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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

ALAMEDA FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 24-26, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Drug Medi-Cal Organized Delivery System (DMC-ODS) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Alameda" may be used to identify the Alameda County DMC-ODS program, unless otherwise indicated.

DMC-ODS INFORMATION

Review Type — Virtual

Date of Review — January 24-26, 2023

DMC-ODS Size — Large

DMC-ODS Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the DMC-ODS on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components (KC) that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	5	0	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	8	7	1	0
Information Systems (IS)	6	5	1	0
TOTAL	**24**	**22**	**2**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Care Coordination for Residential Substance Use Disorder (SUD) Services	Clinical	08/2022	Implementation Phase	Low Confidence
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Non-Clinical	07/2022	Planning Phase	Low Confidence

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Youth ☐ Residential ☒ Outpatient ☐ MAT/NTP ☐ Perinatal ☐ Other	19
2	☐Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP ☐ Perinatal ☐ Other	10

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The DMC-ODS demonstrated significant strengths in the following areas:

- Alameda impressively tracks all required elements of timeliness, produces valuable reports for management decision-making, and reports meeting state standards for all aspects of initial visits.
- Alameda Quality team is an established and strong division for overseeing Quality Improvement (QI) and Quality Assurance (QA) to monitor compliance. As a result, the Information System (IS) team is well prepared for the transition to streamline SmartCare.
- Medication Assisted Treatment (MAT) services are accessed by a strong collaboration with the criminal justice system, Federally Qualified Health Center (FQHC), Bridge Clinic, hospital, and all of which includes a robust level of care coordination for those who are on MAT.

The DMC-ODS was found to have notable opportunities for improvement in the following areas:

- Alameda should record an introductory online training for Clinician's Gateway (CG) which is part of the Alameda's electronic health record (EHR) instead of relying on Providers staff to train their staff. The training provides best-practice training for the use of CG.

- Providers expressed concern about the number of times staff has lost data because of issues with both Insyst and CG.
- Alameda has a very high level of clients leaving treatment before completion, as noted in the California Outcomes Measurement System (CalOMS) data provided by CalEQRO. Client discharge categories for satisfactory and unsatisfactory progress leaving treatment early are at 45.5 percent and 22.3 percent, respectively, indicating that nearly seven out of ten clients who enter treatment are self-discharging early.
- Despite many meetings with county management, contract providers continue to express concerns about feeling heard in their working partnership with the county.

FY 2022-23 CalEQRO recommendations for improvement include:

- Alameda needs to increase the coverage of their Help Desk to cover lunch hours, decrease wait times, and possibly add on-call staff to answer questions and deal with technology issues on the weekend. Analyze whether increasing hardware and software funding or adding staff will stabilize the older technology used by Alameda.
- Alameda should determine if the procurement of the clinical component of the EHR would be beneficial to address duplicative chart entries, reduce errors, improve efficiencies, and provide valuable source of data for use by administration to more comprehensively monitor and report on its system of care.
- Alameda should take meaningful steps to identify and address the issue of premature discharge status within its system of care. This may include a need to obtain data and provide education or other technical assistance (TA), including clinical oversight, to reduce client exits before the completion of treatment episodes.
- Initiate a collaborative effort with providers to identify opportunities for streamlining QI/QA procedures and implement them in the context of the new California Advancing and Innovating Medi-Cal (CalAIM) requirements.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 31 county DMC-ODSs, comprised of 37 counties, to provide specialty SUD treatment services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal DMC-ODS. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal beneficiaries.

DHCS requires the CalEQRO to evaluate DMC-ODSs on the following: delivery of SUD in a culturally competent manner, coordination of care with other healthcare providers, and beneficiary satisfaction. CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (Section 14197.05 of the California Welfare and Institutions Code [WIC]).

This report presents the FY 2022-23 findings of the EQR for Alameda DMC-ODS by BHC, conducted as a virtual review on January 24-26, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the DMC-ODS' use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public SUD system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SUD systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review DMC-ODS-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from multiple source files: Monthly Medi-Cal Eligibility Data System Eligibility File; DMC-ODS approved claims; Treatment Perception Survey (TPS); CalOMS; and the American Society of Addiction Medicine (ASAM) level of care (LOC) data.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each DMC-ODS is provided a description of the source of data and a summary report of Medi-Cal approved claims data. These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized TA related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the DMC-ODS identified as having a significant impact on access, timeliness, and quality of the DMC-ODS service delivery system in the preceding year. DMC-ODSs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- DMC-ODS activities in response to FY 2021-22 EQR recommendations.
- Summary of DMC-ODS-specific activities related to the four KC, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the DMC-ODS' two contractually required PIPs as per 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii).
- Review and validation of each DMC-ODS' NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the DMC-ODS and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county DMC-ODS' reporting systems and methodologies for calculating PMs, and whether the DMC-ODS and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Beneficiary perception of the DMC-ODS' service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of DMC-ODS strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of DMC-ODS beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

DMC-ODS CHANGES AND INITIATIVES

In this section, changes within the DMC-ODS' environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING DMC-ODS OPERATIONS

This review took place during and after the Coronavirus Disease 2019 (COVID-19) pandemic. Alameda continues to participate in county efforts relative to COVID-19. Alameda reports that four principal areas continue to be impacted due to the pandemic. It's the operational policies and procedures; employee operations; community outreach and engagement; and clinical services delivery. Although in-person encounters have resumed largely across the system, telehealth and telephonic services continue to be modalities in use and are monitored by the department. CalEQRO worked with Alameda to design an alternative agenda with virtual rather than onsite review sessions. As a result, CalEQRO completed the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- Alameda initiated the Strategic Planning Initiative and Survey, developed a priority framework for a more robust stakeholder engagement, and created a long-term strategic plan for the community. These include communication and collaboration between Alameda, its contract providers, stakeholders, and the community.
- The DMC-ODS has initiated re-design efforts to implement the Forensic System, including alignment, communication, and organizational structure. This includes forensics, diversion programs, and re-entry services.
- Local initiatives to ready their system for CalAIM include changes to administration, program planning, alignment, communication, organizational structure, payment reform, policy implementation, and data exchange.
- Alameda partnered with Streamline Healthcare Solutions, LLC, to implement the SmartCare billing system. This platform will help to advance the effective delivery of services between contracted providers and staff, resolve system challenges, and facilitate enhanced flexibility for data sharing.
- DHCS approved Alameda for Peer Certification (SB803) to support peer professionals with lived experience or family members with lived experience of up to 160 new members.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

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

Not Addressed is assigned when the county performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2021-22

Recommendation 1: Continue and expand unique culturally sensitive programs for the different Asian Pacific Islander (API) populations to increase access and treatment opportunities. Document these for sharing best practices with others in terms of barriers and successes.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda facilitated multiple stakeholder sessions which included an in-depth API utilization data analysis for specialty mental health and SUD services. The data analysis included specific and detailed looks at PR by ethnicity, primary language, county region, and age. Alameda has also coordinated with the Bay Area Community Health to provide culturally specific treatment through the Asian Wellness Project. Adult & Older Adult System of Care is exploring the feasibility of creating an API full-service partnership team in South County of Alameda.

Recommendation 2: Expand the overdose prevention efforts Alameda DMC-ODS has begun using interventions such as access to Narcan. Consider how work in the new Forensic division may allow for additional prevention strategies with this population being discharged from detention. The jail population being released has well documented elevated risk factors which must be considered as part of discharge planning.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda's Safe Landing Project supports inmates and clients upon re-entry when they leave custody. Because these individuals may be released from jail at any time. Alameda is working with a program provider to expand service hours.
- Alameda also operates the Bridge Clinic that offers same-day services with substance use navigators regardless of insurance status. Services are available via telehealth as well as some in-person services. Clinical services available include MAT, other traditional SUD services, and other supports such as assistance with housing. All services are provided regardless of insurance or another status.

Recommendation 3: Increase availability of the SUD Access Call Center service during peak hours on weekends and holidays, not just business hours.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda has expanded SUD Access call service with contract provider Center Point. Additionally, the Crisis Support Services contract was augmented to expand SUD's 24/7 line after business hours.
- Alameda's Crisis Support Services Line assists beneficiaries after business hours, on weekends, and on holidays. Messages received are uploaded to Center Point for the following Monday or the next business day. This ensures proper follow-up and provides beneficiaries with an additional opportunity for outreach.

Recommendation 4: Develop a plan and begin to address high no-show rates for first face-to-face appointments. CalEQRO can provide some TA based on other county strategies if helpful.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda developed a portal that provides beneficiary a referral services. To connect beneficiaries to services, the Alameda SUD Access team offers 3-way calls including the beneficiary and the provider. These 3-way calls increase the chances of beneficiaries continuing through the process and receiving services by reducing no-shows. Alameda also increased telehealth services and improved service access by eliminating logistical barriers such as transportation.

Recommendation 5: Increase LOC visit/units of service capacity (to the extent possible with the unpredictability of COVID-19) back to pre-pandemic levels or above based on projected community needs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda has seen an increase in staff providing remote services via phone and telehealth by 16 percent. In addition, there was a seven percent increase in SUD services from FY 2020-21 to FY 2021-22.

- There were increases in outpatient, perinatal residential, and recovery residence services in FY 2021-22 with improved timeliness regarding the first service along with the average days from the initial request to the first service. Residential providers within the county have been able to expand service capacity with new beds since the start of the pandemic.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals or beneficiaries are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed. The cornerstone of DMC-ODS services must be access or beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the KC and PMs addressed below.

ACCESSING SERVICES FROM THE DMC-ODS

SUD services are delivered by contractor-operated providers in the DMC-ODS. Regardless of payment source, no services were delivered by county-operated/staffed clinics and sites, with 100 percent delivered by contractor-operated/staffed clinics and sites. Overall, approximately 76.95 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to beneficiaries 24-hours, seven days per week that is operated by contract provider staff and Alameda County Crisis Support Services (CSS); beneficiaries may request services through the Access Line as well as through the following system entry points: Cherry Hill Withdrawal Management Services, Center Point, and SUD navigation system. The DMC-ODS operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. CSS counselors offer crisis support services as needed and link beneficiaries to appropriate services.

In addition to clinic-based SUD services, the DMC-ODS provides telehealth services via video/phone to youth and adults. In FY 2021-22, the DMC-ODS reports having provided telehealth services to 902 adult beneficiaries, 41 youth beneficiaries, and 49 older adult beneficiaries across zero county-operated sites and 26 contractor-operated sites. Among those served, 26 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of

informing the status of implementation of the requirements of WIC Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all DMC-ODSs based upon its review and analysis of each DMC-ODS' NA Certification Tool and supporting documentation, as per federal requirements outlined in the Annual BHIN.

For Alameda County, the time and distance requirements are 15 miles and 30 minutes for outpatient SUD services, and 15 miles and 30 minutes for Narcotic Treatment Program/ Opioid Treatment Program (NTP/OTP) services. These services are further measured in relation to two age groups – youth (0-17) and adults (18 and over).

Table 1A: DMC-ODS Alternative Access Standards, FY 2021-22

Alternative Access Standards	
The DMC-ODS was required to submit an AAS request due to time and distance requirements	☐ Yes ☒ No

- The DMC-ODS met all time and distance standards and was not required to submit an AAS request.

Table 1B: DMC-ODS Out-of-Network Access, FY 2021-22

Out-of-Network (OON) Access	
The DMC-ODS was required to provide OON access due to time and distance requirements	☐ Yes ☒ No

- Because the DMC-ODS can provide necessary services to a beneficiary within time and distance standards using a network provider, the DMC-ODS was not required to allow beneficiaries to access services via OON providers.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which a DMC-ODS informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- Strong collaboration with criminal justice, FQHC's, and system contract providers to ensure beneficiary access.
- Alameda has the ability to do three way calling to assist beneficiaries using its access line. They have an ability to collect data that can be delineated to look at demographics including ethnicity.
- Access line uses local interpretation services. They report that the services are easy to use and works well with incoming callers.
- Beneficiaries reports the providers are meeting their cultural needs.
- Alameda has an opportunity to improve access by increasing outreach to youth. Data show low PR for those obtaining youth SUD services.

ACCESS PERFORMANCE MEASURES

The following information provides details on Medi-Cal eligibles and beneficiaries served by age, race/ethnicity, and eligibility category.

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) 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. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 0.85 percent, with an average approved claim amount of $5,821. Using PR as an indicator of access for the DMC-ODS, Alameda's PR (0.90 percent) exceeds the Statewide rate as it did the previous year.

Table 3: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	# of Eligibles	# of Clients Served	County PR	Similar Size Counties PR	Statewide PR
Ages 0-17	89,338	45	0.05%	0.10%	0.10%
Ages 18-64	239,208	3,205	1.34%	1.43%	1.30%
Ages 65+	86,389	495	0.57%	0.51%	0.43%
TOTAL	**414,935**	**3,745**	**0.90%**	**0.93%**	**0.85%**

- Alameda served 3,745 clients in CY 2021 and the majority (87 percent) of clients served were in the 18-64 group.
- Alameda's total PR was slightly lower than other large counties while exceeding the Statewide PR.
- Alameda's PR for older adults was higher than other large counties and the Statewide PR.
- The PR for Alameda youth beneficiaries was lower for both other large counties and Statewide.

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SUD through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

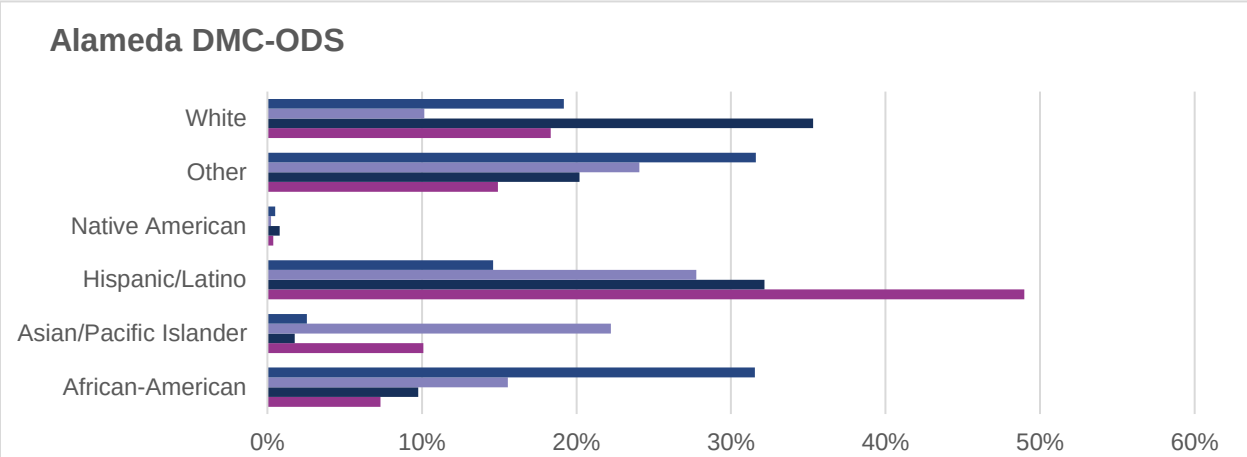
Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity CY 2021

Race/Ethnicity Groups	# of Eligibles	# of Clients Served	County PR	Similar Size Counties PR	Statewide PR
African-American	64,589	1,181	1.83%	1.18%	1.13%
Asian/Pacific Islander	92,227	96	0.10%	0.15%	0.15%
Hispanic/Latino	115,156	547	0.48%	0.58%	0.56%
Native American	949	19	2.00%	2.13%	1.75%
Other	99,856	1,184	1.19%	1.32%	1.15%
White	42,159	718	1.70%	1.84%	1.64%
TOTAL	**414,934**	**3,745**	**0.90%**	**0.93%**	**0.85%**

- As was true in CY 2020, Native Americans had the highest PR although the number of clients served was small.

- PR for Whites and African-Americans were also comparatively high. The African-American PR exceeded the PR for other large counties and the Statewide PR. The White PR is between the rates for other large counties and the Statewide PR.
- PRs for Hispanic/Latinos and Asian/Pacific Islanders were considerably lower.
- The Race/Ethnicity PR are largely the same as the previous year.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity CY 2021



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	32%	3%	15%	1%	32%	19%
County % Eligibles	16%	22%	28%	0%	24%	10%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

- The two largest race/ethnicity groups in Alameda are Hispanic/Latino and Other, followed by API, African-Americans, and Whites.
- African-Americans and White clients are over-represented (32 percent and 19 percent respectably) relative to their population sizes (16 percent and 10 percent respectively).

Penetration Rates and Approved Claim Dollars by Eligibility Category

Table 5: Beneficiaries Served and PR by Eligibility Category, CY 2021

Eligibility Categories	# Eligibles	# Beneficiaries Served	County PR	Similar Size Counties PR	Statewide PR
ACA	151,589	2,045	1.35%	1.66%	1.55%
Disabled	40,091	1,046	2.61%	1.74%	1.54%
Family Adult	61,238	631	1.03%	1.15%	1.05%
Foster Care	1,483	≤10	-	1.25%	1.25%
MCHIP	32,926	-	-	0.09%	0.08%
Other Adult	75,431	70	0.09%	0.09%	0.07%
Other Child	56,952	26	0.05%	0.11%	0.10%
Total	**414,934**	**3,745**	**0.90%**	**0.93%**	**0.85%**

- The Affordable Care Act (ACA) group had the largest number of beneficiaries served, followed by the Disabled group. However, Disabled beneficiaries had a higher PR than ACA beneficiaries.
- Eligibility categories with a high concentration of youths such as foster care, other child, maternal child health (MCHIP) all showed lower PR than statewide averages.

Table 6: Average Approved Claims by Eligibility Category, CY 2021

Eligibility Categories	County AACB	Similar Size Counties AACB	Statewide AACB
ACA	$5,324	$5,493	$5,999
Disabled	$5,170	$5,205	$5,549
Family Adult	$5,893	$4,789	$5,010
Foster Care	$4,966	$2,870	$2,826
MCHIP	$10,142	$3,989	$3,783
Other Adult	$4,395	$4,379	$4,547
Other Child	$6,212	$3,888	$3,460
Total	**$5,544**	**$5,395**	**$5,821**

- Table 6 shows Alameda's AACB by eligibility categories. The claims are compared with AACBs of similar size counties and statewide for all actively implemented DMC-ODS counties.

- Beneficiaries in the MCHIP group had the highest AACB. Because so few beneficiaries are part of MCHIP, the AACB likely contains one or more outliers rather than representing a trend. The MCHIP AACB for CY 2020 was $3,866 which is in line with other large counties and the Statewide average.
- Beneficiaries in the group Other Child had the next highest average approved claim, followed by Family Adult, ACA, and Disabled groups.

Table 7 tracks the DMC-ODS services used by beneficiaries. It shows the diversity of the continuum of care.

Table 7: Services Used by Beneficiaries, CY 2021

County			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	≤10	-	41	0.03%
Intensive Outpatient	391	8.25%	14,586	9.73%
Narcotic Treatment Program	1,892	39.90%	40,196	26.81%
Non-Methadone MAT	220	4.64%	7,837	5.23%
Outpatient Drug Free	1,064	22.44%	44,111	29.42%
Partial Hospitalization	≤10	-	19	0.01%
Recovery Support Services	-	-	5,439	3.63%
Res. Withdrawal Mgmt	479	10.10%	10,869	7.25%
Residential Treatment	583	12.29%	26,859	17.91%
Total	**4,742**	**100.00%**	**149,957**	**100.00%**

- Most Alameda beneficiaries received services from the DMC-ODS through NTP (39.90 percent) and outpatient drug free treatment (22.44 percent).
- 4.64 percent of beneficiaries received non-methadone MAT services from DMC-ODS providers.
- The range of services used by beneficiaries increased over the previous CY 2020.

Table 8: Average Approved Claims by Service Categories, CY 2021

Service Categories	County AACB	Similar Size Counties AACB	Statewide AACB
Ambulatory Withdrawal Mgmt	-	$47	$996
Intensive Outpatient	$1,511	$1,189	$1,630
Narcotic Treatment Program	$4,236	$3,935	$4,271
Non-Methadone MAT	$941	$1,340	$1,454
Outpatient Drug Free	$4,440	$2,370	$2,581
Partial Hospitalization	-	$5,027	$5,027
Recovery Support Services	$4,153	$1,870	$1,761
Res. Withdrawal Mgmt	$1,459	$2,396	$2,438
Residential Treatment	$10,391	$10,433	$10,157
Total	**$5,544**	**$5,395**	**$5,821**

- Alameda's overall AACB for CY 2021 is between the AACB for large counties and the Statewide average.
- Alameda exceeds the Statewide and large counties AACB for outpatient drug free services and recovery support services.
- Alameda's AACB for residential withdrawal management and non-methadone MAT were under the AACB for large counties and Statewide average.

IMPACT OF ACCESS FINDINGS

- Alameda has robust collaboration with their emergency department (ED), FQHC clinics, the criminal justice system, and jails. In addition, they host several meetings with other agencies and coordinate to improve beneficiary access to SUD services.
- Alameda is actively developing and implementing CalAIM requirements and initiatives.
- PR for youth ages 0 to 17 is only 0.05 percent compared to other large counties, with a statewide average of 0.10 percent. Alameda should continue to expand outreach and improve access for youth.
- Alameda should encourage collaboration with providers to improve and provide access to recovery support services.
- Website is user friendly with immediate information easily accessible, specifically spelling out needs for access, crisis, and services available.
- Beneficiaries and staff are knowledgeable about transportation options availability.

- Alameda has integrated a Beneficiary Access Line with a crisis call center which efficiently manages and screens incoming calls for further assessment.

TIMELINESS OF CARE

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors DMC-ODS' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate DMC-ODS timeliness, including the KC and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the DMC-ODS identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness KC ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Component is comprised of individual subcomponents, which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 9: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered MAT Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Residential Treatment	Met
2E	Withdrawal Management Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- Alameda tracks all the required elements of timeliness and produces valuable reports for management decision-making and meeting the report requirements for timeliness to service.

- MAT services indicate a strong collaborative with the local Sheriff's department, county jail, its in-custody provider Wellpath health system, clinics within the FQHC, and SUD providers for the continuum of care. Their strong collaboration efforts have included community and stakeholder education regarding the efficacy and acceptance of MAT, along with naloxone training and community-wide distribution of overdose prevention kits.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, DMC-ODSs complete and submit the Assessment of Timely Access (ATA) form in which they identify DMC-ODS performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2022-23 EQR, the DMC-ODS reported in its submission of the ATA, representing access to care during the 12 months period of FY 2021-22. Table 10 and Figures 2–4 display data submitted by the DMC-ODS; an analysis follows. This data represented the entire system of care.

Claims data for timely access to post residential care and readmissions are discussed in the Quality of Care section.

DMC-ODS-Reported Data

Table 10: FY 2022-23 DMC-ODS Assessment of Timely Access

Timeliness Measure	Average/Rate	Standard[1]	% That Meet Standard
First Non-Urgent Appointment Offered	4.9 Business Days	10 Business Days*	84%
First Non-Urgent Service Rendered	5.7 Business Days	10 Business Days**	82%
Non-Urgent MAT Request to First NTP/OTP Appointment	1.9 Business Days	3 Business Days*	93%
Urgent Services Offered	40.8 Hours	72 Hours**	91%
Follow-up Services Post-Residential Treatment	5.2 Business Days	7 Business Days**	51%
WM Readmission Rates Within 30 Days	12%	n/a	n/a
No-Shows	25%	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** DMC-ODS-defined timeliness standards			
For the FY 2022-23 EQR, the DMC-ODS reported its performance for the following time period: FY 2021-22			

- Average wait time of 4.9 business days from initial service request to first non-urgent SUD appointment offered. The wait time improved from the prior year's rate of 6.1 business days.
- Average wait time of 1.9 business days from initial service request to first non-urgent NTP/OTP appointment offered. The wait time improved from the prior year's rate of 6 business days.
- Average wait time of 1.7 days (40.8 hours) from initial service request to first urgent appointment offered. The wait time increased from 1.1 (26.4 hours) business days reported the prior year.
- Timely post-residential follow-up exceeds 50 percent, well above the rate noted in the claims data presented by CalEQRO in this report.

[1] DHCS-defined standards, unless otherwise noted.

- WM readmission rate of 12 percent within 30 days was lower than the prior year's rate of 23 percent.
- Average no-show rate of 25 percent across all programs was lower than the prior year's rate pf 38 percent. Residential has a 63 percent no show.
-

Figure 2: Wait Times to First Service and First MAT Service

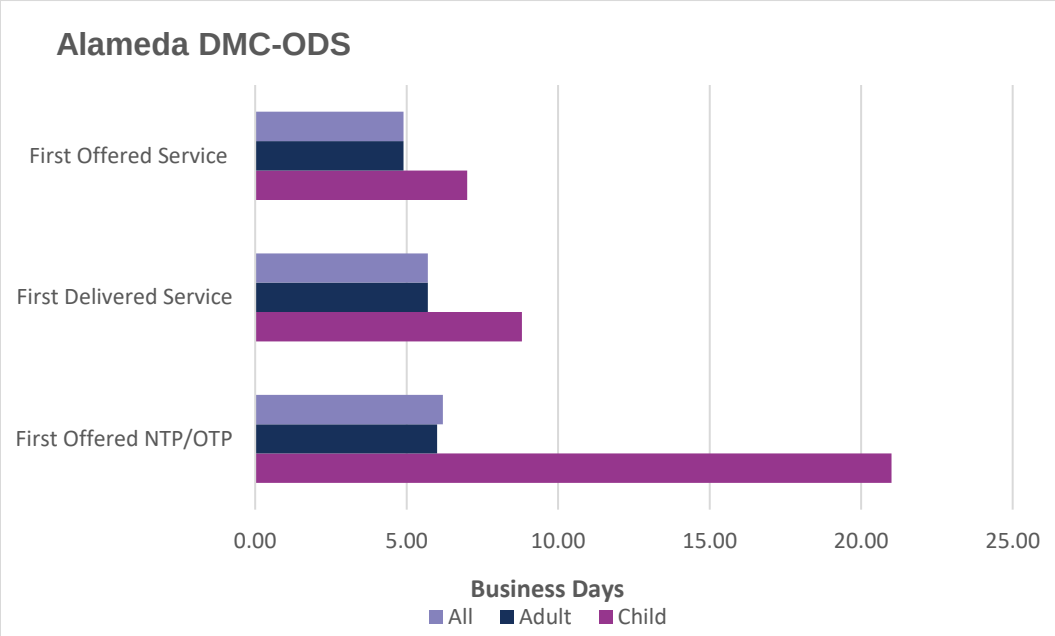


Figure 3: Wait Times for Urgent Services

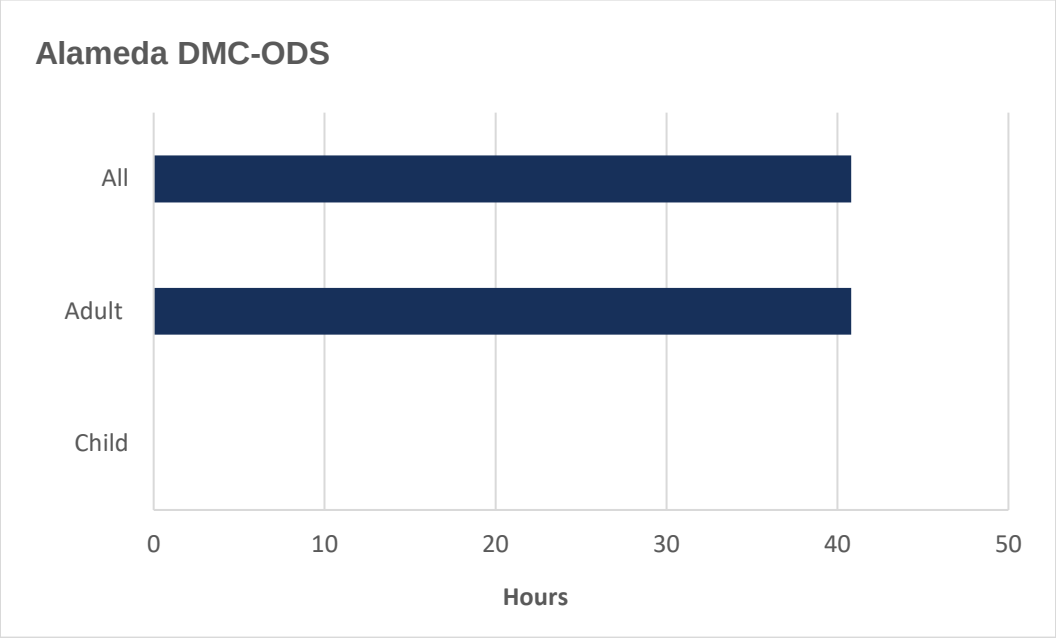
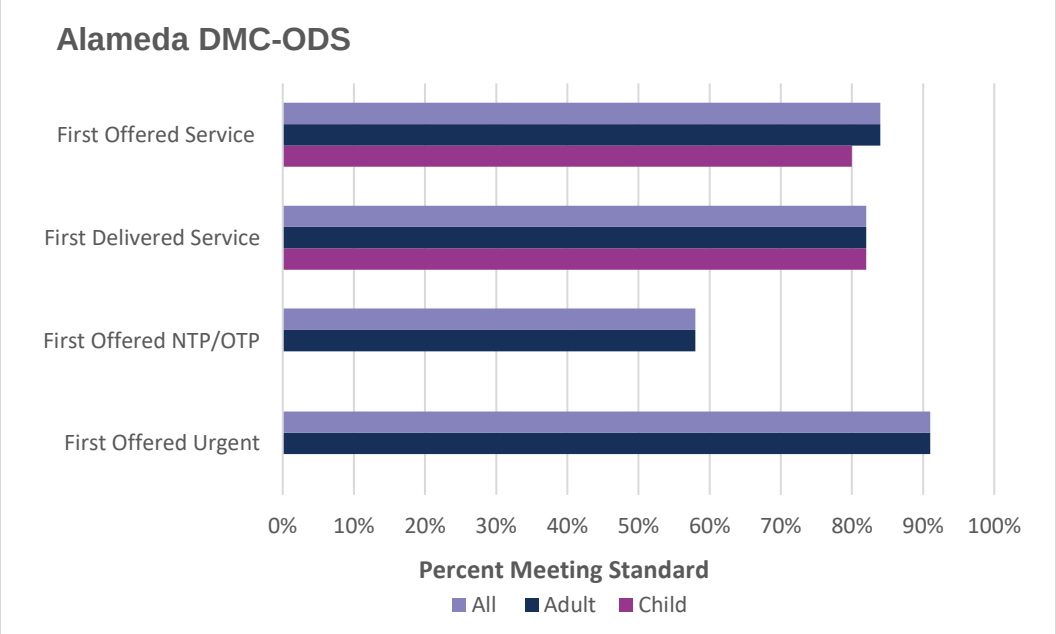


Figure 4: Percent of Services that Met Timeliness Standards



Medi-Cal Claims Data

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the CY 2021 claims.

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

Table 11: Days to First Dose of Methadone by Age, CY 2021

County				Statewide		
Age Groups	Clients	%	Avg. Days	Clients	%	Avg. Days
0 to 17	≤11	-	-	10	0.03%	10.20
18 to 64	1,505	81.13%	1.36	33,162	84.03%	3.41
65+	-	-	0.46	6,292	15.94%	0.41
TOTAL	**1,855**	**100.00%**	**1.19**	**39,464**	**100.00%**	**2.94**

- While the Statewide average days to first dose of methadone is 2.94 days, Alameda clients received their first dose of methadone within 1.19 days after completing the assessment.
- The Statewide average days to first dose of methadone for older adult clients was 0.41 days which is comparable to Alameda's average of 0.46 days.

Transitions in Care

The transitions in care following residential treatment is an important indicator of care coordination.

Table 12: Timely Transitions in Care Following Residential Treatment, CY 2021

County	N = 1,286		Statewide N=	58,923
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	128	9.95%	5,740	9.74%
Within 14 Days	178	13.84%	7,610	12.92%
Within 30 Days	219	17.03%	9,214	15.64%

- All three transition time periods in Table 12 show improvement over the prior CY 2020, with timely transitions within seven days increasing from 8.60 percent to 9.95 percent. As is often the case the DMC-ODS has a rate of timely post-residential follow-up occurring much more frequently as noted above indicating that service activities captured in this data reflects only services claimed under Medi-Cal.

Residential Withdrawal Management Readmissions

Table 13: Residential Withdrawal Management Readmissions, CY 2021

County			Statewide	
Total DMC-ODS admissions into WM	737		14,120	
	#	#	#	%
WM readmissions within 30 days of discharge	132	17.91%	1,128	7.99%

- Table 13 measures the number and percentage of residential WM readmissions within 30 days of discharge.
- The readmission within 30 days of discharge improved from 29.50 percent in CY 2020 to 17.91 percent in CY 2021.

IMPACT OF FINDINGS

- Of 737 Alameda client admissions into residential WM, 17.91 percent were readmitted within 30 days of the discharge compared to the 7.99 percent statewide average for all DMC-ODS counties.
- Alameda tracks and monitors all required elements of timeliness. Data shows a high level of adherence to the timeliness requirements.
- Statewide average days to the first dose of methadone is 2.94 days; Alameda clients received their first dose of methadone within 1.19 days after completing the assessment.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the DMC-ODSs and DHCS requires the DMC-ODSs to implement an ongoing comprehensive QAPI Program for the services furnished to beneficiaries. The contract further requires that the DMC-ODS' quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE DMC-ODS

In the DMC-ODS, the responsibility for QI and QA falls within the Quality Improvement Work Plan (QIWP), which describes Alameda's plan for continuous QI of its MHP, DMC-ODS, and overall systems. Through the QIWP, Alameda will implement QI activities across all systems; Increase the capacity of Alameda's leadership and Quality Management staff to track key indicators addressing client outcomes, program development, and system change; Support decision-making based on performance outcome measures; Increase capability in programs operating across all systems of care.

QIWP is regularly reviewed, analyzed, and updated by QI with input from the Quality Improvement Committee (QIC) and other stakeholders.

The DMC-ODS monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The county QIC was scheduled to meet monthly. Since the previous EQR, the DMC-ODS QIC met 11 times out of 12 months. Of the 30 workplan goals 15 have been met, 12 were partially met, and three were not met.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SUD healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These KC include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 14: Quality Key Components

KC #	Key Components – Quality	Rating
3A	QAPI are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of an ASAM Continuum of Care	Met
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	Met
3F	ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care	Met
3G	Measures Clinical and/or Functional Outcomes of Clients Served	Met
3H	Utilizes Information from the Treatment Perception Survey to Improve Care	Met

Strengths and opportunities associated with the quality components identified above include:

- Alameda has a strong Quality division for overseeing QI and QA to monitor compliance. Data is used to inform decision making for its QI initiatives.
- Despite many meetings with the DMC-ODS, contract providers continue to express concerns about feeling not heard in their working partnership with the county.
- Alameda should take meaningful steps to identify and address the issue of premature discharges within its system of care. This may include a need to obtain data and provide education or other TA, including clinical oversight to reduce client exits prior to the completion of treatment episodes.
- Alameda has entered into a contractual relationship with The Change Companies purchasing e-training modules to ensure all staff and providers conducting assessments have access to (and have completed) the necessary ASAM education prior to them delivering service. Providers requested to have more evidence base practice training available for LPHA and counselors to enhance their ability to provide quality service.
- Alameda shares the general TPS results with its contract providers but not the individual program results to assist them on how to improve care within their own specific program sites.

QUALITY PERFORMANCE MEASURES

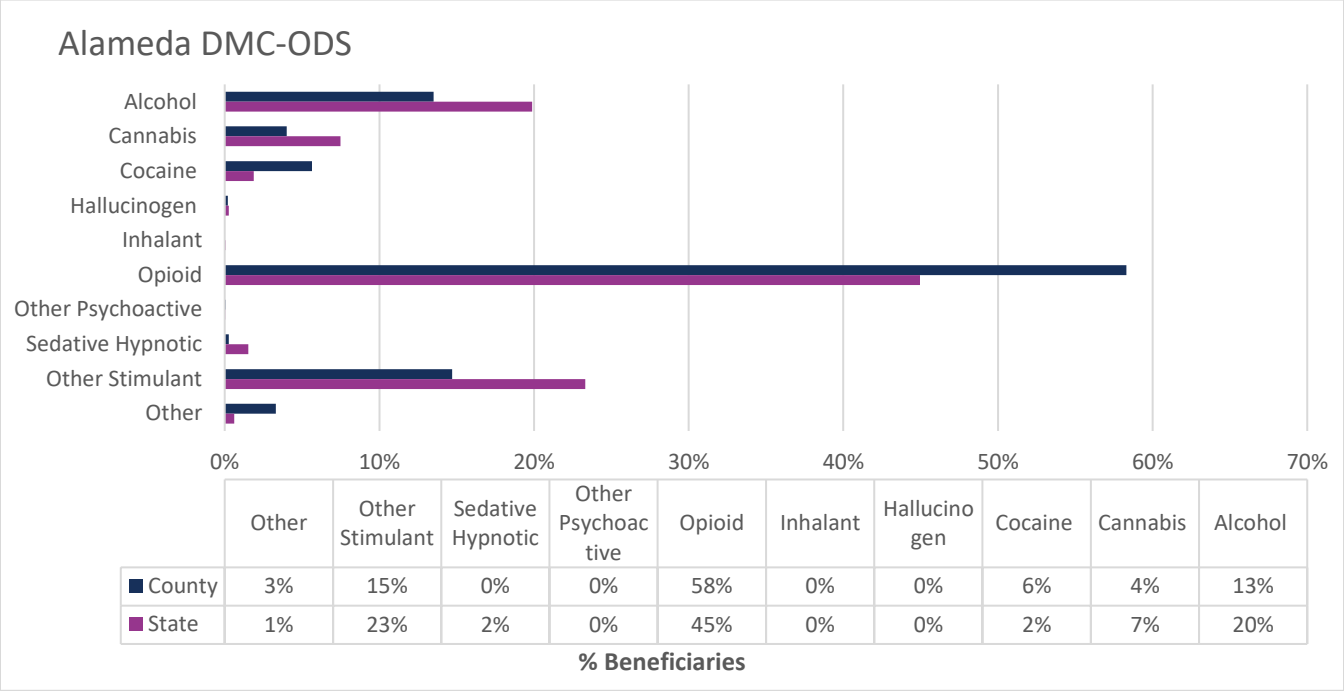
In addition to the KC identified above, the following PMs further reflect the Quality of Care in the DMC-ODS:

- Beneficiaries served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment
- High-Cost Beneficiaries (HCB)
- ASAM congruence
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS Discharge Status Ratings

Diagnosis Data

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SUD, is a foundational aspect of delivering appropriate treatment. Figure 5 and Figure 6 represent the primary diagnosis as submitted with the DMC-ODS' claims for treatment. Figure 5 Percentage of Beneficiaries by Diagnosis Code CY 2021 compares the percentage of DMC-ODS beneficiaries in a diagnostic category to statewide percentages. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 6 Percentage of Approved Claims by Diagnosis Code CY 2021 compares the percentage of approved claims by diagnostic category to statewide percentages.

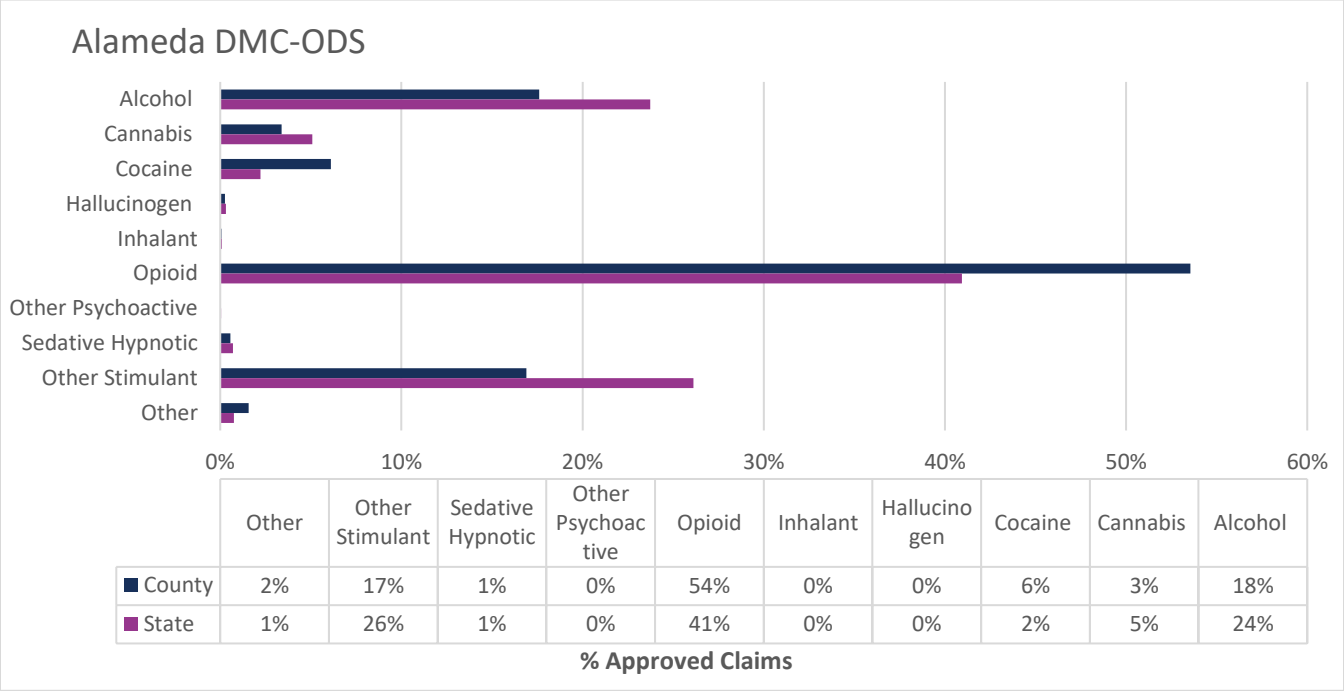
Figure 5: Percentage of Beneficiaries by Diagnosis Code, CY 2021



	Other	Other Stimulant	Sedative Hypnotic	Other Psychoactive	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	3%	15%	0%	0%	58%	0%	0%	6%	4%	13%
State	1%	23%	2%	0%	45%	0%	0%	2%	7%	20%

- Alameda's most prevalent substance use diagnoses were Opioid Use Disorder (58 percent), Other Stimulant Abuse (15 percent) and Alcohol Use Disorder (13 percent).
- This measure is comparable to the results of CY 2020.

Figure 6: Percentage of Approved Claims by Diagnosis Code, CY 2021



	Other	Other Stimulant	Sedative Hypnotic	Other Psychoactive	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	2%	17%	1%	0%	54%	0%	0%	6%	3%	18%
State	1%	26%	1%	0%	41%	0%	0%	2%	5%	24%

Non-Methadone MAT Services

Table 15: DMC-ODS Non-Methadone MAT Services by Age, CY 2021

County					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 0-17	≤11	-	≤11	-	12	0.37%	6	0.19%
Ages 18-64	203	6.33%	46	1.44%	7,505	7.96%	3,873	4.11%
Ages 65+	-	-	≤11	-	447	5.01%	172	1.93%
Total	**221**	**5.90%**	**48**	**1.28%**	**7,964**	**7.15%**	**4,051**	**3.63%**

- Alameda's rate of 5.9 percent was lower than the statewide average of 7.15 percent. Only 1.28 percent of clients received at least three visits for non-methadone MAT. Alameda's rate was almost one-third the statewide average of 3.63 percent.
- This data does not include non-methadone MAT services provided by Federally Qualified Health Centers, hospitals, and private physicians.

Residential Withdrawal Management with No Other Treatment

Table 16: Residential Withdrawal Management with No Other Treatment, CY 2021

	# WM Clients with 3+ Episodes & No Other Services	% WM Clients with 3+ Episodes & No Other Services
County	36	7.79%
Statewide	370	3.40%

- Of the Alameda clients served in residential WM in CY 2021, 7.79 percent had three or more episodes with no other services. Statewide average is 3.40 percent.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. In SUD treatment, this may reflect multiple admissions to residential treatment or residential withdrawal management. High-cost beneficiaries may be receiving services at a level of care not appropriate to their needs. HCBs for the purposes of this report are defined as those who incur SUD treatment costs at or above the 90th percentile statewide.

Table 17: High-Cost Beneficiaries by Age, County DMC-ODS, CY 2021

Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages 0-17	45	≤11	-	$27,438	$219,504	51.84%
Ages 18-64	3,205	145	4.52%	$25,846	$3,747,645	20.88%
Ages 65+	495	≤11	-	$19,880	$99,398	4.16%
Total	**3,745**	**158**	**4.22%**	**$25,738**	**$4,066,546**	**19.59%**

Table 18: High-Cost Beneficiaries by Age, Statewide, CY 2021

Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB% by Total Claims
Ages 0-17	3,230	66	2.04%	$23,446	$1,547,458	13.12%
Ages 18-64	94,361	5,669	6.01%	$23,766	$134,727,122	23.65%
Ages 65+	8,925	289	3.24%	$23,432	$6,771,773	13.99%
TOTAL	**106,516**	**6,024**	**5.66%**	**$23,746**	**$143,046,352**	**22.71%**

- Table 17 indicates the numbers, percent, and costs incurred by Alameda beneficiaries who are identified as high cost. Table 18 has the same information for Statewide high-cost clients.
- In Alameda, 4.22 percent of beneficiaries served were considered high cost based on CY 2021 claims data. This percent was lower than the average percentage for most DMC-ODS counties at 5.66 percent shown in Table 18.
- A total of 158 high-cost clients accounted for 19.59 percent of Alameda's total claims.
- The rate of Alameda's HCBs to total claims dropped from CY 2020 to CY 2021 – 47.99 to 19.59 respectively.

ASAM Level of Care Congruence

Table 19: Congruence of Level of Care Referrals with ASAM Findings, CY 2021 – Reason for Lack of Congruence (Data through Oct 2021)

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable /No Difference	3,062	98.4%	2,178	82.0%	4,867	93.4%
Patient Preference	16	0.5%	330	12.4%	161	3.1%
Level of Care Not Available	≤10	-	20	0.7%	12	0.2%
Clinical Judgement	23	0.7%	92	3.5%	144	2.8%
Geographic Accessibility	≤11	-	≤11	-	≤11	-
Family Responsibility	≤11	-	≤11	-	≤11	-
Legal Issues	≤11	-	≤11	-	≤11	-
Lack of Insurance/Payment Source	≤11	-	≤11	-	12	0.2%
Other	≤11	-	23	0.9%	≤11	-
Actual Level of Care Missing	≤11	-	≤11	-	0	0.0%
TOTAL	**3,113**	**100.0%**	**2,652**	**100.0%**	**5,211**	**100.0%**

- Alameda recorded excellent congruence in ASAM indicated LOC and referred LOC in initial screening (98.4 percent) and follow-up assessment (93.4 percent).
- The ASAM congruence was lower in initial assessment (82.0 percent) mostly due to patient preference or clinical judgement.
- Alameda's ASAM Congruence PM from the prior year is virtually the same.

Initiation and Engagement

An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them. Table 20 displays results of measures for two early and vital phases of treatment-initiating and then engaging in treatment services. Research suggests that those who can engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client's SUD is identified. Based on claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. The second day or visit is what in this measure is defined as "initiating" treatment.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service.

Table 20: Initiating and Engaging in DMC-ODS Services, CY 2021

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	3,652		46		101,279		3,051	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	3,231	88%	40	87%	89,055	88%	2,583	85%
Clients who then engaged in DMC-ODS services	2,589	80%	33	83%	69,161	78%	1,823	71%

- Alameda's adult and youth clients had high rates of initiating DMC-ODS services in CY 2021, at 88.0 percent and 87.0 percent respectively, which were on par with the average for all DMC-ODS counties statewide.
- Both adult and youth clients also had reasonable rates of service engagement at 80.0 percent and 83.0 percent respectively.
- Alameda youth clients improved in both initiation and engagement over the prior year. Engagement increased significantly from 76.4 percent to 83.0 percent.

Length of Stay

Table 21: Cumulative LOS in DMC-ODS Services, CY 2021

	County		Statewide	
Clients with no further treatment for 30+ days	2661		89,610	
LOS for clients across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	124	83	123	87
	#	%	#	%
Clients with at least a 90-day LOS	1,275	48%	43,937	49%
Clients with at least a 180-day LOS	790	30%	25,334	28%
Clients with at least a 270-day LOS	468	18%	14,774	16%

- The mean (average) LOS for Alameda clients was 124 days and the median was 83 days. The results are comparable to the Statewide average and median.
- Claims data shows that 48.0 percent of clients had at least a 90-day LOS, 30.0 percent had at least a 180-day stay, and 18.0 percent had at least a 270-day LOS.
- While Alameda's 90-day LOS rate is comparable to the Statewide rate, the 180-day and 270-day rates are slightly higher than the average for all DMC-ODS counties statewide.

CalOMS Discharge Ratings

Table 22: CalOMS Discharge Status Ratings, CY 2021

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment – Referred	821	17.9%	20,256	19.1%
Completed Treatment - Not Referred	106	2.3%	7,645	6.1%
Left Before Completion with Satisfactory Progress - Standard Questions	2,084	45.5%	14,696	17.5%
Left Before Completion with Satisfactory Progress – Administrative Questions	149	3.3%	7,834	7.4%
Subtotal	*3,160*	*69.0%*	*50,431*	*50.4%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	1,022	22.3%	16,775	17.3%
Left Before Completion with Unsatisfactory Progress - Administrative	376	8.2%	30,398	29.7%
Death	≤15	-	1,609	2.1%
Incarceration	≤10	-	785	0.8%
Subtotal	*1,416*	*31.0%*	*49,567*	*49.6%*
TOTAL	**4,576**	**100.0%**	**99,998**	**100.0%**

- The percentage of discharges rated "Completed Treatment – Referred" dropped from the prior year from 35.1 percent to 17.9 percent.
- The percentage of discharges rated "Completed Treatment – Referred" and – "Not Referred" combined dropped from 36.7 percent in CY 2020 to 20.2 percent for CY 2021.
- There is a markedly high rate of discharged clients rated as "Left Before Completion with Satisfactory Progress" at 45.5 percent of the time compared to just 17.5 percent statewide. The rate is also higher than statewide for those

leaving prematurely with unsatisfactory progress with 22.3 percent compared to 17.3 percent respectively.

IMPACT OF QUALITY FINDINGS

- Alameda should take meaningful steps to identify and address the issue of premature discharges within its system of care. This is worthy of analysis to identify potential causes for clients leaving treatment early and to identify potential interventions to increase length of stay.
- Of the Alameda clients served in residential WM in CY 2021, 7.79 percent had three or more episodes with no other services. Alameda's rate is more than twice the Statewide rate of 3.40 percent.
- Alameda can benefit on engaging their LPHA and counselors to participate in some QI activities.
- Alameda has a robust system of methadone and non-methadone MAT services.
- Alameda has an elevated no-show rate for its residential services with first appointments resulting in 63 percent of prospective clients newly screened and referred for treatment did not show for their initial intake session.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION

All DMC-ODSs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of Alameda's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or DMC-ODS system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual DMC-ODSs, hosts quarterly webinars, and maintains a PIP library at www.calegro.com.

Validation tools for each PIP are located in Table C1 and Table C2 of this report. Validation rating refers to the EQRO's overall confidence that the DMC-ODS (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Care Coordination for Residential SUD Services

Date Started: August 2022

Aim Statement: "The aim of this PIP is to address the low rates of client progress within Alameda County residential treatment programs and to increase successful transfers for discharging clients to the next level of care."

Target Population: All residential clients ages 18 and above.

Validation Information: The DMC-ODS' clinical PIP is in the implementation phase.

[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Summary

The focus of this Care Coordination (case management) PIP is to support beneficiaries within residential treatment by providing care coordination services. Clients who receive care coordination services see increased positive discharges and better transitions and outcomes overall. In Alameda County, residential treatment facilities offer care coordination services in addition to services that are included in the daily bundled rate.

This PIP is focused on increasing the number of clients who engage and benefit from these coordination services, helping to connect to ongoing care and transition. By increasing care coordination services, Alameda is working to support improved recovery as clients will remain more engaged with services leading to positive progress in treatment.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: the DMC-ODS did present some provisional data, but the PIP is still in implementation phase.

CalEQRO provided TA to the DMC-ODS in the form of recommendations for improvement of this clinical PIP including:

- CalEQRO recommended consistency with data collection with monthly review and starting the data analysis to identify the PIP's progress.
- CalEQRO is available for any TA.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up after ED visit for alcohol and other drug abuse or dependence (FUA)

Date Started: July 2022

Aim Statement: "For Medi-Cal beneficiaries with ED visits for SUD, implemented interventions will increase the percentage of follow-up SUD services with ODS within 7 and 30 days by 5 percent by June 30, 2023."

Target Population: The ODS will focus on beneficiaries with a qualifying event as defined in the FUA measure ages 15 years old or above. A qualifying event is an ED visit with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.

Validation Information: The DMC-ODS' non-clinical PIP is in the planning phase.

Summary

Alameda identified the following preliminary intervention for the Non-Clinical population health level intervention by obtaining timely ED data from the local managed care plan (MCP). For data on historical utilization, the DMC-ODS implemented processes to routinely review the data to identify utilization patterns and high-risk populations to better inform follow-up care coordination needs. Alameda will coordinate with MCPs, in order to receive timely ADT (admission, discharge, transfer) data. Alameda's data staff will help create dashboard(s) that will allow for ongoing, real time data review and monitoring. Dashboard(s) will be widely shared to improve follow up for mutually served beneficiaries. The Non-Clinical provider level intervention will create and push alerts to SUD providers on open clients who have ED visits for SUD.

The QI team will work with the system of care directors and other stakeholders to create and roll out an alert system for SUD providers to coordinate ongoing follow-up services Interventions will need to be especially focused on meeting the access and ongoing treatment needs of the African American and Native American populations.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: the interventions were complex and based on computer system implementations which have uncertain timing. However, CalEQRO notes that the general structure of this PIP and the interventions identified to date are likely to produce improvement.

CalEQRO provided TA to the DMC-ODS in the form of recommendations for improvement of this non-clinical PIP including:

- CalEQRO recommends being consistent in the tracking of the data and identifying the support team to monitor and follow up on the data on analysis. Implementation of a strategy could improve results for this PIP's project and result in care improvements for its SUD population.
- CalEQRO is available for any TA as needed.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the DMC-ODS meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the DMC-ODS' EHR, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE DMC-ODS

The EHRs of California's DMC-ODSs are generally managed by county, DMC-ODS IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR systems used by the DMC-ODS are Echo's Insyst and Krassons, Inc. CG which have been in use for 31 and 14 years respectively. Currently, the DMC-ODS is actively implementing a new registration and billing system which requires moderate staff involvement to fully develop.

Approximately 2.36 percent of the DMC-ODS budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under DMC-ODS control.

The DMC-ODS has 1,217 named users with log-on authority to the EHR, including approximately 136 county staff and 1,081 contractor staff. Support for the users is provided by 29 full-time equivalent IS technology positions. The 29 IS technology positions are cross trained to support both SUD and mental health technology users. Currently 2 positions are vacant.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the DMC-ODS' EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data to the DMC-ODS IS as reported in the following table:

Table 23: Contract Provider Transmission of Information to DMC-ODS EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between DMC-ODS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to DMC-ODS	☐ Daily ☐ Weekly ☐ Monthly	%
Electronic batch file transfer to DMC-ODS	☒ Daily ☐ Weekly ☐ Monthly	85%
Direct data entry into DMC-ODSby provider staff	☒ Daily ☒ Weekly ☒ Monthly	15%
Documents/files e-mailed or faxed to DMC-ODS	☐ Daily ☐ Weekly ☐ Monthly	%
Paper documents delivered to DMC-ODS	☐ Daily ☐ Weekly ☐ Monthly	%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. Currently, Alameda beneficiaries do not have access to their DMC-ODS records through a PHR.

Interoperability Support

The DMC-ODS is a member of a HIE. Alameda participates in the Social Health Information Exchange (SHIE) Community Health Record for Alameda County and the DMC-ODS sends beneficiary information to the SHIE for Whole Person Care.

The DMC-ODS engages in electronic exchange of information with the following departments/agencies/organizations: Whole Person Care.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following KCs related to DMC-ODS system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SUD delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 24: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

Strengths and opportunities associated with the IS components identified above include:

- Alameda DMC-ODS continues to make a significant investment in the development and maintenance of their data analytics and to support the use of data as an important element in their decision making.
- In response to changes at the state and federal levels for managing and claiming for SUD activities, Alameda is modernizing their EHR technology. The first step is replacing their registration and billing software that will go live at the beginning of the next fiscal year. Implementation of a new clinical record will follow.
- KC 4C Integrity of Medi-Cal Claims Process, is rated Partially Met because Alameda's claim denial rate exceeds the Statewide average.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

Table 25 shows the amount of denied claims by denial reason, and Table 26 shows approved claims by month, including whether the claims are either adjudicated or denied. This may also indicate if the DMC-ODS is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

This chart appears to reflect a substantially complete claims data set for the time frame claimed.

Table 25: Summary of Denied Claims by Reason Code, CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Exceeds maximum rate	212,538	$4,141,619	82.78%
Other Healthcare Coverage	23,811	$461,112	9.22%
Duplicate/same day service	6,624	$194,081	3.88%
NPI issue	8,797	$129,045	2.58%
Other	163	$35,899	0.72%
Service location not eligible	468	$19,715	0.39%
Beneficiary not eligible	409	$12,932	0.26%
Late submission	103	$6,504	0.13%
Missing valid diagnosis	12	$2,242	0.04%
Total Denied Claims	**252,925**	**$5,003,149**	**100.00%**
Denied Claims Rate	**18.76%**		
Statewide Denied Claims	**16.80%**		

Table 26: Approved Claims by Month, CY 2021

Month	# Claim Lines	Total Approved Claims
Jan-21	47,231	$1,719,153
Feb-21	42,775	$1,623,793
Mar-21	48,178	$2,052,884
Apr-21	45,521	$2,014,943
May-21	44,828	$1,869,939
Jun-21	42,337	$1,782,211
Jul-21	42,149	$1,722,644
Aug-21	42,205	$1,764,520
Sep-21	41,875	$1,867,611
Oct-21	41,170	$1,810,349
Nov-21	40,660	$1,708,615
Dec-21	41,548	$1,731,068
Total	**520,477**	**$21,667,729**

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Alameda has a well-developed data warehouse that contains a variety of data sources.
- The DMC-ODS data warehouse uses extensive data checking and validation methods.
- Alameda DMC-ODS management and supervisors use data to gather information about the effectiveness and equity of services delivered.
- Alameda contracted directly with Streamline Healthcare Solutions for their SmartCare registration and billing IS. The county did not join the CalMHSA Semi-Statewide EHR coalition because they have modifications important to their processes and workflows that are not part of the coalition's implementation.
- Alameda is actively working on implementation of SmartCare, a new registration and billing IS.
- Alameda should record an introductory online training for CG instead of relying on contract providers staff to train their staff. The training provides a best practice training for use of CG.
- Alameda needs to increase the coverage of their Help Desk to cover lunch hours, decrease wait times, and possibly add on-call staff to answer questions and deal with technology issues on the weekend.
- Contract providers expressed concern about the number of times staff have lost data because of issues with both Insyst and CG. Analyze whether increasing hardware and software funding or adding staff will stabilize the older technology used by Alameda.
- Consider expediting the procurement of the clinical component of the Alameda's EHR. The use of older technologies and the integration of that technology with a modern system creates many issues for not just technical staff but for both administrative and clinical staff.

VALIDATION OF CLIENT PERCEPTIONS OF CARE

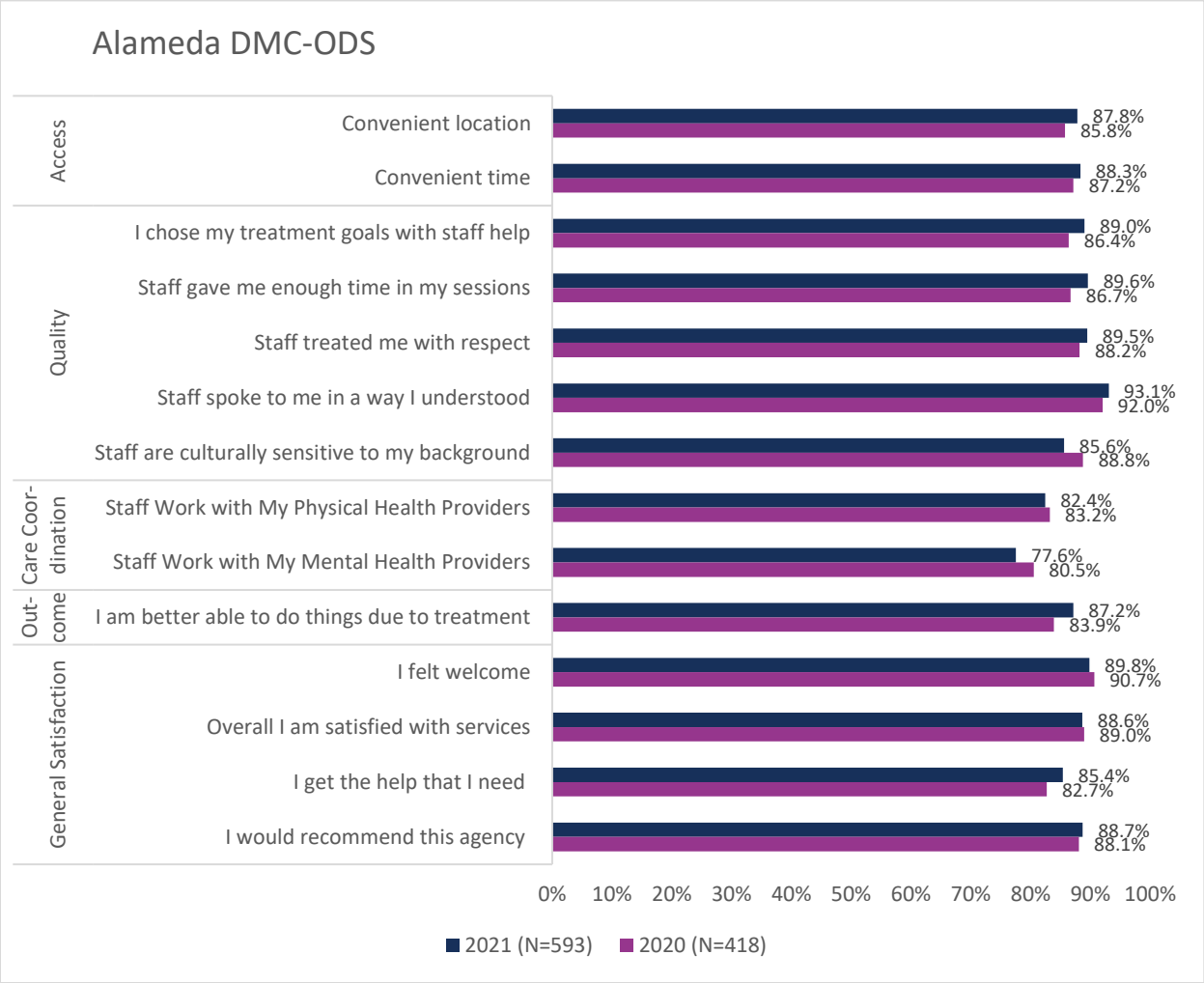
TREATMENT PERCEPTION SURVEYS

The TPS consists of ratings from the 14 items yield information regarding five distinct domains: Access, Quality, Care Coordination, Outcome, and General Satisfaction. DMC-ODSs administer these surveys to beneficiaries once a year in the fall and submit the completed surveys to DHCS. As part of its evaluation of the statewide DMC-ODS Waiver, the University of California, Los Angeles (UCLA) evaluation team analyzes the data and produces reports for each DMC-ODS.

The DMC-ODS continues to be implementing and monitoring the results of the beneficiary survey annually. Alameda will work to improve participation across all providers, program types, and demographics to ensure representative responses. Alameda shares results with contract providers.

The DMC-ODS clients gave high ratings in Quality and General Satisfaction domains and rated Care Coordination questions lowest.

Figure 7: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA



- Clients responded to most TPS domain questions favorably.
- CY 2021 ratings exceeded the prior year for most questions.
- Ratings for care coordination with mental and physical health providers were lower than the prior year though low ratings in this domain is consistent with most other DMC-ODS counties.

CONSUMER FAMILY MEMBER FOCUS GROUPS

Consumer and family member (CFM) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested 90-minute focus groups with consumers (DMC-ODS beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included 19 participants from outpatient treatment. All beneficiaries participating received clinical services from the DMC-ODS.

Summary of focus group findings

All beneficiaries reported that the access and intake process was fast and easy. Beneficiaries reported that the staff are helpful and accommodating to their needs. Most of the beneficiaries are referred for admission to the program via the access line screening and assessment sites via CenterPoint, Cherry Hill, direct referral from the court, a mental health provider, and by way of self-referral. Participants in the focus group report they feel welcome to the program and that their counselor is very supportive and encourages them to obtain a 12-Step sponsor. MAT is also discussed during intake or in their sessions with the clinicians. All participants noted that the program is very supportive and accommodating to their personal medical, mental health, and probation needs as well as other appointments. Transportation to appointments is provided by the program either by giving them bus tokens or by calling for transport via the health plan. Beneficiaries shared that, when needed, program staff communicated with other service providers, including court and probation. Telehealth is also available to them. Clients report that the program saved their life and helps them with relapse prevention.

Recommendations from focus group participants included:

- Provide more activities and groups in the program.
- Hire more staff and counselors. Staff are overwhelmed.

Consumer Family Member Focus Group Two

CalEQRO conducted 90-minute focus groups with consumers (DMC-ODS beneficiaries) members during the review of the DMC-ODS. CalEQRO requested a diverse group of adult beneficiaries from two different residential facilities who initiated residential services in the preceding 12 months. The focus group was held virtually and included 10 participants. All beneficiaries participating received clinical services from the DMC-ODS.

Summary of focus group findings

Most of the participants report the intake process was easy and staff are helpful and accommodating. They stated they were referred for admission via access line, direct

referral from jail, the drug court program, mental health, an outpatient clinic, the hospital, or an ED. Some beneficiaries report they are admitted on the same day after the release from jail while others noted waiting up to three weeks. All report that their counselors are very supportive and encourage them to get recovery sponsors. The beneficiaries reported that MAT is also discussed during intake and its use is supported. The program is very supportive and accommodating for personal, medical, mental health, probation, and other appointments. One stated that the program is very patient with their appointment needs. Transportation to appointments is provided by the program, ride-share companies, bus, or by calling the health plan to arrange the transportation. Participants shared that, when needed, program staff were communicative with other service providers, including their PCP, therapist, court, and probation.

Recommendations from focus group participants included:

- More family contact or family group
- Outside privileges and activities

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Participants in both focus groups were generally happy with the services provided to them. They were complimentary towards their counselors and felt that the treatment programs were responsive to their needs. Programs work with clients who relapse and help them remain in treatment.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the DMC-ODS' programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SUD managed care system.

STRENGTHS

1. Alameda established a strong division for overseeing QA and QI with the Substance Use QI Coordinators Group that monitors compliance with state regulations and work with providers to ensure that treatment is accessible, timely, and of high quality. (Quality)
2. Alameda impressively tracks all required elements of timeliness, produces useful reports on timeliness for management decision-making, and reports meeting state standards for all aspects of initial visits. (Timeliness, IS)
3. MAT services include strong commitment across the system and use, including coordinating methadone and other non-methadone MAT in the local jail, along with Naloxone distribution. (Access, Timeliness, Quality)
4. Interface with criminal justice system is excellent with a variety of specialty courts, re-entry process, and strong MAT service presence within inmate services. Alameda has a strong formal level of coordination with the new Sheriff's administration. (Access, Timeliness, Quality)
5. Alameda is well prepared for the EHR transition to Streamline SmartCare and is poised for successful implementation. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Contract providers report that there is little to no opportunity as a group to dialogue and provide meaningful input into system change and development. (Quality)
2. Alameda has an elevated no-show rate for its residential services with first appointments resulting in 63 percent of prospective clients newly screened and referred for treatment who did not show for their initial intake session. (Access, Timeliness, Quality)
3. Alameda has a very high level of clients leaving treatment prior to completion as noted in the CalOMS data provided by CalEQRO. Client discharge categories for both satisfactory and unsatisfactory progress leaving treatment early are at 45.5 percent and 22.3 percent respectively indicating that nearly seven out of ten clients who enter treatment are self-discharging early. (Access, Quality)

4. Alameda administration does not utilize and is unaware of, any formal opioid or overdose safety coalition or task force, thereby limiting a truly comprehensive understanding or coordinated approach to reducing the impacts of these pronounced issues on the local community. (Quality)
5. Providers expressed concern about the number of times staff have lost data because of issues with both Insyst and CG. Analyze whether increasing hardware and software funding or adding staff will stabilize the older technology used by Alameda. (IS)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the DMC-ODS in its QI efforts and ultimately to improve beneficiary outcomes:

1. Establish new and specific opportunities for providers and line staff to give input into system change and participate in system development. (Quality)
2. Alameda should conduct thorough analyses and begin interventions to address the root causes to reduce the no-show rate for its residential level of care admission process. They should continue with these efforts to increase prospective client's initial connection to treatment. (Access, Timeliness, Quality)
3. Alameda should take meaningful steps to identify and address the issue of premature discharge within its system of care. This may include a need to obtain data and provide education or other technical assistance including clinical oversight to reduce client exits prior to the completion of treatment episodes. (Access, Quality)
4. Alameda should explore local cooperatives that are addressing parts of the opioid and overdose epidemic (such as the Bay Area medical association collaborative to support safe prescribing) and consider convening a local comprehensive task force that can enhance efforts to reduce overdose and fatalities by bringing together a multidisciplinary and coordinated set of initiatives and strategies across agencies and the community. (Quality)
5. Consider expediting the procurement of the clinical component of the Alameda's EHR. The use of older technologies and the integration of that technology with a modern system creates many issues for not just technical staff but for both administrative and clinical staff. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from DMC-ODS Director

ATTACHMENT F: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions - Alameda 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 PMs
Quality Improvement Plan, implementation activities, and evaluation results, NACT
Information systems capability assessment/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 including validation and analysis
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments
Mental Health 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 – contracted
Youth Services
Client/family member focus groups such as adult, youth, special populations, and/or family
Access Call Center
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Anita Catapusan, Lead Quality Reviewer
Patrick Zarate, Assistant Director, Second Reviewer
Lorrie Sheets, Information System Reviewer
Katie Faires, Consumer/Family Member Reviewer

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-review and the post-review meetings and in preparing the recommendations within this report.

DMC-ODS County Sites

Alameda County Health Behavioral Health Services
2000 Embarcadero Cove, Suite 400
Oakland, California 94606

DMC-ODS Contract Provider Sites

No sites were visited as this was a virtual review.
All sessions were held via video conference.

Table B1: Participants Representing the DMC-ODS and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aguero	Brandi	Clinic Manager, Lifeline Treatment Services	MedMark Services
Balentine	John	Executive Director	Second Chance, Inc.
Bass	Anthony	Lead Intake Coordinator, Substance Use Disorder	Horizon Services
Becerra	Eliseo	Compliance & Outcomes Director	Horizon Services
Benjamin	Danielle	Information Systems Analyst	Alameda County Behavioral Health
Bernhisel	Penny	Clinical Program Supervisor, Behavioral Health Forensic Court Programs	Alameda County Behavioral Health
Biblin	Janet	Info Systems Manager, Quality Improvement	Alameda County Behavioral Health
Briggs	Kim	Substance Use Disorder Counselor	Options Recovery
Burch	Michelle	Executive Director	HAART
Cabrera	Jose	Management Analyst, Decision Support Team	Alameda County Behavioral Health
Camp	Suzoni	Chief of Operations	Options Recovery
Cannady	Angel	Program Manager, Oakland	Magnolia Women's Recovery Programs
Cannady	Angel	Program Manager, Oakland	Magnolia
Capece	Karen	Interim Plan Administrator/Deputy Director,	Alameda County Behavioral Health
Carlisle	Lisa	Child & Young Adult System of Care Director	Alameda County Behavioral Health
Castro	Dan	Counselor	Second Chance, Inc.
Ceja	Nancy	Associate Program Specialist	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Chapman, MD	Aaron	Behavioral Health Medical Director and Chief Medical Officer	Alameda County Behavioral Health
Chau	Mandy	Audit and Cost Reporting Director, Finance	Alameda County Behavioral Health
Chiang	Katy	Analyst, Information Systems	Alameda County Behavioral Health
Cipresso	Gina	Intake Screener, Substance Use Disorder	Horizon Services
Clinton	Regina	Compliance Manager	MedMark Services
Coombs, MD	Angela	Office of the Medical Director Associate Medical Director	Alameda County Behavioral Health
Cooper Kahn	Mia	Senior Manager of Behavioral Health	Community Health Center Network
Cruz	Itzia	Residential Clinical Supervisor	Horizon Services
Currie	Peter	Senior Director of Behavioral Health, Integrating Behavioral and Physical Health	Alameda Alliance
Diedrick	Sheryl	Analyst, Information Systems	Alameda County Behavioral Health
Dietz	Adam	Mental Health Navigator, Office of Collaborative Court Services	Telecare Corporation
Dillon	Narges	Executive Director	Crisis Support Services of Alameda County
Dixon	Amanda	Forensic Case Manager	Center Point
Douglas	James	Program Manager, SUD Helpline	Center Point, Inc.
Eady	Rashad	Program Specialist, Quality Improvement	Alameda County Behavioral Health
Edwards	Charles	Interim ACCESS Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Elliot	Anne	Critical Care Manager, Crisis System of Care	Alameda County Behavioral Health
Evans	Chris	Special Projects Manager	Second Chance, Inc., Inc.
Fielder	Aminata	Clinical Director	Options Recovery
Forsythe	Robert	Information Systems Analyst, Information Systems	Alameda County Behavioral Health
Gerchow	Christine	Juvenile Justice Health Services Director	Alameda County Behavioral Health
Gibbs	Laphonsa	Child & Young Adult Outpatient Services Division Director	Alameda County Behavioral Health
Gireaud-Ferko	Nathalie M.	Director of Administration	New Bridge Foundation
Grajeda	Willie	Manager of Forensic Team	Center Point
Grilley	Stephen	Division Director, Criminal Justice Programs	Center Point, Inc.
Guerry	Danielle	Clinical Director, Alameda Court Collaborative Program	Telecare Corporation
Hall	Lorenza	Senior Management Analyst, Decision Support Team	Alameda County Behavioral Health
Henderson	Nicole	Rehab Counselor	Options Recovery
Herring, MD	Andrew	Substance Use Disorder Treatment Medical Director	Alameda Health Systems
Houston	Fonda	Substance Use Operational Specialist	Alameda County Behavioral Health
Lannuzzi	Cristi	Health Care Services Agency (HCSA) Interim Technology Strategy Director	Wellbrook Partners

Last Name	First Name	Position	County or Contracted Agency
Jimenez	Richard	Vice President	Center Point, Inc.
Jones	Kate	Adult & Older Adult Services Director	Alameda County Behavioral Health
Jordan	Kevin	Substance Use Disorder Counselor	Options Recovery
Judkins	Andrea	Supervising Financial Services Specialist, Fiscal Services	Alameda County Behavioral Health
Kayman, MD	Joshua	Consulting Psychiatrist for Substance Use Disorder Programs	Alameda County Behavioral Health
Keimer	Elizabeth	Mental Health Assessor	Telecare Corporation
Lee	Sun Hyung	Transition Age Youth Services Division Director	Alameda County Behavioral Health
Lesova	Svetlana	Assistant Director of In-Custody Services, Forensic, Diversion, and Re-Entry Services System of Care	Alameda County Behavioral Health
Lewis	Stephanie	Acting Crisis System of Care Director	Alameda County Behavioral Health
Lewis	Shawnica	Substance Use Disorder Counselor I	AARSHealthRIGHT360
Lewis	Clyde	Substance Use Disorder Services Director	Alameda County Behavioral Health
Lopez	Rickie	Assistant Finance Director	Alameda County Behavioral Health
Louie	Jill	Budget and Fiscal Services Director	Alameda County Behavioral Health
Lozano	Ed	Applications Development Manager, Information Systems	Alameda County Behavioral Health
Martinez	Jennifer	Principal	Wellbrook Partners
Mcfarland	Samuel	Substance Use Disorder Certified Counselor	Options Recovery

Last Name	First Name	Position	County or Contracted Agency
McKenzie	Anna	Management Analyst, Contracts Unit	Alameda County Behavioral Health
Meinzer Valentino	Chet	Information Systems Manager, Decision Support Team	Alameda County Behavioral Health
Miller	Denise	Substance Use Disorder Counselor	Options Recovery
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	Alameda County Behavioral Health
Moore	Lisa	Billing & Benefits Support Director	Alameda County Behavioral Health
Narvaez	Cheryl	EPSDT Coordinator, Children and Young Adult System of Care	Alameda County Behavioral Health
Nolan Satchwell	Bridget	CalAIM Data and Exchange Operations Consultant	Wellbrook Partners
Orozco	Gabriel	Management Analyst, Decision Support Team	Alameda County Behavioral Health
Patterson	Robert	Relief Intake Counselor, Cherry Hill Detox	Options Recovery
Pendleton	Laurel	Quality Improvement Project and Planning Manager, Quality Improvement	Alameda County Behavioral Health
Peterson	Camille	Analyst, Information Systems	Alameda County Behavioral Health
Phan	Jade	Information Systems Manager	Alameda County Behavioral Health
Philips	Anna	Clinical Services Director	Horizon Services
Phillips	Justin	Executive Director	Options Recovery
Phipps	Brion	Clinical Review Specialist Supervisor, Quality Assurance	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Provost	John	Services Manager, Information Systems	Alameda County Behavioral Health
Purciel-Hill	Marnie	Performance Improvement Manager, Quality Improvement	Alameda County Behavioral Health
Rankin	Lauren	Program Contract Manager, Contracts	Alameda County Behavioral Health
Raynor	Charles	Pharmacy Services Director	Alameda County Behavioral Health
Rejali	Torfeh	Quality Assurance Administrator	Alameda County Behavioral Health
Reynolds	Dywayne	Substance Use Disorder Counselor	Options Recovery
Richholt	Kinzi	Chief Nursing Officer, Office of the Medical Director	Alameda County Behavioral Health
Sabar	Jennifer	Data Specialist, FSCM Case Manager RADT	Center Point, Inc.
Sampson	Sakara	Administrative Specialist II, Quality Improvement	Alameda County Behavioral Health
Schrick	Juliene	Utilization Management Division Director	Alameda County Behavioral Health
Schulz	Henning	Adult Outpatient Services Division Director	Alameda County Behavioral Health
Serrano	Cecilia	Finance Director	Alameda County Behavioral Health
Severn	Angela	Counselor, Alcohol and Other Drug (AOD) Treatment	Options Recovery
Shallcross	Lori	Clinical Review Specialist, Utilization Management	Alameda County Behavioral Health
Smith	Freddie	Integrated Care Services Division Director	Alameda County Behavioral Health
Smith	Gary	Program Manager, Cherry Hill Detox	Horizon Services

Last Name	First Name	Position	County or Contracted Agency
Sobky	Chris	Co-Executive and Clinical Director, Hayward	HAART
Sooryanarayana	Kripa	Financial Services Specialist II, Budget & Fiscal Services	Alameda County Behavioral Health
Steven	Stefanie	Program Manager, Hayward	Magnolia Women's Recovery Programs
Steven	Stefanie	Program Manager, Hayward	Magnolia
Strange	Samuel	Substance Use Disorder Certified Counselor	Options Recovery
Sudduth	Nicole	Director Of Behavioral Health	West Oakland Health Council
Taizan	Juan	Forensic, Diversion, & Re-Entry Services Director	Alameda County Behavioral Health
Tribble	Karyn	Director	Alameda County Behavioral Health
Urive	Serena	Treatment Center Director	MedMark Services
Vargas	Wendi	Contracts Director	Alameda County Behavioral Health
Vela	Rebecca	Admissions Counselor	Options Recovery
Vertilus	Lynette	Substance Use Disorder Registered Counselor) and Assessment Specialist	Center Point
Wagner	James	Clinical Operations Deputy Director	Alameda County Behavioral Health
Williams	Ulrika	Treatment Center Director	
Williams	Ulrika	Clinic Director	BAART Programs
Wong	Jenny	Management Analyst, Quality Management	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Woodland	David	Clinical Review Specialist, Quality Assurance	Alameda County Behavioral Health
Yamamoto	Melissa	Administrative Support Manager, Substance Use Disorder System of Care	Alameda County Behavioral Health
Yuan	Eric	Manager, Integrated Care Services	Alameda County Behavioral Health
Zastawney	Wendy	Clinical Review Specialist Supervisor, ACCESS Program	Alameda County Behavioral Health
Zavala	Linda	Assistant Manager	Center Point

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	This PIP was found to have low confidence and currently still in implementation phase at the time of the PIP submission.
General PIP Information	
MHP/DMC-ODS Name: Alameda County DMC-ODS	
PIP Title: Care Coordination for Residential SUD Services	
PIP Aim Statement: The aim of this PIP is to address the low rates of client progress within Alameda County residential treatment programs and to increase successful transfers for discharging clients to the next level of care.	
Date Started: 08/2022	
Date Completed:	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): All residential clients ages 18 and above.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The focus of this Care Coordination (case management) PIP is to support beneficiaries within Residential Treatment by providing care coordination services
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Various stakeholders in the county were involved in identifying the problem, including internal SUD staff and directors, as well as contracted agencies
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The Alameda County BH leadership and Staff will coordinate and work with QI/QA/UR Team, SUD Director, QI Committee, and contracted community SUD providers to provide care coordination focus to support beneficiaries in residential treatment and to have continuum of care.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Number and percentage of clients receiving case management services in residential treatment	11/1/2021-10/31/2022	438/882 49.7%	December 2022	58/158 36.7%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2. Number and percentage of clients who received case management within seven days of enrollment	11/1/2021–10/25/2022	267/765 34.9%	December 2022	50/15 30.0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
PM 3. Number and percentage of clients who received at least three case management services per month while enrolled in Residential Treatment	Oct 2022	29/89 32.6%	December 2022	32/96 33.3%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A
PM 4. Number and percentage of clients who remained in Residential Treatment at least 30 days of care	11/1/2021-10/31/2022	364/632 57.6%	X Not applicable—PIP is in Planning or implementation phase, results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 5. Number and percentage of clients discharged from Residential Treatment with treatment progress.	11/1/2021-10/31/2022	323/632 51.1%	X Not applicable—PIP is in Planning or implementation phase, results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 6. Number and percentage of clients transitioning successfully to the next level of care. (three or more visits in 34 days)	11/1/2021-10/31/2022	150/632 23.7%	X Not applicable—PIP is in Planning or implementation phase, results not available	N/A	☐ Yes ☐ No N/A	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: CalEQRO recommended consistency with data collection monthly and starting the data analysis to identify PIP's progress. CalEQRO is available for any TA.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	This non-clinical PIP was found to have low confidence, because the interventions were complex and based on computer system implementations which have uncertain timing. The general structure of this PIP and the interventions identified to date are likely to produce improvement.
General PIP Information	
MHP/DMC-ODS Name: Alameda County DMC-ODS	
PIP Title: Follow-Up After ED visit for alcohol and other drug abuse or dependence (FUA)	

General PIP Information
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for SUD, implemented interventions will increase the percentage of follow-up SUD services with the ODS within 7 and 30 days by 5 percent by June 30, 2023.
Date Started: 07/2022
Date Completed:
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here: 15 years -19 years old.
Target population description, such as specific diagnosis (please specify): The DMC-ODS will focus on beneficiaries with a qualifying event as defined in the FUA measure. A qualifying event is an ED visit with a principal diagnosis of AOD abuse or dependence, The highest concentration was for people 20-29 years old, followed by the 30-39 and 55-59 year-old age groups.

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The first intervention is to start receiving an ADT (Admit, Discharge, Transfer) data feed from the MCPs in addition to the claims data the Plan is currently receiving. It will be supported thru ED, MCP, Care Coordination and Peer Support.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provider Level Intervention will create and push alerts to SUD providers for open clients who have ED visits for SUD

Improvement Strategies or Interventions (Changes in the PIP)
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Alameda QI team will work with the system of care directors and other stakeholders to create and roll out an alert system for SUD providers to coordinate ongoing follow-up services. Establishment of a timely (at least daily) ADT data exchange with the MCP and to get the number and % of Plan clients who received a follow up substance use treatment service from the DMC-ODS within 7 or 30 days after ED visit for SUD

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
DMC Follow up post ED visits within 7 days due to alcohol or other drugs	CY 2021	Only 9% has follow up	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
DMC follow -up post ED visits within 30 days due to alcohol or other drugs	CY 2021	Only 16% has follow up	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: CalEQRO recommends being consistent in the tracking of the data and identifying the support team to monitor and follow up on the data on analysis. Implementation of a strategy could improve results for this PIP's project and improve SUD population. CalEQRO is available for any TA as needed.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the KC, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

A letter from the DMC-DOS Director was not required to be included in this report.

ATTACHMENT F: ADDITIONAL PERFORMANCE MEASURE DATA

Table F1: CalOMS Living Status at Admission, CY 2021

Admission Living Status	County		Statewide	
	#	%	#	%
Homeless	1,362	41.5%	24,459	28.0%
Dependent Living	402	12.2%	19,800	22.7%
Independent Living	1,520	46.3%	43,052	49.63%
Total	**3,284**	**100.0%**	**87,311**	**100.0%**

Table F2: CalOMS Legal Status at Admission, CY 2021

Admission Legal Status	County		Statewide	
	#	%	#	%
No Criminal Justice Involvement	2,709	82.5%	56,468	64.7%
Under Parole Supervision by CDCR	104	3.2%	1,641	1.9%
On Parole from any other jurisdiction	37	1.1%	1,575	1.8%
Post release supervision - AB 109	283	8.6%	21,095	24.2%
Court Diversion CA Penal Code 1000	74	2.2%	1,321	1.5%
Incarcerated	24	0.7%	350	0.4%
Awaiting Trial	52	1.6%	4,798	5.5%
Total	**3,283**	**100.0%**	**87,248**	**100.0%**

Table F3: CalOMS Employment Status at Admission, CY 2021

Current Employment Status	County		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	469	14.3%	11,089	12.7%
Employed Part Time - Less than 35 hours	237	7.2%	6,543	7.5%
Unemployed - Looking for work	1,014	30.9%	26,943	30.9%
Unemployed - not in the labor force and not seeking	1,564	47.6%	42,736	48.9%
Total	**3,284**	**100.0%**	**87,311**	**100.0%**

Table F4: CalOMS Types of Discharges, CY 2020

Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	2,851	62.3%	50,245	50.2%
Administrative Adult Discharges	543	11.9%	40,626	40.6%
Detox Discharges	1,121	24.5%	7,740	7.7%
Youth Discharges	61	1.3%	1,387	1.4%
Total	**4,576**	**100.0%**	**99,998**	**100.0%**