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FY 2021-22
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:

February 8 - 10, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 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” shall be used to identify the Alameda County DMC-ODS program, unless otherwise indicated.

DMC-ODS INFORMATION

DMC-ODS Reviewed — Alameda

Review Type — Virtual

Date of Review — February 8-10, 2022

DMC-ODS Size — Large

DMC-ODS Region — Bay Area

DMC-ODS Location — Oakland

DMC-ODS Beneficiaries Served in CY 2020 — 4,163

DMC-ODS Threshold Language(s) — Spanish, Cantonese, Mandarin, Vietnamese

SUMMARY OF FINDINGS

Of the five recommendations for improvement that resulted from the FY 2020-21 EQR, the DMC-ODS addressed or partially addressed five recommendations.

California External Quality Review (CalEQRO) evaluated the DMC-ODS on the following four Key Components that impact beneficiary outcomes; among the 23 components evaluated, the DMC-ODS met or partially met the following, by domain:

- Access to Care: 100 percent met (three of three components)
- Timeliness of Care: 83.3 percent met (five of six components), and 16.7 percent partially met (one of six)
- Quality of Care: 100 percent met (eight of eight components)
- Information Systems (IS): 100 percent (six of six components

The DMC-ODS submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Recovery Coaches for Withdrawal Management (WM),” was found to be active in the Other remeasurement phase with a moderate confidence validation rating. The non-clinical PIP, “Improving Timely Access to Residential Treatment,” was found to be active in the Other remeasurement phase with a low confidence validation rating.

CalEQRO conducted two consumer member focus groups, comprised of a total of seven participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The DMC-ODS demonstrated significant strengths in the following areas: 1) a thorough and comprehensive cultural competence and quality improvement (QI) plan with goals linked to a strategic plan; 2) use of data to adapt and improve capacity and engagement with beneficiary needs including at-risk and under-represented groups; 3) expanded and integrated services to substance use disorder (SUD) clients in the criminal justice system; 4) enhanced efforts to facilitate continuity of care with case management teams and community engagement and communication strategies.

The DMC-ODS was found to have notable opportunities for improvement in the following areas: 1) a decrease in service visits due to COVID-19 and workforce impacts in most levels of care (LOC) compared to pre-pandemic levels; 2) increasing overdose levels due to opioids such as fentanyl and in some cases fentanyl and methamphetamines; 3) low levels of treatment services to youth; 4) add substance use Access Line screenings and referrals on weekends and afterhours; 5) a disproportionally low percentage of Asian/Pacific Islander (API) beneficiaries being served.

FY 2021-22 CalEQRO recommendations for improvement include: 1) increase direct service delivery levels to pre-pandemic levels or more based on current community needs; 2) continue pro-active communication and engagement efforts with the community, contractors, key stakeholders, and underserved communities such as API by leadership and key clinical representatives to tailor SUD programs to meet local needs; 3) consider adding SUD Access Line services in peak hours on weekends, noon to 1am; 4) expand services to youth including at-school sites coordinated with mental health (MH) and other stakeholders; 5) continue positive partnerships to expand services to API populations.

INTRODUCTION

BACKGROUND

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 Drug Medi-Cal-Organized Delivery Systems (DMC-ODS), comprised of 37 counties, to provide substance use 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 DMC-ODS. DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO (CalEQRO), to review and evaluate the care provided to the Medi-Cal beneficiaries.

Additionally, DHCS requires the CalEQRO to evaluate counties on the following: delivery of SUD treatment services 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 (AB) 205.

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Alameda DMC-ODS by Behavioral Health Concepts, Inc., conducted as a virtual review on February 8-10, 2022.

METHODOLOGY

CalEQRO's review emphasizes the county's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public behavioral health 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 county-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 are derived from multiple source files, unless otherwise specified. These statewide data sources include Monthly Medi-Cal Eligibility Data System Eligibility File, DMC-ODS approved claims, the Treatment Perception Survey (TPS), California Outcomes Measurement System (CalOMS), and the American Society of Addiction Medicine (ASAM) LOC data. CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020, unless otherwise indicated. As part of the pre-review process, each county is provided a description of the source of data and a summary report of their PM, including Medi-Cal approved claims data. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the county's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of two elements pertaining to NA: Alternate Access Standards (AAS) requests and use of out-of-network (OON) providers.
- Summary of county-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, including 16 PMs.
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the county's quality and operational processes.
- Consumer perception of the county's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of county 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 suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of county beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE DMC-ODS ENVIRONMENT AND WITHIN THE COUNTY

In this section, the status of last year's (FY 2020-21) EQRO review recommendations are presented, as well as changes within the county's environment since its last review.

ENVIRONMENTAL IMPACT

County was impacted with reduced residential capacity and continued staffing shortages due to illness and staff redirection to public health but to a lesser degree compared to other large counties.

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.

- New leadership developed a new strategic plan and goals including better communication systems and modernized methods of reaching at-risk populations and groups. This effort included extensive community stakeholders.
- QI work plan was updated with measurable goals and baselines to reflect the new strategic plan and so was the organizational structure of the department.
- A new division of Forensic Services was added reporting to the Director with integrated programs and new case management teams.
- Alameda is preparing for California Advancing and Innovating Medi-Cal (CalAIM) including upgrading its computer software for behavioral health to be able to do value-based billing systems.
- A new Office of Equity was added to the organization reporting to the Director and the diversity of the staff overall was enhanced.
- The MH and DMC-ODS both began planning to participate in the peer certification program with DHCS and their contract partners.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 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 2020-21

Recommendation 1: Develop recovery residence housing master plan including enough for those children in conjunction with partners with incremental goals.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

Alameda County has implemented both centralized and partnership strategies to address homelessness. These efforts are in addition to DMC-specific activities, and collectively make up the below “master plan” activities:

- Over the course of 2021, Alameda County centralized its homelessness programs under a new Office of Homeless Care and Coordination, a new unit in Alameda County Health Care Services Agency. (https://homelessness.acgov.org/index.page). DMC-ODS coordinates with this office to meet the needs of unhoused individuals and families, which include those with substance use needs.
- In FY 2020-21, Alameda County Behavioral Health (ACBH), the integrated department including the DMC-ODS, and Mental Health Plan (MHP) added 23 recovery residence beds, with the support of funding from probation and AB109. The current 100 recovery residence beds, includes 12 beds at four different sites that specifically serve women with children. Continued recovery residence bed expansion in FY 2021-22 is currently underway with state funds. Alameda County also recently approved a 75-bed expansion and funding through 2025. These beds will improve capacity but will take time to develop and add to existing services.
- ACBH will survey recovery residence, residential, and outpatient providers to determine monthly bed utilization and need for linkage to recovery residences when discharged from a 24-hour setting. This survey will help in understanding the percent of perinatal clients who may want to reunite with their kids, which can be a motivational tool to stay in treatment. Survey outcomes and conversations

with external partners will determine the number of beds and target populations needed. This will help determine the master plan requested.

Recommendation 2: Continue efforts to expand SUD service capacity to at-risk and unhoused populations and those with health disparities to targeted expansions and activities.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

As noted above, Alameda County has implemented both centralized and partnership strategies to address homelessness.

- Over the course of 2021, Alameda County centralized its homelessness programs under a new Office of Homeless Care and Coordination, a new unit in Alameda County Health Care Services Agency. (https://homelessness.acgov.org/index.page) DMC-ODS coordinates with this office to meet the needs of unhoused individuals.
- ACBH partners with the City of Oakland, which launched Community Cabins to serve homeless individuals. ACBH with links to DMC-ODS contract providers to provide mobile response and linkage to services including the substance use continuum of care as needed. DMC-ODS staff have also supported Project Roomkey and other homeless initiatives and do both harm reduction and connections to treatment whenever possible.

Recommendation 3: Refine and if needed re-design PIPs to continue working on the important issues linked to system access and transitions in care without hopefully the major confounding issues of COVID-19 making all personal contact impossible. TA will be available as needed for this and other needs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- ACBH continued both PIPs into this fiscal year and made significant refinements, addressing ongoing COVID concerns and adding new interventions with support and consultation from CalEQRO. These are detailed in the PIP section and validation tool.

Recommendation 4: Plan to add data staff to support the launch of the new data billing system while maintaining the current billing system until all of the cost-reports and audits are completed. This is critical for fiscal to be able to ensure all funds are recouped from current service efforts.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

In support of the launch of the new patient tracking, billing, and managed care system (SmartCare) while maintaining the current billing system (InSyst), ACBH has devised the following plan of actions:

- A project team was created to support the SmartCare system implementation. This team has four positions that are currently filled by contract staff until job codes are approved for continued funding and recruitment of these four new positions.
- If needed, IS will enlist additional support from the Alameda Temporary Assistance Pool (a source of temporary staff for short-term project support) to maintain SmartCare and InSyst.
- Any system enhancement and field creation in the legacy systems will be routed through a formal system change request process to manage staff bandwidth and minimize duplicate efforts.
- ACBH has contracted with Xpio Health to assist with managing specific aspects of the SmartCare implementation, including data migration and project communication to augment resources.

Recommendation 5: Continue efforts to prevent overdoses from drugs and alcohol in partnership with the community and strategic actions to increase awareness of fentanyl and other dangerous drugs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In both the FY 2020-21 and FY 2021-22 QI Work Plans, ACBH included “Reduce the number of deaths of clients in opioid treatment programs” through actions including increasing the distribution of overdose reversal medication in opioid treatment programs and increasing utilization of counseling/case management services in opioid treatment programs.
- On November 30, 2021, ACBH announced to providers that it had created a new procedure code to track the distribution of naloxone/Narcan when ACBH funds are not used for payment. This is required to enable ACBH to track these efforts across the system.
- As a result of these efforts, the number and rate of discharges to death from opioid treatment programs decreased from 26 (2.8 percent) in FY 2019-20 to 23 (2.5 percent) in FY 2020-21.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All DMC-ODSs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the DMC-ODS provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's national provider identification number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient SUD services and Narcotic Treatment Program (NTP)/Opioid Treatment Program (OTP) services, for youth and adults. If these standards are not met, DHCS requires the DMC-ODS to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if a DMC-ODS can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with DMC-ODS staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the DMC-ODS's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the DMC-ODS, or its subcontractors.

FINDINGS

For Alameda County, the time and distance requirements for urban zips codes are 30 minutes and 15 miles for outpatient SUD services, and 30 minutes and 15 miles for NTP/OTP services. Alameda also has rural zip codes with their appropriate standards, 60 miles and 90 minutes. And zip codes for which large county standards applied.

These zip codes met large county standards for nearest OON providers which were available as approved by DHCS. Alameda applied for an AAS for these zip codes: (i.e., 94539, 94566, 94568, 94586, 94538, 94588, 94536, 94619, 94605, 94550, 94551, 95377, 95391) for adult NTP/OTP services. Youth services met NTP/OTP standards without an AAS. Both adult and youth outpatient met time and distance standards for outpatient services.

Alternative Access Standards and Out-of-Network Access

DHCS required the DMC-ODS to submit an AAS request for the five zip codes for which time and/or distance standards were not met as noted above. There were OON providers available for contracted services, however. As of the time of the FY 2021-22 EQR, the DMC-ODS had received a determination from DHCS on January 19, 2022, regarding the AAS request and their other submissions that they had a conditional pass.

Planned Improvements to Meet NA Standards

Alameda is working to expand access to medication assisted treatments (MAT) particularly for opioid use disorders (OUD) in partnership with federally qualified health clinics (FQHC) in the more remote rural areas of the county where it would not be feasible to establish a fully staffed NTP/OTP clinic. It is possible at these clinics to provide a range of Federal Drug Administration (FDA) approved medications for OUD including new long-acting injectable options. Some also have SUD counseling as well as their own pharmacy and lab capacity onsite which is convenient for optimal patient care.

DMC-ODS Activities in Response to FY 2020-21 AAS

The DMC-ODS was approved to submit all supporting documents demonstrating the plan of correction was successfully implemented with solutions documented in the response by March 1, 2022, to DHCS. Also required is the Certification of NA Data and Documentation Submission letter.

In the large zip codes, there will be contracts for OON providers to ensure access to care as needed for beneficiaries.

ACCESS TO CARE

BACKGROUND

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 Key Components and PMs addressed below.

ACCESS IN ALAMEDA COUNTY

Regardless of client payment source, all Alameda SUD direct services were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 64.33 percent of services provided are claimed to Medi-Cal. The county role is focused on outreach, engagement, coordination, education, administrative functions, and quality of care

The DMC-ODS has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: outpatient programs, narcotics treatment programs and a residential WM program. The DMC-ODS operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services and is operational Monday through Friday business hours. In the evenings and on weekends, calls are directed to the Crisis Support Services which provides crisis support and a brief evaluation. If the individual is requesting substance use services, they take all the needed information and provide a referral the next business day to the substance use Access Line which reaches out to provide a full ASAM screening and referral to treatment. If the request is urgent, the substance use client is referred to Cherry Hill WM residential for evaluation or the local emergency department depending on the situation and level of need.

There are other access points, besides the Access Line in the Alameda DMC-ODS. This is clear in the provider directory online for the public. Persons seeking treatment can also directly go to any of the outpatient providers, NTP/OTP providers, perinatal providers, FQHC primary care programs providing DMC-ODS outpatient services or WM residential treatment providers. Only residential treatment access must go through the Access Line or other specific referral channels such as Drug Court, Probation, or County Drug program referral. The Access Line staff uses three-way calling to link individuals to providers for intake appointments. They also use the daily census log for

residential beds (available every morning by 9:30am) to identify vacant residential treatment beds (this is a new tool developed as part of the PIP).

The DMC-ODS provides both clinic/site based and telehealth services. Specifically, the DMC-ODS delivers medication support, crisis services, group therapy, group education and support, individual therapy, case management, and new client intake and assessment services via telehealth to youth and/or adults. During FY 2020-21, the DMC-ODS reports having served 1,252 adult beneficiaries, 64 youth beneficiaries, and 42 older adult beneficiaries via telehealth across 35 contractor-operated sites. Among those served, 74 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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 as critical to access. A DMC-ODS informs the Medi-Cal eligible population of resources, monitors access, and availability of quality services that ultimately lead to improved beneficiary outcomes.

Each Access Key Component is comprised of individual subcomponents which are 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 1: Key Components – Access

KC #	Key Component – Access	Rating
1A	Service Access are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts its NA to Meet SUD Client Service Needs	Met
1C	Collaboration and Coordination of Care to Improve Access	Met

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

- Call Center staff have taken the initiative to use the organized provider meetings to strengthen Call Center-Provider relationships, improve efficiency and understanding of their working relationships and program needs.
- The addition of the three-way calls has increased understand of the needs of the beneficiary, for the Call Center counselor, and the providers. It has also greatly

increased understanding of teamwork on appropriate and successful engagement and placements into care.

- There are often SUD clients in the emergency departments or in crisis and needing assistance with linkage to treatment on weekends. An opportunity for improvement would be keeping the substance use Call Center staff open on weekends till the early evening to assist these cases instead of the current process of waiting till next business day to find them and call them back to link to care.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the DMC-ODS:

- Total beneficiaries served, stratified by age and race/ethnicity.
- Penetration rates, stratified by age, race/ethnicity, and eligibility categories.
- Approved claims per beneficiary (ACB) served, stratified by age, race/ethnicity, eligibility categories, and service categories.
- Initial service used by beneficiaries.

Total Beneficiaries Served

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

Alameda served 4,163 clients in CY 2020 and the majority (82 percent) of clients served were in the 18-64 group. Alameda's total penetration rate was slightly higher than large counties and the statewide average but the rate for clients ages 12-17 was lower.

Table 2: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2020

Alameda				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	42,416	65	0.15%	0.26%	0.25%
Ages 18-64	233,289	3,428	1.47%	1.44%	1.26%
Ages 65+	58,938	670	1.14%	0.90%	0.77%
TOTAL	**334,643**	**4,163**	**1.24%**	**1.18%**	**1.03%**

Table 3 shows the penetration rates by race/ethnicity compared to large counties and statewide rates. Native Americans had the highest penetration rate although the number

of clients served was small. Penetration rates for Whites and African Americans were high but Hispanic/Latinos and Asian/Pacific Islanders had considerably lower rates.

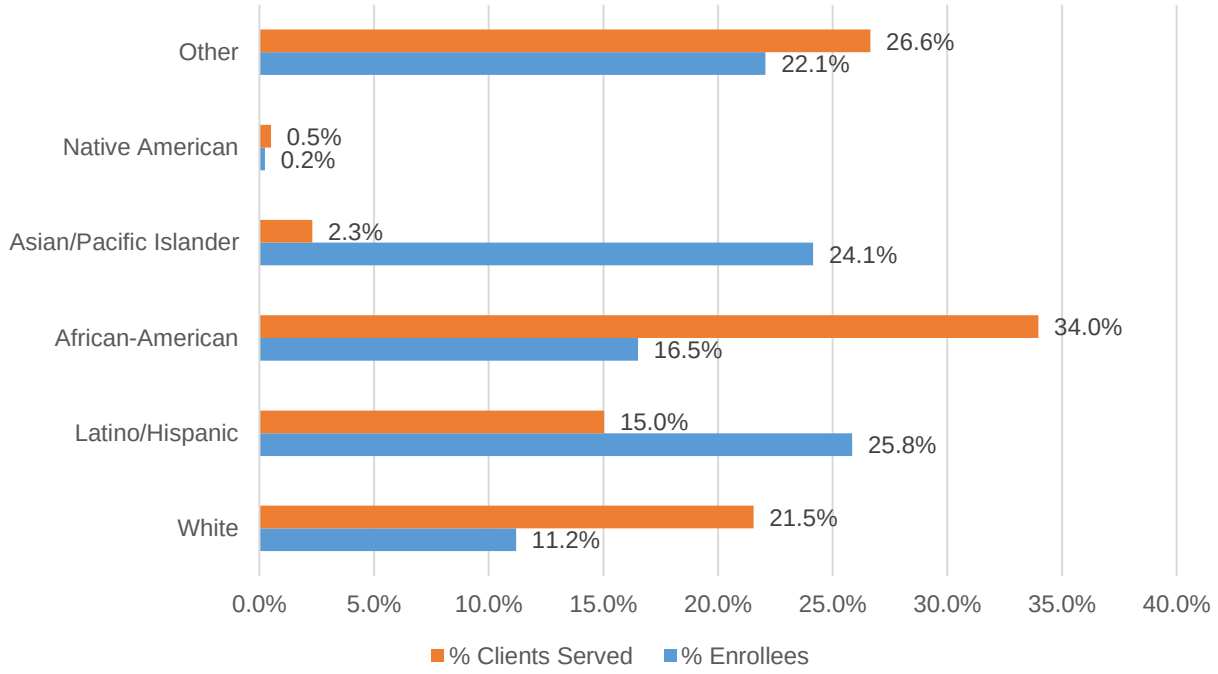
Table 3: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2020

Alameda				Large Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	37,454	897	2.39%	2.34%	1.96%
Latino/Hispanic	86,492	626	0.72%	0.76%	0.69%
African American	55,255	1,414	2.56%	1.53%	1.34%
Asian/Pacific Islander	80,811	96	0.12%	0.17%	0.17%
Native American	790	21	2.66%	2.77%	1.84%
Other	73,843	1,109	1.50%	1.58%	1.41%
TOTAL	**334,645**	**4,163**	**1.24%**	**1.18%**	**1.03%**

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

The two largest race/ethnicity groups in Alameda are Latino/Hispanics and Asian/Pacific Islanders, followed by Other, African Americans, and Whites. Latino/Hispanics and Asian/Pacific Islanders are under-represented in the number of clients served (15 percent and 2.3 percent respectively), but the African Americans and White clients are over-represented relative to their population sizes (34 percent and 21.5 percent respectively).

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Penetration Rates and Approved Claim Dollars by Eligibility Category

The average ACB 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.

Tables 4 and 5 highlight penetration rates and average approved claims by eligibility category.

The Affordable Care Act (ACA) group had the largest number of clients served, followed by the Disabled group. However, Disabled clients had a higher penetration rate than ACA clients. Eligibility categories with a high concentration of youths (Foster Care, Other Child, MCHIP) all showed lower penetration rates than statewide averages.

Table 4: Clients Served and Penetration Rates by Eligibility Category, CY 2020

Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Penetration Rate	Penetration Rate
Disabled	39,888	1,364	3.4%	1.8%

Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Penetration Rate	Penetration Rate
Foster Care	1,095	13	1.2%	2.3%
Other Child	25,600	37	0.1%	0.3%
Family Adult	53,441	617	1.2%	1.1%
Other Adult	64,172	121	0.2%	0.1%
MCHIP	18,072	21	0.1%	0.2%
ACA	131,601	2,098	1.6%	1.6%

Table 5 shows Alameda's approved claims by eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Clients in the Family Adult group had the highest average approved claim, followed by the ACA, and Disabled groups.

Table 5: Average Approved Claims by Eligibility Category, CY 2020

Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Beneficiaries Served	Average Approved Claims	Average Approved Claims
Disabled	39,888	1,364	$4,389	$4,559
Foster Care	1,095	13	$1,223	$2,037
Other Child	25,600	37	$3,768	$2,492
Family Adult	53,441	617	$5,271	$4,231
Other Adult	64,172	121	$3,214	$3,386
MCHIP	18,072	21	$3,866	$2,748
ACA	131,601	2,098	$4,831	$5,131

Table 6 tracks the initial DMC-ODS service used by clients to determine how they first accessed services and shows the diversity of the continuum of care. The majority of Alameda clients entered the DMC-ODS through NTP/OTP services (53.1 percent) and outpatient treatment (19.6 percent).

Table 6: Initial DMC-ODS Service Used by Beneficiaries, CY 2020

Alameda			Statewide	
DMC-ODS Service Modality	#	%	#	%
Outpatient treatment	807	19.6%	33,885	33.1%
Intensive outpatient treatment	251	6.1%	2,679	2.6%
NTP/OTP	2,191	53.1%	40,908	40.0%
Non-methadone MAT	*	0.02%	291	0.3%

Alameda			Statewide	
DMC-ODS Service Modality	**#**	**%**	**#**	**%**
Ambulatory Withdrawal	-	0.00%	22	0.02%
Partial hospitalization	-	0.00%	23	0.02%
Residential treatment	401	9.7%	16,620	16.3%
Withdrawal management	437	10.6%	6,790	6.6%
Recovery Support Services	38	0.9%	1,006	1.0%
TOTAL	**4,126**	**100.0%**	**102,224**	**100.0%**

Table 7 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of DMC-ODS service usage by clients in CY 2020. Services most used by Alameda clients were narcotic treatment (43.5 percent), outpatient services (20.4 percent), residential WM (11.4 percent) and residential treatment (10.9 percent). Only 4.3 percent of clients received non-methadone MAT services from DMC-ODS providers.

Table 7: Average Approved Claims by Service Categories, CY 2020

Service Categories	Alameda % Served	Statewide % Served	Alameda Average Approved Claims	Statewide Average Approved Claims
Narcotic Tx. Program	43.5%	30.7%	$4,088	$4,097
Residential Treatment	10.9%	17.5%	$8,863	$8,846
Res. Withdrawal Mgmt	11.4%	6.8%	$1,508	$2,057
Ambulatory Withdrawal Mgmt	0.0%	0.0%	$0	$654
Non-Methadone MAT	4.3%	5.2%	$864	$1,093
Recovery Support Services	1.7%	2.7%	$4,058	$1,521
Partial Hospitalization	0.0%	0.0%	$0	$1,926
Intensive Outpatient Tx	7.7%	6.4%	$1,462	$966
Outpatient Services	20.4%	30.6%	$3,761	$2,037
TOTAL	**100.0%**	**100.0%**	**$4,804**	**$4,894**

IMPACT OF FINDINGS

Into the third year of DMC-ODS implementation, Alameda showed a very small increase in the number of beneficiaries served based on CY 2020 claims data. When comparing units of service by LOC to the prior year which was pre-COVID-19, most LOC units

provided were lower than the prior year. This was a common experience for most DMC-ODS counties though the degree of impact varied.

The overall penetration rate for services was higher than large-sized counties and the statewide average although the rate for clients 12-17 was lower.

Latino/Hispanics and Asian/Pacific Islanders are the two largest race/ethnicity groups, but they were under-represented in the total number of clients served. More outreach to these communities will be needed to promote the benefits of SUD services.

Telehealth services saw a robust growth of over 100 percent from the previous year, as contract providers navigated around COVID-19 related barriers to deliver services to beneficiaries. Alameda carefully monitored utilization by phone and video session of each type of service by site and client group and was concerned about satisfaction, access, and quality related to the client experience.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and the ability to achieve desired outcomes. Studies have shown that the longer it takes to engage in treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critically important at key points in the system, including requests for initial, routine, and urgent services. To provide timely access to treatment services, the county must have the infrastructure to track timeliness and a regular process to review the metrics. Counties then need to make adjustments to their service delivery system in order to ensure that timeliness standards are being met. CalEQRO uses a number of indicators for tracking, and trending timeliness, including the Key Components and PMs, addressed below.

TIMELINESS IN ALAMEDA COUNTY

The DMC-ODS reported timeliness data in aggregate. Further, timeliness data presented to CalEQRO represented the complete DMC-ODS delivery system which is the contract provider delivery system. In Alameda at this time, the county role is coordination and quality oversight, not direct SUD services.

Generally, the timeliness of services saw a small increase in most types compared to the prior year, but they still remained within state required standards on average for FY 2020-21.

Alameda provides detailed business rules for interpretation of timeliness data measures which is helpful in interpretation. This is rarely done by other counties and especially system wide (including contractors) and would be positive to require for thorough validation.

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 Key Components ratings, and the performance for each measure is addressed in the PM section.

Each Timeliness 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 8: Key Components – Timeliness

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

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

- First rendered service occurred within average of 5.8 days 83 percent of the time including adults and youth.
- NTP and FQHC providers offered MAT visits within an average of three to six days for medication after assessment, but this was a complex measure as many clients were on non-methadone medications which require tapering to start methadone which is medically appropriate. Adjustment of the measure by medication type may be required in the future with access to pharmacy data. Also, NTPs reported problems with new starts of methadone due to a face-to-face physician assessment requirement which was not waived.

PERFORMANCE MEASURES

DHCS has established timeliness metrics to which DMC-ODSs must adhere for initial offered appointments for non-urgent outpatient SUD services, non-urgent MAT, and urgent care. In preparation for the EQR, DMC-ODSs complete and submit the Assessment of Timely Access form in which they identify DMC performance across several key timeliness metrics for a specified time period.

Additionally, utilizing approved claims data, CalEQRO analyzes DMC-ODS performance on WM readmission and follow-up after residential treatment.

In addition to the Key Components identified above, the following PMs further reflect the Timeliness of Care in the DMC-ODS:

- First Non-urgent Appointment Offered
- First Non-urgent Appointment Rendered
- Non-Urgent MAT Request to First NTP/OTP Appointment

- Urgent Services Offered
- Average Days for Follow-up Post-Residential Treatment
- WM Readmission Rates Within 30 Days
- No-Shows

DMC-ODS-Reported Data

For the FY 2021-22 EQR, the DMC-ODS reported its performance for FY 2020-21 timeliness actuals.

- Average wait time of 6.1 days from initial service request to first non-urgent SUD appointment offered.
- Average wait time of six days from initial service request to first non-urgent NTP/OTP appointment offered.
- Average wait time of 1.1 days from initial service request to first urgent appointment offered. Figures are reported in calendar days rather than hours because providers record dates rather than exact times for requests and offered appointments.
- Average WM readmission rate of 23 percent within 30 days.
- Average no-show rate of 38 percent across all programs which was higher than the prior year.

Table 9: FY 2020-21 DMC-ODS Assessment of Timely Access Data

FY 2020-21 DMC Assessment of Timely Access Data			
Timeliness Measure	Average/Rate	Standard[1]	% That Meet Standard
First Non-Urgent Appointment Offered	6.1 Days	10 Business Days	83%
First Non-Urgent Service Rendered	5.8 Days	10 Business Days	83%
Non-Urgent MAT Request to First NTP/OTP Meds Appointment	6 Days 3 Median	3 Business Days	54%
Urgent Services Offered	1.1 Days	48 Hours	93%
Follow-up Services Post-Residential Treatment		7 Days	10%
WM Readmission Rates Within 30 Days	23%		
No-Shows	38%		

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 2020 claims.

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

On average, Alameda clients received their first dose of methadone within a day after completing the assessment, which was similar to the statewide experience. But non-methadone medications often require tapering and tapering can delay start of methadone. This may account for varied data submitted from the DMC-ODS.

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

Table 10: Days to First Dose of Methadone by Age, CY 2020

Alameda				Statewide		
Age Groups	Clients	%	Avg. Days	Clients	%	Avg. Days
Ages 12-17	-	0.00%	<1	*	n/a	n/a
Ages 18-64	1,653	75.1%	<1	33,027	80.4%	<1
Ages 65+	547	24.9%	<1	*	n/a	n/a
TOTAL	**2,200**	**100.0%**	**<1**	**41,093**	**100.0%**	**<1**

Transitions in Care

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

In CY 2020, 8.6 percent of Alameda clients had a care transition within 7 days following residential treatment, which was slightly higher than the statewide experience. In total, 25.32 percent of clients had a transition admission between 31 to 365 days following residential treatment and that was a higher rate than the statewide average of 20.31 percent.

Table 11: Timely Transitions in Care Following Residential Treatment, CY 2020

Alameda (n= 1,023)			**Statewide (n= 49,799)**	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	88	8.60%	3,757	7.54%
Within 14 Days	118	11.53%	5,160	10.36%
Within 30 Days	152	14.86%	6,422	12.90%
Any days (TOTAL)	**259**	**25.32%**	**10,112**	**20.31%**

Any day indicates between 1 day and 365 following the discharge they engaged in a billable Medi-Cal treatment service.

Residential Withdrawal Management Readmissions

Table 12 measures the number and percentage of residential WM readmissions within 30 days of discharge. Of 1,057 Alameda client admissions into residential WM, 29.5 percent were readmitted within 30 days of the discharge compared to the 11.1 percent statewide average for all DMC-ODS counties.

Table 12: Residential Withdrawal Management Readmissions, CY 2020

Alameda		**Statewide**
Total DMC-ODS admissions into WM	1,057	11,647

Alameda			Statewide	
	#	%	#	%
WM readmissions within 30 days of discharge	312	29.5%	1,291	11.1%

IMPACT OF FINDINGS

Based on CY 2020 claims data, Alameda clients had timely access to routine and urgent visit across the continuum of care, and a higher percentage of clients discharged from residential treatment transitioned to another LOC than the statewide experience.

According to DMC-ODS self-reported data for FY 2020-21, Alameda clients had a high rate (23 percent) of being readmitted to residential WM within 30 days of discharge compared to statewide. Also, the average no-show rate for assessment visits into new programs across all LOCs was 38 percent.

QUALITY OF CARE

BACKGROUND

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.
- Intervention for performance improvement.

In addition, the contract between the DMC-ODSs and DHCS requires the DMC-ODSs to implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services furnished to beneficiaries. The contract further requires that the DMC-ODS's 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 ALAMEDA COUNTY

In the DMC-ODS, the responsibility for QI is under the Quality Management (QM) Program Director, who directly oversees five FTEs: QI Analytics Manager, QI Performance Improvement Manager, QI Project & Planning Manager, Quality Assurance (QA) Administrator, and Utilization Management (UM) Division Director. Of this total, 22 are primarily assigned to DMC-ODS related functions though they work as a team to accomplish all needed QI, QA, and UM functions. QI goals relate areas of improvements in treatment outcomes and symptoms as well as the treatment experience for the client, not specifically the regulatory requirements.

The DMC-ODS monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Improvement Work Plan (QIWP), and the annual evaluation of the QIWP. The QIC, comprised of staff clinicians, clinical managers, contractors, persons with lived experience, data analysts, and family members is scheduled to meet monthly. Since the previous EQR, the DMC-ODS QIC met 12 times. Of the 30 identified FY 2020-21 QIWP goals, the DMC-ODS met or partially met 93 percent of its goals. They also produced a thorough summary of these findings as well as a planned set of goals for this coming year with detailed data-linked baselines, and analysis for findings for the prior year. Linkage between the QI goals and the new strategic plan were clear. Effective communication and engagement in treatment access were key elements of these goals.

The DMC-ODS utilizes the TPS, CalOMS, and ASAM brief and full assessments, satisfaction, and outcome tools. ASAM is required for LOC placements.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SUD services healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These Key Components include an organizational culture that prioritizes quality, utilizes data to inform and make decisions, engages in QI activities, matches beneficiary needs to appropriate services, coordinates care with other providers, routinely monitors outcomes, satisfaction, and medication practices, and promotes transparent communication with focused leadership and strong stakeholder involvement.

Each Quality 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 13: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement 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	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 Client Perception of Care Surveys to Improve Care	Met

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

- This year ACBH including the DMC-ODS completely re-did its public facing communication tools and using them to support access and engagement of clients and public education, such as the new website in all threshold languages, the interactive Provider Directory, and the new contractor portal systems.

- Additional quality can be achieved with direct assistance from the point of access requests to the first appointment to reduce the no-show rate for first appointments.

PERFORMANCE MEASURES

In addition to the Key Components 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

Table 14 compares the breakdown by diagnostic category of the Alameda and the statewide number of beneficiaries served and total approved claims amount, respectively, for CY 2020. Alameda's leading substance use diagnoses were Opioid Use Disorder (58.3 percent), Other Stimulant Abuse (14.7 percent), and Alcohol Use Disorder (13.5 percent).

Table 14: Percentage Served and Average Cost by Diagnosis Code, CY 2020

Diagnosis Codes	Alameda		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	13.5%	$6,267	17.6%	$5,936
Cannabis Use	4.0%	$4,056	8.0%	$2,921
Cocaine Abuse or Dependence	5.6%	$5,191	1.8%	$5,769
Hallucinogen Dependence	0.2%	$50,493	0.2%	$6,112
Inhalant Abuse	0.02%	$11,826	0.0%	$8,581
Opioid	58.3%	$4,413	47.4%	$4,788
Other Stimulant Abuse	14.7%	$5,525	23.1%	$5,269

Diagnosis Codes	Alameda		Statewide	
	% Served	Average Cost	% Served	Average Cost
Other Psychoactive Substance	0.05%	$2,628	0.1%	$7,114
Sedative, Hypnotic Abuse	0.3%	$10,053	0.5%	$6,077
Other	3.3%	$2,261	1.2%	$2,923
Total	**100.0%**	**$4,804**	**100.0%**	**$4,962**

Non-Methadone MAT Services

Table 15 shows the number and percentage of all beneficiaries served who received at least one visit for non-methadone MAT as indicated within its claims system. Alameda's rate of 5.3 percent was lower than the statewide average of 7 percent. Only 1.2 percent of clients received at least three visits for non-methadone MAT. This indicator constitutes a measure of engagement for MAT use and Alameda's rate was almost one-third the statewide average of 3.3 percent. It is important to note that this data does not include non-methadone MAT services provided by Federally Qualified Health Centers, hospitals, and private physicians.

Table 15: DMC-ODS Non-Methadone MAT Services by Age, CY 2020

Alameda					Statewide			
Age Groups	At Least one Service	% At Least one Service	3 or More Services	% 3 or More Services	At Least one Service	% At Least one Service	3 or More Services	% 3 or More Services
Ages 12-17	-	0.0%	-	0.0%	*	n/a	*	n/a
Ages 18-64	200	5.8%	45	1.3%	6,698	7.6%	3,227	3.7%
Ages 65+	19	2.8%	*	0.6%	*	n/a	*	n/a
TOTAL	**219**	**5.3%**	**49**	**1.2%**	**7,146**	**7.0%**	**3,397**	**3.3%**

Residential Withdrawal Management with No Other Treatment

Alameda served 568 clients in residential WM in CY 2020, and 11.27 percent had three or more episodes with no other services. This rate was significantly higher than the statewide rate of 3.34 percent. It suggests that residential WM programs may not have engaged clients in discharge planning and follow-up case management to reduce their readmissions.

Table 16: Residential Withdrawal Management with No Other Treatment, CY 2020

Alameda			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	568	11.27%	8,824	3.34%

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High costs of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than other beneficiaries receiving services. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

Table 17 indicates the numbers, percent, and costs incurred by beneficiaries who are identified as high-cost. Beneficiaries in this category incurred DMC-ODS treatment costs that were in the 90th percentile or higher of statewide DMC-ODS treatment costs. In Alameda, 3.96 percent of beneficiaries served were considered high-cost based on CY 2020 claims data. This percent was lower than the average percentage for most DMC-ODS counties at 5.42 percent shown in Table 18. A total of 165 high-cost clients accounted for 47.99 percent of Alameda's total claims.

Table 17: High-Cost Beneficiaries by Age, DMC-ODS, CY 2020

Alameda						
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Ages12-17	65	*	4.62%	$25,107	$75,320	47.91%
Ages 18-64	3,428	154	4.49%	$20,998	$3,233,623	49.82%
Ages 65+	670	*	1.19%	$17,381	$139,044	25.90%
TOTAL	**4,163**	**165**	**3.96%**	**$20,897**	**$3,447,987**	**47.99%**

Table 18: High-Cost Beneficiaries by Age, Statewide, CY 2020

Statewide					
Age Groups	Total Beneficiary Count	HCB Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims
Ages 12-17	3,980	53	1.33%	$19,547	$1,036,014
Ages 18-64	89,545	5,355	5.98%	$20,688	$110,786,886
Ages 65+	10,277	217	2.11%	$20,676	$4,486,743
TOTAL	**103,802**	**5,625**	**5.42%**	**$20,677**	**$116,309,644**

ASAM Level of Care Congruence

Table 19 indicates that Alameda recorded excellent congruence in ASAM indicated LOC and referred LOC in initial screening (97.8 percent) and follow-up assessment (94.5 percent). The ASAM congruence was lower in initial assessment (81.8 percent) mostly due to patient preference or clinical judgement.

Table 19: Congruence of Level of Care Referrals with ASAM Findings, CY 2020

Alameda ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
CY 2020	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	2,486	97.8%	1,905	81.8%	5,058	94.5%
Patient Preference	22	0.9%	292	12.5%	130	2.4%
Level of Care Not Available	*	0.1%	*	0.3%	*	0.1%
Clinical Judgement	15	0.6%	109	4.7%	142	2.6%
Geographic Accessibility	*	0.0%	*	0.04%	*	0.02%
Family Responsibility	0	0.0%	*	0.1%	*	0.04%
Legal Issues	*	0.04%	*	0.4%	*	0.1%
Lack of Insurance/Payment Source	14	0.5%	*	0.04%	*	0.1%
Other	*	0.0%	*	0.2%	*	0.1%
Actual Level of Care Missing	*	0.0%	*	0.0%	*	0.0%
TOTAL	2,542	100.0%	2,330	100.0%	5,353	100.0%

Initiation and Engagement

Alameda's adult and youth clients had high rates of initiating DMC-ODS services in CY 2020, at 90.3 percent and 85.9 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 79.6 percent and 76.4 percent respectively, which were similar to statewide experiences.

Table 20: Initiating and Engaging in DMC-ODS Services, CY 2020

	Alameda				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	4,062		64		98,320		3,904	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	3,667	90.3%	55	85.9%	87,609	89.1%	3,179	81.4%
Clients who then engaged in DMC-ODS services	2,918	79.6%	42	76.4%	69,099	78.9%	2,230	70.1%

Length of Stay

Table 21 is a measure of how long the System of Care can retain clients in its services and counts the cumulative time that clients participated in all types of service they received sequentially without an interruption of more than 30 days. When treatment retention is considered in this manner with clients transitioning according to their clinical needs, research supports a lengthier time in treatment as predictive of positive outcomes for recovery from addiction.

The mean (average) LOS for Alameda clients was 145 days (median 90 days), compared to the statewide mean of 142 days (median 88 days). Claims data indicates that 50.4 percent of clients had at least a 90-day LOS; 32.4 percent had at least a 180-day stay, and 20.5 percent had at least a 270-day LOS. Each of these percentages was slightly higher than the average for all DMC-ODS counties statewide.

Table 21: Cumulative LOS in DMC-ODS Services, CY 2020

Alameda			Statewide	
Clients with a discharge anchor event	3,721		110,817	
LOS for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	145	90	142	88
	#	%	#	%
Clients with at least a 90-day LOS	1,877	50.4%	54,782	49.43%
Clients with at least a 180-day LOS	1,205	32.4%	32,644	29.46%
Clients with at least a 270-day LOS	762	20.5%	20,256	18.28%

CalOMS Discharge Ratings

Table 22 displays the ratings by counselors in the CalOMS discharge summary form of their clients' progress in treatment. The first four rating options are positive, and the last four rating options indicate a lack of satisfactory progress for varied reasons.

A significantly higher percentage of Alameda clients (74.8 percent) had a positive discharge status rating in CY 2020 compared to the statewide average (46 percent).

Table 22: CalOMS Discharge Status Ratings, CY 2020

Discharge Status	Alameda		Statewide	
	#	%	#	%
Completed Treatment - Referred	1,804	35.1%	16,988	17.8%
Completed Treatment - Not Referred	84	1.6%	5,541	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	1,713	33.3%	13,830	14.5%
Left Before Completion with Satisfactory Progress – Administrative Questions	239	4.6%	7,566	7.9%
Subtotal	*3,840*	*74.8%*	*43,925*	*46.0%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	910	17.7%	13,918	14.6%
Left Before Completion with Unsatisfactory Progress - Administrative	364	7.1%	36,618	38.3%
Death	12	0.2%	341	0.4%
Incarceration	*	0.2%	722	0.8%
Subtotal	*1,296*	*25.2%*	*51,599*	*54.0%*
TOTAL	**5,136**	**100.0%**	**95,524**	**100.0%**

IMPACT OF FINDINGS

In CY 2020 data visits provided were less for all LOCs due to COVID-19 impacts with some services much more dramatically impacted than others.

A lower percentage of beneficiaries received non-methadone MAT from DMC-ODS NTP providers than other counties statewide, but Alameda added FQHC providers which CalEQRO at this time does not have data for their services to share, but it added more capacity especially in the rural areas of the county.

A higher percentage of clients who had residential WM had three or more episodes with no other services. This data supports Alameda's high residential WM readmission rate (29.5 percent per CY 2020 claims data and 23 percent per Alameda's self-reported FY 2020-21 timeliness data).

Client ASAM LOC referrals and placements show high congruence match to patient needs in initial screening, initial assessment, and follow-up assessments. However, a large percentage of these clients (38 percent) are not showing up for their initial assessments, than the prior year.

CalOMS data indicates a significantly higher percentage of clients in treatment had a positive discharge status rating in CY 2020 compared to the statewide average showing progress in treatment. Also, CalOMS had a low administrative discharge rate indicating once admitted into care, clients did not leave without telling their counselors, but worked with the program to completion and based on the discharge ratings had high rates of improvement.

Adults who participated in the CY 2021 TPS rated questions in the quality domain favorably, with an average 89.84 percent indicating ‘Agree’ or ‘Strongly Agree’.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

Each DMC-ODS is required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan'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 improvement at a member, provider, and/or DMC-ODS system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested individually by the DMC-ODS, hosting quarterly webinars, and maintaining a PIP library at www.calegro.com.

Validation tools for each PIP are located in Appendix C of this report. "Validation rating" refers to the EQRO's overall confidence that the PIP (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.

CLINCIAL PIP

General Information

Clinical PIP Submitted for Validation: Recovery Coaches for WM

Date Started: October 2019

Aim Statement: Does providing recovery coach services to WM clients result in a ten percent increase in connections to follow-up services and a ten percent decrease in recidivism to WM?

Target Population: All adult clients in level 3.2 WM residential. All WM adult clients served by the recovery coach are one group since there is only staff coach at this time. This group is a random subset of the total WM residential client population.

Validation Information The DMC-ODS's clinical PIP is in the Other remeasurement phase and is considered active and concluding this year. It is considered moderate

[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

confident level that the methodology is sound, data was collected in consistent manner monthly with adequately sampling over an extended period of time.

Summary

The prior year of this PIP there were many problems due to COVID-19 factors due to census changes, contact restrictions limiting contact with clients, and illness of staff. With vaccinations and analysis of data, changes were made to the PIP. A new intervention was added whereby the Recovery Coach did special groups in the WM program to engage clients consistently to develop a therapeutic alliance to assist in discharge planning. This intervention proved successful and increased successful placements post discharge as reflected into outpatient.

Also, the immediate period prior to leaving was the most critical time for planning the transition to the next LOC and housing services with the client. So, given the limited time of one recovery coach doing the services, the job was re-structured to prioritize client care during this time period. This was documented in the chart. This was the second intervention change in PIP design.

Also built into the design, clients who were not able to take advantage of a recovery coach were compared to those who were in relation to the key metrics: transitions in care and readmissions. Those without a recovery coach did not have as much success with transitions, but they did do somewhat better on readmissions.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because the methodology was sound and resulted in clear results with regard and consistent data measurements over extended periods of time. The readmission data was considered expected due to an anomaly not considered in the re-design. There was a strong therapeutic alliance developed between the recovery coach and the clients transitioned and for clients who were not able to find stable housing upon discharge as well as treatment there was a risk of seeking readmission. This put them at risk of seeking the residential program for shelter as well a source of support.

The TA provided to the DMC-ODS by CalEQRO consisted of:

- Discussed lessons learned from prior year's PIP and problems.
- Discussed interventions to strengthen impact of the recovery coach effect they were hoping to achieve and how to document them.
- Measuring comparison group since they were unable to offer this service to all WM clients at this time and changes to the design.
- Reviewed data charts and statistical results from robust data collection over time.

CalEQRO recommendations for improvement of this clinical PIP include:

- Add the two interventions learned through analysis of lessons learned from the prior year's problems and things that did work including measuring 10 days after and 30 days after.
- Add control group comparison of those who do not have a recovery coach.
- Keep the same recovery coach with program all year to foster therapeutic alliance model with client engagement and document frequency of contacts.
- Keep to regular and consistent time period re-measurements.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving Timely Access to Residential Treatment

Date Started: August 2019

Aim Statement: Do the following interventions improve timeliness of access to residential treatment by 20 percent? 1)Improved procedures for engaging individuals assessed as needing residential treatment; 2) three-way phone protocol for intake appointments with providers; and 3) a daily bed availability resource tool.

Target Population: All adults screened with ASAM as needing residential treatment regardless of SUD diagnosis.

Validation Information: The DMC-ODS's non-clinical PIP is in the Other remeasurement phase and is considered active and in its final year.

Summary

This PIP saw small progress from the first two interventions, but timeliness of access to this LOC was still not within state standards. Also, there were still beds not being filled and utilized. At the same time, due to COVID-19 bed availability was reduced due to infection potential, so there was increased pressure on available bed capacity. Systems needed to still be improved to make access easier for clients and the assessment process quicker. The third intervention was supposed to launch in September but there was a delay, and it just began in January 2022. It tracks beds every morning by location, sex, and LOC and provides this to the Access team so they can make sound referrals to sites for assessments with clients. As of the time of the review an assessment of impact of this intervention was not available. This was important to consider relative to the effectiveness of the design of the PIP. Even with this intervention, it is anticipated there may still be timeliness delays.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because the methodology is generally good but there are areas of the root cause analysis which still leave open other potential causes of the problem that could be adding to the delays.

Some of these issues include the following: Are there adequate numbers of intakes per site to fill vacant bed capacity? Do clients need supports to get to first appointments given high no-show rates? Why residential programs cannot take requests from clients seeking services in their local communities directly and coordinate with the county? Are there too many steps in the process causing timeliness delays or frustrating clients seeking access? Or does Alameda DMC-ODS have the right mix of beds at the right LOC? Is part of the problem the inability to discharge clients because of lack of housing causing problems with access to beds?

The TA provided to the DMC-ODS by CalEQRO consisted of:

- Reviewed drafts and data sheets as well as interviewed Access staff to provide feedback on draft PIP, design and barriers to final timely placement.
- Developed suggestions for the reduction of steps in assessment process based on success of county programs with low timeliness to residential treatment.
- One key action suggested is to reduce the 61 percent no-show rate for assessments for residential treatment.
- Also, CalEQRO shared a different program resource directory format that was public facing used by another county to allow clients and families to directly identify residential treatment programs close to their homes for access to care and it showed the public if they had empty beds.
- Ongoing video, email, and phone consultation on these matters and refinement of the PIP.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- Consult with other counties who do have residential timeliness compliance and their continuum design and workflows.
- Consider being able to make referrals seven days per week not just five as the SUD Access line does not make referrals weekends and holidays.
- Consider adding case management or peer navigator supports from client request to assessment appointment for residential intakes since these clients are considered high need based on their ASAM LOC.
- Increase the number of intakes at sites with highest average vacancy levels.

- Provide monthly data analysis of impact of new daily residential bed resource tool.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

INFORMATION SYSTEMS IN ALAMEDA DMC-ODS

California DMC-ODS EHRs fall into two main categories, those that are managed by county IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the DMC-ODS is Krasson, Inc's Clinician's Gateway, which has been in use for 13 years. Currently, the DMC-ODS plans to initiate a Request for Proposal for a new EHR in 18 to 24 months.

Approximately 3.44 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 ACBH control. Alameda's IS budget is on par with other DMC-ODS counties and slightly above the statewide average.

The DMC-ODS has 752 named users with logon authority to the EHR and the billing system, including approximately 118 county-operated staff and 634 contractor-operated staff. These are not discrete counts due to duplication of users who have access to both systems. Support for the users is provided by 6.5 full-time equivalent (FTE) IS technology positions. Currently two positions are unfilled.

As of the FY 2021-22 EQR, all contract providers have access to directly enter data into the DMC's EHR. Line staff that has direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the DMC-ODS IS as reported in the following table:

Table 23: Contract Providers' Transmission of Beneficiary Information to the DMC-ODS EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between DMC-ODS IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange (EDI) to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☒	Electronic batch file transfer to DMC-ODS IS	☒ Daily ☐ Weekly ☐ Monthly	85%
☒	Direct data entry into the DMC-ODS IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	15%
☐	Documents/files e-mailed or faxed to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☐	Paper documents delivered to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Total Percentage			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 online access to their health records through a PHR.

Interoperability Support

The DMC-ODS is a member or participant in 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.

IS KEY COMPONENTS

CalEQRO identifies the following Key Components related to DMC-ODS system infrastructure that are necessary to meet the quality and operational requirements necessary to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the 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: Key Components – IS Infrastructure

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	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

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

- ACBH has selected a new billing/managed care system (SmartCare) to replace InSyst, its legacy billing system that has been in use for over 30 years.
- In support of the SmartCare implementation, ACBH has budgeted new technology and data analytics positions to ensure there are adequate resources to manage the new project as well as current IS.
- The SUD website was updated to include videos of client recovery stories and Yellowfin dashboards that show client demographics by population trend, age group, ethnicity, and service modality.
- A Salesforce-based new Provider Directory has been created that supports data filtering and searches. ACBH plans to launch the new Provider Directory in March.
- A secured data portal has been created for distribution of SUD reports to users via ShareFile.
- A Microsoft Teams portal was created to support bilateral communication with contract providers.
- In the last year, IT expanded e-prescribing and medical staff functionality in Clinician's Gateway for the SUD environment.
- The FY 2020-21 claims denial rate of 10.6 percent was higher than the statewide average, and the top denial reason (43 percent of denied claims) being Alameda not the county of responsibility for clients served.

IMPACT OF FINDINGS

Alameda is implementing a new billing and claims processing system with a planned go-live date of July 1, 2023. The new system will be ACBH's CalAIM billing solution with enhanced capabilities in reporting and analytics, patient tracking, and payment to contract/managed care providers.

In addition to implementing the new billing system, ACBH IT staff are tasked to support other priorities such as the SUD NACT 274 file and the procurement of a Conga Contract Lifecycle Management system.

ACBH recognizes the importance of maintaining adequate resources to support new projects as well as manage current systems and has devised a plan that includes new technology and data analytics positions to support these efforts. ACBH has also created governance structures to manage all system change requests.

VALIDATION OF CLIENT PERCEPTIONS OF CARE

BACKGROUND

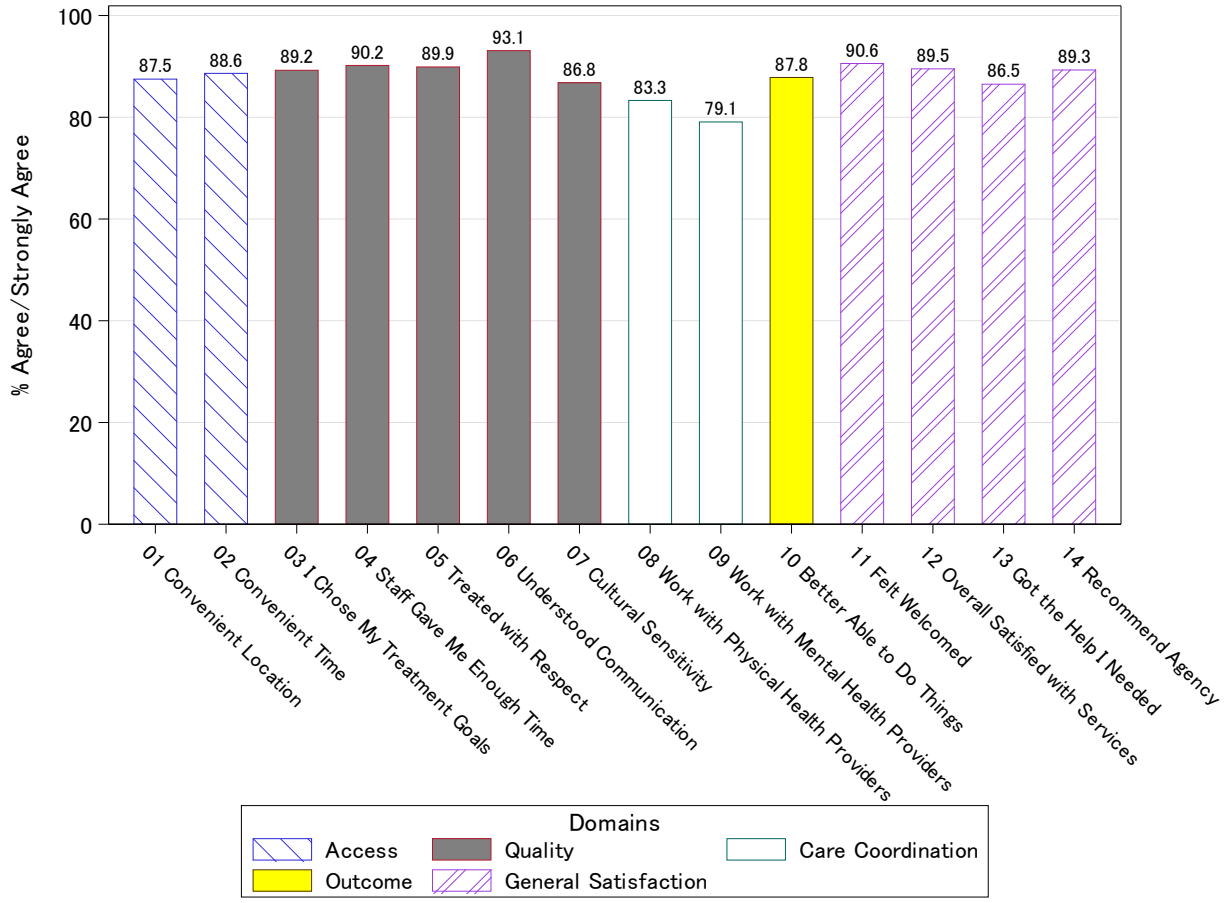
CalEQRO examined available client satisfaction surveys conducted by DHCS, the DMC-ODS, or its subcontractors.

TREATMENT PERCEPTION SURVEY

The TPS consists of ratings from the 14 items yield information regarding 5 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.

Adult clients responded to most TPS domain questions favorably, and high ratings were noted in all questions except care coordination with mental health providers. This appears to be the experience shared by clients across all active DMC-ODS counties. In total, 668 clients participated in the CY 2021 adult TPS.

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



CONSUMER FAMILY MEMBER FOCUS GROUP

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 review planning process, CalEQRO requested two 90-minute focus groups with adult clients and/or their family members, containing 6 to 8 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult clients who were participating in treatment some time since the beginning of the DMC-ODS Waiver in 2016 to the present and were now utilizing services at Humanistic Alternatives to Addiction, Research and Treatment (HAART) NTP for MAT (either for the methadone or for non-methadone) with counseling and supports.

Participants were encouraged to complete an online survey, which was provided to the facilitator in advance of the group. Six participants joined the group online video experience.

Participants described their experience as the following on the survey:

Table 25: CFM Focus Group One

Question	Average	Range
1. I easily found the treatment services I needed.	9	8-10
2. I got my assessment appointment at a time and date I wanted.	8	6-10
3. It did not take long to begin treatment soon after my first appointment.	9	8-10
4. I feel comfortable calling my program for help with an urgent problem.	8	7-9
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	10	10
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	7	5-10
7. I found it helpful to work with my counselor(s) on solving problems in my life.	9	8-10
8. Because of the services I am receiving, I am better able to do things that I want.	5	5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	5	5

Clients described their treatment experience with the MAT program and the DMC-ODS as follows:

Counselors also provide direct phone lines for easy access as well as information with the video zoom links for counseling sessions at this MAT program. Program is responsive and flexible. Most residential treatment programs coordinated MAT with

HAART. Some housing still does not like methadone like Shepards Gate. One participant reported, “As soon as I could get other housing I did, and this helped me a lot with becoming stable. I enrolled in HAART and kept my counselor for six months of really good support while pregnant. Now I am doing well in the community and still continuing in the program.” Many reported improved experience with this provider in support and responsiveness to their SUD individual needs.

Participants reported good coordination with health clinics, probation, child welfare, and mental health.

Recommendations from focus group participants included:

- Having more take-home doses when stable is really helpful. Group strongly requested this continue as it made it easier for them to work, go to school, stay active in children’s lives, and not miss doses.
- Group liked some telehealth, but also some face-to-face visits.
- Continue safety protocols with COVID-19 as many people homeless and so easy to get sick and spread germs.
- Continue offering all options for MAT medications so clients have choice.
- Continue offering the wrap-around supportive counseling approach which really makes HAART special as program.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse API group with a contract agency Health Right 360 who worked with CalEQRO and the county to do outreach to a broad group of clients. They provided written survey feedback but failed to come to the actual group. Four translators were present to support the various languages anticipated for the group. The contractor and county are to be recognized for the effort they took to organize this group. In the future, it was requested CalEQRO offer individual interviews with the CFM consultant because of the level of stigma associated with SUD issues in the API community and fear of groups. CalEQRO expressed their willingness to be flexible with this group of clients to get their input on services.

Participants described their experience as the following on survey forms (4):

Table 26: CFM Focus Group Asian Pacific Islanders

Question	Average	Range
1. I easily found the treatment services I needed.	7	7-7
2. I got my assessment appointment at a time and date I wanted.	8	6-9

Question	Average	Range
3. It did not take long to begin treatment soon after my first appointment.	9	8-10
4. I feel comfortable calling my program for help with an urgent problem.	10	10
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	7	7
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	10	10
7. I found it helpful to work with my counselor(s) on solving problems in my life.	10	10
8. Because of the services I am receiving, I am better able to do things that I want.	5	5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	5	5

Recommendations from focus group participants included:

- There were no verbal comments. A few written comments were on the survey forms.
- My counselor is kind and a good listener and has helped me very much.
- It is hard for me to talk to others about these issues. This is a safe place where you can find help.

IMPACT OF FINDINGS

It is clear that this program is making a difference for the clients who are participating in care and confidentiality is particularly important to them. The integration of cultural practices into the treatment process was incredibly positive and appreciated by the participants particularly the graduation ceremony and use of symbols of healing and wellness for the Asian Pacific Islander group especially, though this was seen as important overall.

Unique approaches to gathering the consumer voice and perspective are needed for the API group. Next year CalEQRO will plan with the county some individual interviews instead of a group to support this feedback.

The MAT group at HAART, a non-profit NTP/OTP program with a large group of clients on non-methadone medications as well, was seen by participants as a very positive experience when compared with other methadone programs they have gone to in the

past. Also, it was coordinating well with residential and housing sites for care and applying safety protocols in a way that participants appreciated and wanted continued. This use of take-home doses and other modifications of the program for COVID-19 were positively experienced by clients and they experienced them as improving compliance with care.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the DMC-ODS's 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 DMC-ODS managed care system.

STRENGTHS

1. The DMC-ODS QIWP and CCP were thorough, well-developed with baselines and clear goals and objective, effective use of data related to community needs, and recently updated for more community inclusion and diversity. (Quality, Access)
2. The DMC-ODS improved engagement and communication activities such as the new public website, the new interactive Provider Resource Directory, both in all threshold languages, and the interactive DMC-ODS contractor portal and other activities as noted. (Access, Quality)
3. New Daily Report Summary of Residential Treatment Bed Resources was added. (Access, Timeliness)
4. The DMC-ODS demonstrates strong use of data to improve care quality in use of Yellowfin dashboards across the continuum, the HIE to enhance coordination and continuity of care with other agencies, and pro-actively working with providers on CalAIM data systems to meet state implementation deadlines for July 2023. (Access, Timeliness, Quality, IS)
5. Addition of the Forensic Division and Case Management Teams to address integrated services for one of the most vulnerable populations in the community. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The DMC-ODS serves a disproportionately low percentage of API beneficiaries relative to the Medi-Cal eligible population. Feedback from contractors and stakeholders shared the unique needs of this community related to severe stigma and how treatment would need to be approached very differently. (Access, Timeliness, Quality, IS)
2. Overdose rates from fentanyl and methamphetamines are very high and impacting many communities of color disproportionately. (Access)
3. The SUD Access Call Center system uses the Mental Health Crisis line nights and weekends to respond to requests for services and screenings. Their

information is taken to give to the SUD Access Call Center staff the next business day. (Access)

4. No-show rates for first assessment appointments average 38 percent, with a low of 24 percent for outpatient to a high of 61 percent for residential treatment. (Quality)
5. Capacity or visits at each LOC decreased in 2020 compared to the prior year, resulting in clients accessing less care. (Access, Timeliness, Quality)

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. Continue and expand unique culturally sensitive programs for the different API populations to increase access and treatment opportunities. Document these for sharing best practices with others in terms of barriers and successes. (Access, Timeliness, Quality)
2. Expand the overdose prevention efforts Alameda DMC-ODS has begun using interventions such 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. (Access, Quality)
3. Increase availability of the SUD Access Call Center service during peak hours on weekends and holidays, not just business hours. (Access, Timeliness)
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. (Access)
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. (Access)

ATTACHMENTS

ATTACHMENT A: CalEQRO Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT E: County Highlights

ATTACHMENT A: CALEQRO REVIEW AGENDA

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

Table A1: CalEQRO Review Sessions – Alameda DMC-ODS

Table A1: 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
Access Call Center Interview of Line Staff and separate of managers/supervisors
QI Plan, Cultural Competence, NA, Timeliness Data, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing Residential Capacity Report, Dashboards, Contractor Portal, Continuum of Care & units of service, Provider enrollment issues, out of county billing problems
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 - Residential Timeliness, Recovery Coach WM Transitions
Stakeholders, Health, Criminal Justice, Jail, Hospital, Health Plan, MH Meetings
MATs Focus Group - HAART
Mental Health coordination with DMC-ODS and Co-occurring Disorders
Criminal justice coordination with DMC-ODS and transitions from Prisons with MAT
Quality Planning Initiatives and CalAIM initiative including data, contractors, strategic planning, new engagement tools, new website demo, new provider directory demo
API Focus Group
Data Follow-up Issue Meeting
Exit interview: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rama K Khalsa, PhD, Lead Reviewer
Jan Tice, Second Reviewer
Caroline Yip, IS Reviewer
Valerie Garcia, Consumer Family Consultant

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

Alameda's DMC-ODS review was all virtual sessions linked to these sites.

DMC-ODS Site

Alameda County Health & Behavioral Health Services
2000 Embarcadero Cove, Suite 400
Oakland, California (CA) 94606

Contract Provider Sites for Focus Groups

HAART
10850 MacArthur Blvd.
Oakland, CA 94605
HAARTOakland.org

HealthRight360
33440 Alvarado Niles Rd
Union City, CA 94507

Table B1: Participants Representing the DMC-ODS

Last Name	First Name	Position	Agency
Adam	Janice	ACBH Public Information Officer	Alameda County Health Care Services Agency
Belgasi	Tejasi	Director of Outpatient Services	Asian American Recovery Services
Biblin	Janet	Info Systems Manager, QI	ACBH
Buenavista	Razelle	Managing Director	Asian American Recovery Services
Capece	Karen	Quality Management Program Director	ACBH
Carlisle	Lisa	Child & Young Adult System of Care Director	ACBH
Chapman	Aaron	Chief Medical Officer	ACBH
Courson	Natalie	IS Deputy Director	ACBH
Dawal	Marcus	Interim Chief Probation Officer	Alameda County Probation Department
Douglas	James	Program Manager	Center Point
Dunn	Ellen	Adult Forensic Behavioral Health of Adult Forensic	ACBH
Eady	Rashad	Program Specialist, QI	ACBH
Elliot	Ann	Critical Care Manager	ACBH
Espiridion	Ricca	SUD Continuum of Care Assistant Director	ACBH
Fielder	Aminata	Lead Clinical Counselor	Options Recovery Services
Hall	Lorenza	Senior Management Analyst, Data Services Team	ACBH
Henry	Krishna	Administrative Assistant, QM	ACBH
Herring	Andrew	General Emergency Medicine	Alameda Health Systems

Last Name	First Name	Position	Agency
Houston	Fonda	Substance Use Operational Specialist	ACBH
Jones	Yvonne	Adult Forensic	ACBH
Tribble	Karyn	Behavioral Health Director	ACBH
Judkins	Andrea	Supervising Financial Services Specialist, Budget & Fiscal Services	ACBH
Lewis	Clyde	SUD Continuum of Care Director	ACBH
Lopez	Rickie	Assistant Finance Director	ACBH
Louis	L.D.	Deputy District Attorney	District Attorney Office, Alameda County
Mehta	Ravi	Chief Compliance & Privacy Officer Director	Alameda County Health Care Services Agency
Meinzer	Chet	Information Systems Manager, DST	ACBH
Momoh	Imo	Deputy Director/Plan Administrator	ACBH
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	ACBH
Moore	Lisa	Billing & Benefits Support Director	ACBH
O'Neill	Gavin	Principal Analyst, Manager, Collaborative Courts	Superior Court of California, County of Alameda
Orozco	Gabriel	Management Analyst, QM	ACBH
Peterson	Camille	IS Analyst	ACBH
Phillips	Justin	Executive Director	Options Recovery Services
Meinzer	Chet	Information Systems Manager, DST	ACBH
Momoh	Imo	Deputy Director/Plan Administrator	ACBH

Last Name	First Name	Position	Agency
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	ACBH
Moore	Lisa	Billing & Benefits Support Director	ACBH
O'Neill	Gavin	Principal Analyst, Manager, Collaborative Courts	Superior Court of California, County of Alameda
Orozco	Gabriel	Management Analyst, QM	ACBH
Peterson	Camille	IS Analyst	ACBH
Phillips	Justin	Executive Director	Options Recovery Services
Rassette	Kim	Administrative Specialist II, QI	ACBH
Rejali	Tore	Quality Assurance Administrator	ACBH
Sampson	Sakara	Administrative Specialist II, QI	ACBH
Schrick	Juliene	Utilization Management Division Director	ACBH
Serrano	Cecilia	Finance Director	ACBH
Sooryanarayana	Kripa	Financial Services Specialist II, Budget & Fiscal Services	ACBH
Taizan	Juan	Forensic, Diversion, and Re-entry Services Director	ACBH
Tribble	Karyn	Director	ACBH
Vargas	Wendi	Assistant Director, Contracts Unit	ACBH
Wagner	James	Deputy Director, Clinical Operations	ACBH
Wilson	Javarre	Ethnic Services Manager	ACBH
Wong	Jenny	Management Analyst, QM	ACBH

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	Final year of this PIP
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Alameda DMC-ODS	
PIP Title: Recovery Coaches for WM	
PIP Aim Statement: Does providing recovery coach services to WM clients result in a ten percent increase in connections to follow-up services and a ten percent decrease in recidivism to WM?	
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 SUD diagnoses in WM residential 3.2 services. Primary drug use was methamphetamines, secondary was alcohol, third was cocaine, fourth was opioids, and the rest were very small numbers of mixed drugs and marijuana. These were based on numbers of primary diagnoses by admission.
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) Cooperate with peer navigator on considering options for care after WM.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Enhance support for individuals in WM to understand treatment options and assist them get into those programs with benefits.
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) Consider methods for making this peer support service available to persons transitioning from one LOC to another.

Performance measures (be specific and indicate measure steward and NQF 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
Increased engagement at lower LOCs after residential WM within 10 days.	2/1/18	38 % 275/722	☐ Not applicable—PIP is in Planning or implementation phase, results not available	7/1/21-11/30/21 Intervention group 77/184 Non-intervention group 28/160	☒ Yes ☐ No	☒ Yes ☐ No 133% difference County did not evaluate using P value
Increase engagement at lower LOCs after residential within 30 days.	2/1/18	38% 275/722	☐ Not applicable—PIP is in Planning or implementation phase, results not available	7/1/21-11/30/21 Intervention group 83/`84 Non-intervention group 35/160	☒ Yes ☐ No	☒ Yes ☐ No 105% difference County did not evaluate using P value

Performance measures (be specific and indicate measure steward and NQF 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
Percent of clients who returned to WM within 30 days of discharge.	12/1/2018	61/722	2021	7/1/21-11/30/21 Intervention group 10% Non-intervention group -9%	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Results not conclusive

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): 17 measurements

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:

- Add the two interventions learned through analysis of lessons learned from the prior year's problems and things that did work including measuring 10 days after and 30 days after.
- Add control group comparison of those who do not have a recovery coach.
- Keep the same recovery coach with program all year to foster therapeutic alliance model with client engagement and document frequency of contacts.
- Keep to regular and consistent time period re-measurements.

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 is the last year of this PIP.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Alameda DMC-ODS	
PIP Title: Improving Timely Access to Residential Treatment	
PIP Aim Statement: Do the following interventions improve timeliness of access to residential treatment by 20 percent? a) Improved procedures for engaging individuals assessed as needing residential treatment. b) Three-way phone protocol for arranging intake appointments with providers; and c) A daily bed availability resource tool.	
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:	
Target population description, such as specific diagnosis (please specify): All access callers screened by ASAM as needing residential treatment services with all SUD diagnoses.	

General PIP Information
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) Members call the Access line and activities.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Access Team providers change their work flows to incorporate three-way calling and also the new daily report of who has vacant beds.
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) DMC-ODS works to ensure vacant beds are rapidly filled by Access Team with new requests and get supports they need to get to the program for assessments, and ancillary supports.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percent of residential treatment bed capacity utilized by clients	FY 2018-19	22,074/42,136 52.4%	☐ Not applicable—PIP is in Planning or implementation phase, results not available	33,242/65,335 bed days 50.9% FY 2020-21	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: No P ratio calculated by the county. No results available.
Average time from screening to first residential appointment	FY 2018-19	9 days 20 % goal	☐ Not applicable—PIP is in Planning or implementation phase, results not available	12 days 159 with intake, 249 eligible) FY 2020-21	☐ Yes ☒ No	☐ Yes ☒ No No P ratio calculated by the county.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Average time from screening to actual residential appointment	FY 2018-19	16.43 days	☐ Not applicable—PIP is in Planning or implementation phase, results not available	13 days 99 served, 249 eligible) 20.9% FY 2020-21	☐ Yes ☒ No zero	☐ Yes ☐ No No P ratio calculated by the county. Result zero
% of three-way calls for appointments	NA	NA	☐ Not applicable—PIP is in Planning or implementation phase, results not available	79.2% 126/159 total eligible for residential trt. FY 2020-21	☐ Yes ☒ No	☐ Yes ☒ No No P ratio completed by the county
% of providers who update their bed availability daily	NA	NA	Bed availability survey Jan 2022	NA	NA	NA

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and decided 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): 23 re-measurements

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.

PIP Validation Information
EQRO recommendations for improvement of PIP: • Consult with other counties who do have residential timeliness compliance and their continuum design and workflows. • Consider being able to make referrals seven days per week not just five. • Consider adding case management from request to first appointment for residential intakes as some counties do since they are considered high need clients and other need testing and many other supports to successfully transition into residential treatment. CalEQRO had specific recommendations.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CalOMS Living Status at Admission, CY 2020

Admission Living Status	Alameda		Statewide	
	#	%	#	%
Homeless	1,394	39.8%	25,577	27.9%
Dependent Living	604	17.3%	22,882	25.5%
Independent Living	1,500	42.9%	43,711	46.6%
TOTAL	**3,498**	**100.0%**	**92,170**	**100.0%**

Table D2: CalOMS Legal Status at Admission, CY 2020

Admission Legal Status	Alameda		Statewide	
	#	%	#	%
No Criminal Justice Involvement	2,675	76.5%	58,971	64.0%
Under Parole Supervision by CDCR	229	6.5%	1,849	2.0%
On Parole from any other jurisdiction	28	0.8%	1,305	1.4%
Post release supervision - AB 109	376	10.7%	23,836	25.9%
Court Diversion CA Penal Code 1000	83	2.4%	1,382	1.5%
Incarcerated	53	1.5%	442	0.5%
Awaiting Trial	54	1.5%	4,348	4.7%
TOTAL	**3,498**	**100.0%**	**92,133**	**100.0%**

Table D3: CalOMS Employment Status at Admission, CY 2020

Current Employment Status	Alameda		Statewide	
	#	%	#	%
Employed Full-Time - 35 hours or more	389	11.1%	10,461	11.3%
Employed Part Time - Less than 35 hours	209	6.0%	6,784	7.4%
Unemployed - Looking for work	1,070	30.6%	28,853	31.3%
Unemployed - not in the labor force and not seeking	1,830	52.3%	46,072	50.0%
TOTAL	**3,498**	**100.0%**	**92,170**	**100.0%**

Table D4: CalOMS Types of Discharges, CY 2020

Discharge Types	Alameda		Statewide	
	#	%	#	%
Standard Adult Discharges	3,580	69.7%	40,731	42.6%
Administrative Adult Discharges	625	12.2%	45,247	47.4%
Detox Discharges	828	16.1%	7,946	8.3%
Youth Discharges	103	2.0%	1,600	1.7%
TOTAL	**5,136**	**100.0%**	**95,524**	**100.0%**