

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

Total legal entities: 11 Total sites: 17

Total number of legal entities billing DMC-ODS: 11

Average estimated billed hours per month: 2,441

Comments:

Methodology used to capture monthly estimated billed hours of Level 1.0**Outpatient:**

Billing data for services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system. Billing, which is entered on a per minute basis, was converted to hours and then averaged across the seven-month range.

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

Estimated billed hours per month: 32

Total legal entities: 3 Total sites for all legal entities: 10

Total number of legal entities billing DMC-ODS: 1

Average estimated billed hours per month: 32

Comments:

There are three providers in Fresno County that are DMC certified to provide intensive outpatient treatment. Currently, one of these providers, the County-operated program Pathways to Recovery, is billing for these services. One additional provider, Fresno New Connections, is expected to begin offering this level of care during 2020.

Methodology used to capture monthly estimated billed hours of Level 2.1**Outpatient/Intensive:**

Billing data for services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system. Billing, which is entered on a per minute basis, was converted to hours and then averaged across the seven-month range.

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

Total sites for all legal entities: 0

Total number of legal entities billing DMC-ODS: 0

Total number of programs: 0

Average client capacity per day: 0

Average estimated billed treatment days per month: 0

Comments:

Fresno County does not offer this optional this level of care.

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: 4

Total number of legal entities billing DMC-ODS: 4
 Number of program sites: 4
 Total bed capacity: 317
 Average estimated billed bed days per month: 3,241

Comments:

Residential Level 3.1 - Fresno County Hispanic Commission (Men only - 12 beds), Turning Point Quest House (Men only - 30 beds), Mental Health Systems (Women and Perinatal Populations – 60 beds), and WestCare California (Men, Women, Perinatal Populations – 215 beds).

Methodology used to capture monthly estimated billed bed days for Level 3.1 Residential:

Billing data for services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system. Bed days billed during this period were then averaged across the seven-month range.

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

Total sites for all legal entities: 0
 Number of program sites: 0
 Total number of legal entities billing DMC-ODS: 0
 Total bed capacity: 0
 Average estimated billed bed days per month: 0
 (Can be flexed and combined in some settings with 3.5)

Comments:

Fresno County does not currently offer this level of care. Identifying a provider with the capacity to make these services available is a priority for year two of DMC-ODS implementation.

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

Total sites for all legal entities: 3
 Number of program sites: 3
 Total number of legal entities billing DMC-ODS: 3
 Total bed capacity: 305
 Average estimated billed bed days per month: 1,189
 (Can be flexed and combined in some settings with 3.5)

Comments:

Residential Level 3.5 - Turning Point Quest House (Men only - 30 beds), Mental Health Systems (Women and Perinatal Populations – 60 beds), and WestCare California (Men, Women, and Perinatal Populations – 215 beds).

These three providers also provide Residential Level 3.1. The bed capacity is the same per program and beds are allocated between Level 3.1 and 3.5 based on need.

Methodology used to capture monthly estimated billed bed days for Level 3.5 Residential:

Billing data for services provided from January 1, 2019 through July 31, 2019 was pulled from the Avatar system. Bed days billed during this period were then averaged across the seven-month range.

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: 0

Number of legal entities: 0

Total bed Capacity: 0

Average estimated billed bed days per month: 0

Comments:

Fresno County has Memorandums of Understanding (MOUs) with Managed Care Plans CalViva and Anthem Blue Cross. Beneficiaries who are identified as meeting medical necessity for this level of care would be referred to the Managed Care Plans. Fresno County SUD treatment providers are required to facilitate the linkage to the Managed Care Plan by assisting the beneficiary with placing the call and providing transportation, if needed.

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

Access)

Number of program sites: 0

Total number of legal entities billing DMC-ODS: 0

Number of legal entities: 0

Total bed capacity: 0

Average estimated billed bed days per month: 0

Comments:

Fresno County has Memorandums of Understanding (MOUs) with Managed Care Plans CalViva and Anthem Blue Cross. Beneficiaries who are identified as meeting medical necessity for this level of care would be referred to the Managed Care Plans. Fresno County SUD treatment providers are required to facilitate the linkage to the Managed Care Plan by assisting the beneficiary with placing the call and providing transportation, if needed.

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: 2

Number of program sites: 2

Total bed capacity: 63

Comments:

Fresno County contracts with two Recovery Residence Programs, WestCare and Turning Point. Turning Point provides 25 beds for men's recovery residence services and WestCare provides 14 beds for men and 10 beds for women. Mental Health Systems (MHS) will open their Recovery Residence services in early 2020 and will provide an additional 14 beds for women.

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

The following providers, which Fresno County anticipates adding to the system of care, are in the process of becoming DMC certified.:

Clinica Sierra Vista (OPT, MAT)

CAP (Residential, Withdrawal Management 3.2)

First Steps Recovery (Residential, OPT, IOT)

Central Star Behavioral Health (OPT, Residential)

LAGS (MAT)

Groups (MAT)

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