Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

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

ALAMEDA DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
December 10-12, 2019

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ALAMEDA DMC-ODS EXECUTIVE SUMMARY

Beneficiaries Served in Fiscal Year (FY) 2018-19 —3761
Alameda Threshold Language(s) — Spanish, Cantonese, Vietnamese, Mandarin, Tagalog
Alameda Size — Large
Alameda Region — Bay Area
Alameda Location — East of San Francisco, North of Santa Clara, West of San Joaquin and South of Contra Costa
County Seat — Oakland
Year One of DMC-ODS Services
Onsite Review Process Barriers — none

Introduction

Alameda County officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in July 2018 for Medi-Cal recipients as part of California's 1115 DMC Waiver. Alameda was the sixth county to launch in California's Bay Area Region and twenty-fifth statewide. In this report, "Alameda County" shall be used to identify the Alameda DMC-ODS program unless otherwise indicated.

Alameda is a large county with 1.68 million individuals on the east side of San Francisco Bay and a large area extending to Contra Costa County to the north, San Joaquin to the east, and Santa Clara County to the south. Alameda County includes a diverse mix of ethnic populations with 49.7 percent white, 11.2 percent African American, 22.4 percent Latino, 31.5 percent Asian, and 5.3 percent with two or more races. Thirty-two percent of the community members are foreign born according to the most recent census data, and there is a large veteran population linked to several naval and military installations in the county. Nine percent of the county residents currently live below the poverty level according to the Healthy Alameda report published in 2019 by the Department of Public Health for Alameda County, and the current estimated median home costs $842,585. The unemployment rate is currently 4.96 percent and approximately five percent of residents are disabled.

During this FY 2019-20 Alameda County review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to DMC access, timeliness, quality, and outcomes related to this first-year implementation of DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2018-19.

Access

Alameda County had numerous efforts in their initial year of services to expand access. Some of this was driven by the planning process they did to develop their plan and identify gaps in their continuum of care and add additional providers and capacity. Other access efforts were not mandated as part of the Waiver requirements but based on principles of quality substance use disorder (SUD) care for high risk populations such as the criminal justice population.

Alameda County enhanced the role of the Access Call Center contractor to include screening and linkage for residential authorization and created three other “gates” or portals for referrals for residential treatment to try to insure speedy access or key referral sources and populations. Clients may also contact any of the full continuum of contracted providers directly for an assessment.

Alameda County expanded program capacity in fourteen outpatient contracts (nine adult, three adolescent, and two perinatal), 185 residential treatment beds, 81 recovery residence beds, 34 out of county residential beds, and out of county OTP/NTP (Opioid Treatment Program/Narcotic Treatment Program) providers as needed to improve access and meet network adequacy goals. Not all these programs have been granted their DMC-ODS PED (Provider Enrollment Division) certification at the time of the review, therefore claims data is not reflected in current performance measure charts.

Buprenorphine and suboxone were added to services available in the opioid treatment programs, particularly the HAART (Humanistic Alternatives to Addiction Research and Treatment) Program.

Alameda also implemented a major SUD counseling and MAT (medication assisted treatment) program in Santa Rita Jail for all inmates who have a SUD and could benefit from treatment during and after confinement. They have a licensed NTP in the detention facility, medical staff doing inductions and treatment, and counseling staff. There are also policies and procedures for smooth transitions of inmates into the community on their medications or who need SUD counseling.

Timeliness

The Access Call Center, which is operated by a contractor, is using Avaya software and has minimal wait times and a low rate of dropped calls. The Access Call Center and other key gates for residential treatment authorizations are tracking routine timeliness measures and residential placements. There are still challenges with clients who directly present to contract agencies and other sites for tracking their requests for services. NTP access to medications is also prompt based on performance measure data, and clients routinely present directly at the NTP sites.

Alameda also implemented a reconfiguration of their mental health computer system called Clinicians Gateway to support their SUD contract agencies and county programs as an interim product linked to their existing practice management system while they do a full RFP (request for proposal) for a new system (which could take up to two years). This infrastructure is critical to care quality and transitions in care; however, implementing a new computer system at the same time as the launch of the DMC-ODS added significant administrative challenges to county and contract staff. Also, the help desk for the new software is not adequately staffed to support the needs of contractors and county users; with an unacceptable rate of wait times and dropped calls. As a result, Alameda has experienced challenges with tracking timeliness as well as other metrics linked to managed care. The general lack of IS resources in this area is critical to supporting the work of the clinical programs in the DMC-ODS in access, authorizations, treatment planning supports, and billing, and can only be described as urgent in terms of impact on operations and services.

Staff reported and showed improvements since the beginning of the DMC-ODS implementation process, but the help desk issues and the training supports need further improvements. The timeliness data and dashboards were new and not entirely reliable at the time of the review. Goals were clear to the managers who were actively working to meet them and have ways to capture critical data. This is a common problem in the initial start-up year especially if a new computer system is also launched at the same time. Recommendations and discussion on these issues are described in more detail in the full report, particularly in sections linked to timeliness data.

There were also placement and access issues in residential treatment and WM (withdrawal management) LPHA (Licensed Practitioner of the Healing Acts) that needed to be addressed because it was taking too long for the clients to get into approved beds and many were offered beds but not accepting them. So, Alameda designed and is implementing a Performance Improvement Project (PIP) to address these concerns with a set of interventions to improve the upfront engagement processes.

Quality

The culture of the Alameda County leadership and contractors was strongly oriented to meeting client needs via solid SUD quality of care. Alameda's commitment to continuity of care was also shown in committing resources to the Care Connect electronic health record project for county and contract staff, making it clinically focused, and developing user friendly dashboards and tools. As stated in the prior sections, the primary area needing to be urgently addressed is staffing of the helpdesk/helpline and its overall support and development. This effort will make a difference for client care, billing, and staff satisfaction if done with appropriate supports. Alameda is making a solid effort which will benefit the system, but it does need additional resources.

Other quality efforts observed by CalEQRO in the Alameda County review were a solid system of tracking care utilization, efforts to meet final rule requirements and

documentation including Network Adequacy, and embedding ASAM criteria into screening, assessment processes and tools system wide. Quality Improvement and Cultural Competence plans were clear, had current updates and were relevant to current issues and challenges.

Another unique element of quality was a cross-department Health Information Exchange (HIE) resource which included Social Services, Health, Mental Health, and SUD as well as information on housing and housing resources. The HIE also included a "chat area" for case managers to coordinate across organizations to meet their clients' needs, particularly when a client is in crisis. The HIE has rich information to help with problem solving and crisis management and supports client confidentiality with numerous security levels. Alameda's Whole Person Care initiative had played a major role with funding this HIE; the SUD program was just beginning to participate and was getting releases to support their efforts related to 42 CFR Part 2.

Outcomes

There were several challenges, as is common in a start-up year, which impacted some of the desired outcomes. Thirty-three of the clinical programs who were part of 19 contract agencies were awarded contracts. Half of these programs had never billed Drug Medi-Cal before and so there was significant training and infra-structure development needed to get ready to be able to document and bill DMC-ODS Medi-Cal appropriately. And as of January 1, 2020 Narcotic Treatment Programs (NTPs) must also become certified and bill Medicare which is also extremely complex for persons with both Medicare and Medi-Cal which is true of approximately 30% of the clients who are disabled or elderly. The new computer supports are critically important to help all of them with these tasks, but it is yet another challenge for staff to train in and learn how to use the new electronic documentation and claiming systems, as well as the many new requirements for the Drug Medi-Cal Waiver.

There are and continue to be major workforce hiring challenges for county and contract organizations to meet the higher requirements for staff licensing (LPHA and SUD certified counselor) of the Waiver. These challenges have limited program expansion. In addition, overall staffing stability is challenged by Kaiser and other organizations such as health clinics that began hiring SUD counselors and LPHAs at paying higher wages.

Despite these challenges, the client satisfaction ratings on the Treatment Perception Survey (TPS) were positive—above 74 percent in all categories. The CalOMS data showed providers rated 75 percent of their clients as having improved in treatment, and 52 percent as having completed their treatment programs. Alameda County hopes to use these data sources more fully in their second year to look at outcomes for specific programs and levels of care. There was considerable variability between contract agencies in some of the TPS ratings which may have been related to small response rates in the first year but does warrant follow-up.

Client/Family Impressions and Feedback

There were three focus groups conducted with SUD clients: one residential group, one Spanish speaking group, and one adult group at an NTP program. The clients expressed positive experiences with access to care in the new DMC-ODS system and reported it had improved from the prior system which was more based on the criteria of the individual program, not their needs. Some of the clients with long histories of SUD and trauma felt that 90 days of residential treatment was too short to stabilize and then make smooth stepdown transitions unless there was lots of housing with counselor "wrap around for first 30 days". They emphasized that is was not easy going back into their stressful circumstances, especially for those in long- term homelessness with SUDs.

Clients compared the non-profit NTP with other NTPs in the county. They conveyed the impression that the non-profit was more open and flexible to providing modalities other than methadone. They explained that the non-profit provided more counseling and case management supports, and more opportunities for clients to choose buprenorphine rather than methadone.

Clients in the review focus groups requested more help from the DMC-ODS with housing issues. They asked for more treatment program accommodation of social activities at the program for clients to develop friendships and community, not just treatment sessions. They also expressed appreciation of drop-in hours for crisis issues and would like more case management assistance. They also recommended that treatment programs recognize many women had previous sexual trauma and need their own groups to help address them; they suggested this applied to some men as well. They remarked that it is difficult to self-disclose these and some other gender-specific matters in some of the co-ed groups. Many wanted help with understanding if they might qualify for benefits if they could not work right away. Clients also acknowledged that planning for transitions to other levels of care provoked anxiety for which they needed more help from counselors than was available; they suggested that some programs needed additional counselors who could provide more time for these case management activities.

Recommendations

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

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has received 40 implementation and fiscal plans for California counties to provide Medi-Cal covered specialty DMC-ODS services to DMC beneficiaries under the provisions of Title XIX of the federal Social Security Act. DHCS has approved and contracted with 31 of those counties as of January 15, 2020, and EQRO has scheduled each of them for review.

This report presents the FY 2019-20 EQR (External Quality Review) findings of the Alameda County FY 2018-19 implementation of their DMC-ODS by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

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

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

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

DMC-ODS Information System Capabilities[3]

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

Validation of State and County Client Satisfaction Surveys

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

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

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

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

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

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

The Behavioral Health Department had a new Director. This position had been vacant for several years, and the candidate chosen was someone who had worked for the department before and had knowledge of the local community. Also, the Quality Improvement Director recently retired and had been in his leadership position for several decades so hiring and training of new staff was a high priority.

Past Year's Initiatives and Accomplishments

As noted in the executive summary, Alameda County based on its planning process released an RFP and contracted with 33 SUD contract agencies to address service needs at different levels of care and different areas of the county, specifically outpatient services, intensive outpatient services, residential, and recovery residences. Many providers had never billed Medi-Cal and needed to apply for DMC-ODS certification through PED. When the Waiver launched in July 2018 ten of the providers still did not have certification and could not bill. At the time of the review in December 2019, one of the providers still did not have certification. Because of this billing data is incomplete and does reflect the full measure of clinical activity provided in this first year of services.

- Expanded outpatient, residential, and WM residential treatment.
- Expanded NTP/OTP services to add buprenorphine, naloxone, disulfiram in several sites throughout the county and contracted with providers outside the county as well.
- Developed WM 3.2 Recovery Coach PIP and implemented.
- Developed Residential Timely Access PIP and implemented.
- Developed and launched phase I of Clinician Gateway EHR (Electronic Health Record) for county and contractor staff to use for charting, authorizations, treatment plans, coordination of care.
- Hired and trained many county and contract agency staff on ASAM, TPS, Billing, Medi-Cal charting, Beneficiary Rights and Responsibilities, Best Practices as reflected in the STCs.
- Implementing and monitoring a priority population standard of treatment for underserved and high-risk populations.
- Laid the foundation and launched the Santa Rita Jail SUD treatment program linked to the DMC-ODS.

- At the start of the Waiver had contracted with 19 agencies that provided 33 DMC treatment programs offering the full continuum of SUD care (OS,IOS, residential, WM, NTP, recovery residences).
- Implementation and scaling of the SUD Access & Referral Helpline linked to 24 hour service access systems including residential authorization via county management.

Alameda County Goals for the Coming Year

- Complete PED certification for all providers and bill for all services back to application date to reflect care provided.
- Refine and stabilize new programs in ASAM models of care, individualized treatment, treatment planning, documentation, and links to billing and continuity of care including case management and recovery services.
- Stabilize and refine Clinician's Gateway to meet needs of the DMC-ODS programs and provide quality documentation in an efficient and effective manner to support the best possible care for clients, and the needs of the organization related to management of the SUD system.
- Address the issues targeted in the two Performance Improvement Projects.
- Identify an adolescent residential treatment provider in the Bay area that can serve the youth of the County.
- Evaluate the fiscal needs and staffing patterns of the contractors' programs to make needed adjustments based on the first-year experience of the DMC-ODS.
- Implement and monitor the Priority Population Standards of Treatment.
- Participate and enhance the Community Health Record system (HIE).
- Establish system wide minimum appropriate drug testing standards.
- Release an RFP for a full Practice Management and EHR system built for behavioral health on current technologies.
- Continue to seek new providers to meet Network Adequacy standards and emerging client needs.

PERFORMANCE MEASURES

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

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

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

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

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

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

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

HIPAA Guidelines for Suppression Disclosure

Values are suppressed on PM reports to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (* or blank cell), and where necessary a complimentary data cell is suppressed to prevent calculation of initially suppressed data. Additionally, suppression is required of corresponding percentages (n/a); and cells containing zero, missing data or dollar amounts (-). These PMs use FY 2018-19 claims data that is approved or pended.

DMC–ODS Clients Served in FY 2018-19

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

FY 2018-19 Table 1 shows Alameda' number of clients served and penetration rates overall and by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties.

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

Alameda County has a higher penetration rate than other large counties and the statewide average for other DMC-ODS counties even with the incomplete data due to billing delays because one of their major programs is still waiting for Medi-Cal certification.

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

Table 1: Penetration Rates by Age, FY 2018-19					
Alameda				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	42,674	37	0.09%	0.21%	0.19%
Ages 18-64	236,281	3,078	1.30%	1.02%	0.91%
Ages 65+	57,337	646	1.13%	0.69%	0.61%
TOTAL	**336,291**	**3,761**	**1.12%**	**0.85%**	**0.76%**

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

Table 2 below shows Alameda' average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties. Average approved claims are higher than statewide which is similar to other counties in the bay area region

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

Table 2: Average Approved Claims by Age, FY 2018-19			
Alameda			Statewide
Age Groups	Total Approved Claims	Average Approved Claims	Average Approved Claims
Ages 12-17	$131,244	$3,547	$1,364
Ages 18-64	$12,319,508	$4,002	$3,035
Ages 65+	$3,058,673	$4,735	$3,024
TOTAL	**$15,509,426**	**$4,124**	**$2,968**

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.

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

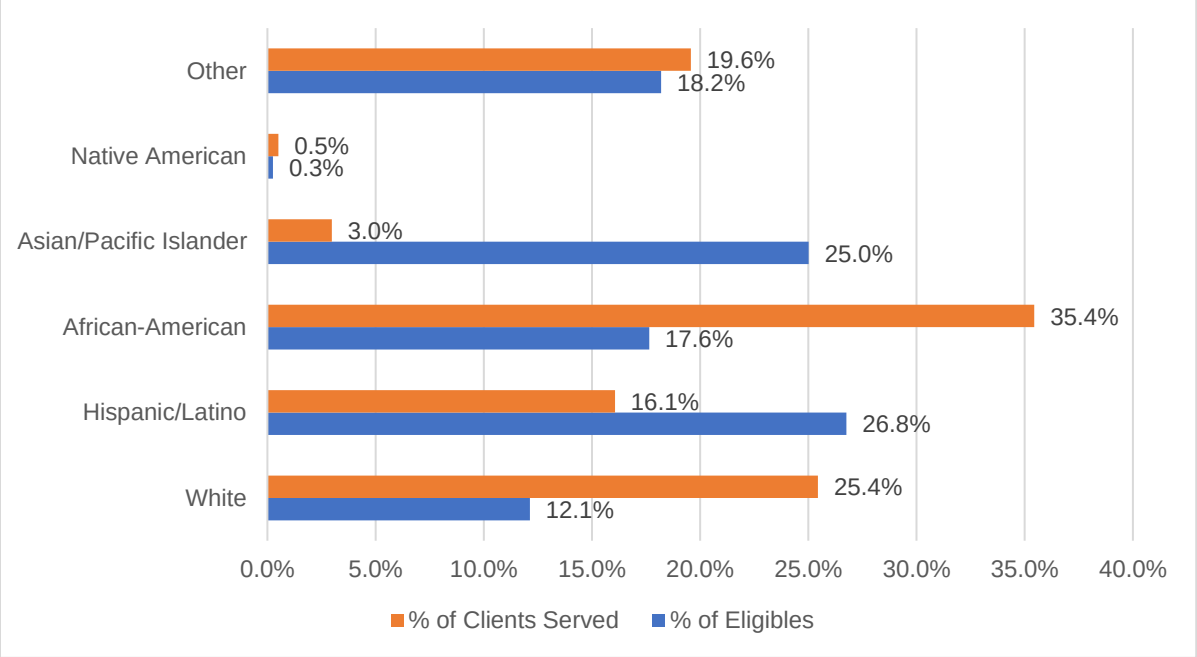


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. White and African American clients are over-represented in terms of percent of services provided while Asian/Pacific Islanders and Latino populations are underrepresented. These are groups that Alameda is planning to do special outreach to engage in services in their planning.

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

Table 3: Penetration Rates by Race/Ethnicity, FY 2018-19					
Alameda				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	40,779	957	2.35%	1.79%	1.48%
Latino/Hispanic	89,994	604	0.67%	0.59%	0.54%
African American	59,327	1,333	2.25%	1.12%	1.02%
Asian/Pacific Islander	84,131	112	0.13%	0.13%	0.13%
Native American	883	19	2.15%	1.94%	1.27%
Other	61,179	736	1.20%	0.87%	0.84%
TOTAL	**336,293**	**3,761**	**1.12%**	**0.85%**	**0.76%**

Table 4 below shows Alameda' penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. Similar to other counties ACA represents the largest eligibility group.

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

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2018-19				
Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	41,190	1,325	3.22%	1.39%
Foster Care	1,160	*	n/a	1.25%
Other Child	25,141	21	0.08%	0.20%
Family Adult	53,348	584	1.09%	0.77%
Other Adult	64,351	100	0.16%	0.09%
MCHIP	18,874	16	0.08%	0.15%
ACA	131,668	1,833	1.39%	1.18%

Table 5 below shows Alameda's approved claims per penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. Disabled and other adult which are often seniors constitute the most expensive groups of persons getting services.

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

Table 5: Average Approved Claims by Eligibility Category, FY 2018-19				
Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	41,190	1,325	$4,341	$2,935
Foster Care	1,160	*	n/a	$935
Other Child	25,141	21	$2,733	$1,333
Family Adult	53,348	584	$3,972	$2,582
Other Adult	64,351	100	$4,541	$2,819
MCHIP	18,874	16	$4,203	$1,436
ACA	131,668	1,833	$3,733	$3,065

Children 12 and under rarely need treatment for SUD. Foster Care, Other Child and Maternal and Child Health Integrated Program (MCHIP) include children of all ages contributing to a low penetration rate.

Table 6 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of service usage by clients in FY 2018-19. The largest group of clients were served in the NTPs followed by outpatient.

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

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2018-19			
Service Categories	**# of Clients Served**	**% Served**	**Average Approved Claims**
Narcotic Tx. Program	2,404	56.6%	$4,122
Residential Treatment	338	8.0%	$4,672
Res. Withdrawal Mgmt.	*	n/a	$1,025
Ambulatory Withdrawal Mgmt.	-	-	$0
Non-Methadone MAT	199	4.7%	$445
Recovery Support Services	*	n/a	$2,910
Partial Hospitalization	-	-	$0
Intensive Outpatient Tx.	349	8.2%	$4,197
Outpatient Drug Free	950	22.4%	$2,587
TOTAL	**4,245**	**100.0%**	**$4,124**

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

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

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

Opioid dosing is made available within one day after assessment and evaluation on average in the NTP programs in Alameda which is similar to statewide.

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

Table 7: Days to First Dose of Methadone by Age, FY 2018-19						
	Alameda			Statewide		
Age Groups	Clients	%	Avg. Days	Clients	%	Avg. Days
Ages 12-17	-	-	-	*	n/a	n/a
Ages 18-64	1,771	76.3%	<1	25,547	79.7%	<1
Ages 65+	551	23.7%	<1	*	n/a	n/a
Total Count	**2,322**	**100%**	**<1**	**32,047**	**100%**	**<1**

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

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

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

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

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

For an initial year of DMC-ODS services, this is a high rate of access to non-methadone medications and can to linked to HAART promotion and support of these medications at two sites in the county, despite the extra costs associate with billing and initial phases of treatment. Clients in the focus group were very complimentary of this provider and the client centered approach to care for addiction treatment.

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

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2018-19								
	Alameda				Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	-	-	n/a	*	n/a	*	n/a
Ages 18-64	166	5.4%	*	n/a	2,356	3.7%	945	1.5%
Ages 65+	33	5.1%	*	n/a	*	n/a	*	n/a
TOTAL	**199**	**5.3%**	**28**	**0.7%**	**2,553**	**3.4%**	**1,002**	**1.3%**

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

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

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

Table 9 show two aspects of this expectation — (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

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

This is a modest level of transitions to a lower level of care and can be seen as a baseline for year one to improve from. This is a new CMS measure that is very important in terms of continuity of care and sustained recovery of time.

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

Table 9: Timely Transitions in Care Following Residential Treatment FY 2018-19				
	Alameda (n= 7,085)		Statewide (n= 17,046)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	19	5.0%	893	5.2%
Within 14 Days	34	8.9%	1,256	7.4%
Within 30 Days	47	12.3%	1,561	9.2%
Any days (TOTAL)	**68**	**17.8%**	**2,161**	**12.7%**

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

Access Line Quality and Timeliness

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

Table 10 shows Access Line critical indicators from July 1, 2018 through June 30, 2019. The call center is operated by a non-profit contract agency and does not have three-way calling capacity. They reported problems with referral agencies not answering the phone to take appointment calls and other difficulties, but in general the statistics for year one were typical of many call centers starting services. The process and linkage to residential and withdrawal management placements are the focus of two of their Performance Improvement Projects to enhance timeliness and reduce dropouts. Some problems were reported with Spanish speaking callers.

Table 10: Access Line Critical Indicators, August 10th, 2018-July 10, 2019

Table 10: Access Line Critical Indicators August 10th, 2018 - July 10th, 2019	
Average Volume	616 calls per month
% Dropped Calls	4.0%
Time to answer calls	15 seconds
Monthly authorizations for residential treatment	Call center does not provide authorizations for residential treatment.
% of calls referred to a treatment program for care, including residential authorizations	58% of callers screened for trt are linked to care through the Access Line, Alameda has four special “gates” for residential treatment authorizations, access routes requests to them
Non-English capacity	The Access Call Center uses Language Line Solutions, which is provided through Alameda County.

High-Cost Beneficiaries

Table 11a provides several types of information on the group of clients who use a substantial amount of DMC-ODS services in Alameda. These persons, labeled in this table as high-cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $8,683 in approved claims per year. The table lists the average approved claims costs for the year for Alameda HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes. To provide context and for comparison purposes, Table 11b provides similar types of information as Table 11a, but for the averages for all DMC-ODS counties statewide.

Alameda has 11 percent HCBs and links this to “revolving door” at WM and residential.

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

Table 11a: High Cost Beneficiaries by Age, Alameda, FY 2018-19						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	37	3	8.1%	$10,869	$32,607	24.8%
Ages 18-64	3,078	132	4.3%	$11,904	$1,571,341	12.8%
Ages 65+	646	8	1.2%	$11,864	$94,911	3.1%
TOTAL	**3,761**	**143**	**3.8%**	**$11,880**	**$1,698,859**	**11.0%**

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

Table 11b: High Cost Beneficiaries, Statewide, FY 2018-19					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	2,978	25	0.8%	$11,297	$282,432
Ages 18-64	63,116	4,048	6.4%	$13,344	$54,017,855
Ages 65+	7,770	199	2.6%	$13,279	$2,642,488
TOTAL	**73,864**	**4,272**	**5.7%**	**$13,329**	**$56,942,775**

Residential Withdrawal Management with No Other Treatment

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

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

Table 12: Residential Withdrawal Management with No Other Treatment, FY 2018-19				
Alameda			**Statewide**	
	# WM Clients	**% 3+ Episodes & no other services**	**# WM Clients**	**% 3+ Episodes & no other services**
TOTAL	-	-	3,105	1.9%

Asterisks and n/a indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). *Alameda WM was not certified and could not bill but served 1,531 clients in WM in FY 2018-19 in Cherry Hill WM.*

Use of ASAM Criteria for Level of Care Referrals

The clinical cornerstone of the DMC-ODS Waiver is use of ASAM Criteria for initial and ongoing level of care placements. Screeners and assessors are required to enter data for each referral, documenting the congruence between their findings from the screening or assessment and the referral they made. When the referral is not congruent with the LOC indicated by ASAM Criteria findings, the reason is documented. Alameda had a very high congruence between ASAM findings and the referrals to treatment. Matching these is intended to optimize meeting clients SUD needs in treatment.

Table 13: Congruence of Level of Care Referrals with ASAM Findings, December 2017-June 2018

Table 13: Congruence of Level of Care Referrals with ASAM Findings, December 2017 – June 2018						
Alameda ASAM LOC Referrals	**Initial Screening**		**Initial Assessment**		**Follow-up Assessment**	
If assessment-indicated LOC differed from referral, then reason for difference	**#**	**%**	**#**	**%**	**#**	**%**
Not Applicable - No Difference	1,696	85.27%	2,065	88.32%	3,073	88.84%
Patient Preference	116	5.83%	145	6.20%	51	1.47%
Level of Care Not Available	30	1.51%	*	n/a	*	n/a
Clinical Judgement	*	n/a	*	n/a	18	0.52%
Geographic Accessibility	-	-	*	n/a	-	-
Family Responsibility	-	-	*	n/a	-	-
Legal Issues	-	-	*	n/a	*	n/a
Lack of Insurance/Payment Source	-	-	16	0.68%	*	n/a
Other	145	7.29%	97	4.15%	306	8.85%
Actual Referral Missing	-	-	-	-	-	-
TOTAL	**1,989**	**100.0%**	**2,338**	**100.0%**	**3,459**	**100.0%**

Diagnostic Categories

Table 14 compares the breakdown by diagnostic category of the Alameda and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2018-19. Based on the services utilization patterns it is not surprising that opioids are the higher diagnostic category seen followed by other stimulants.

Many counties are seeing an increase in methamphetamine use and it is being mixed with other drugs including fentanyl with legal consequences for the users.

Alameda has a task force working on these issues and a prevention plan as well working to mitigation as much as possible related to youth and to overdose prevention. Many key officials are part of these groups providing leadership to assist in this public health epidemic.

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

Table 14: Percentage Served and Average Cost by Diagnosis Code FY 2018-19				
Diagnosis Codes	**Alameda**		**Statewide**	
	% Served	**Average Cost**	**% Served**	**Average Cost**
Alcohol Use Disorder	12.1%	$3,895	16.0%	$5,870
Cannabis Use	3.1%	$3,221	8.0%	$1,116
Cocaine Abuse or Dependence	3.7%	$4,501	2.4%	$5,342
Hallucinogen Dependence	0.1%	$1,256	0.3%	$4,353
Inhalant Abuse	-	-	-	$4,785
Opioid	68.2%	$4,324	45.4%	$3,372
Other Stimulant Abuse	12.5%	$4,011	25.1%	$4,865
Other Psychoactive Substance	-	$2,530	0.8%	$4,035
Sedative, Hypnotic Abuse	0.3%	$3,931	0.6%	$6,565
Other	0.1%	$4,442	1.4%	$3,730
TOTAL	**100%**	**$4,124**	**100%**	**$4,010**

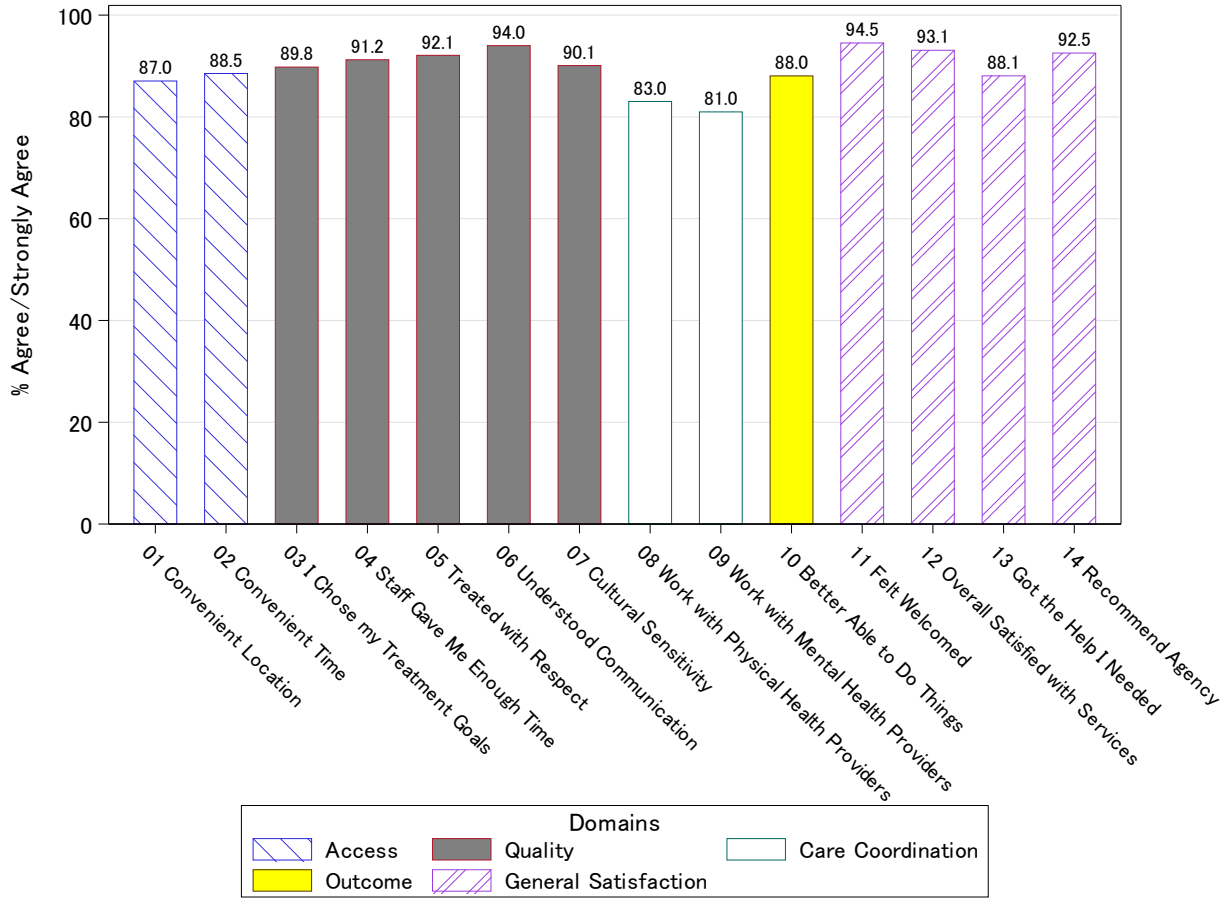
Asterisks, n/a and - indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

Client Perceptions of Their Treatment Experience

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

Alameda for the first year of services have very high ratings of adult satisfaction across all domains. The areas similar to other counties that are the lowest is the area of coordination with physical health and mental health which is still above the 80th percentile.

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, Alameda, TPS Results from UCLA (n=972)



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

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

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

higher rate of homelessness than the rest of the state and lower links to criminal justice system.

Table 15: CalOMS Living Status at Admission, CY 2018

Table 15: CalOMS Living Status at Admission, CY 2018				
Admission Living Status	**Alameda**		**Statewide**	
	#	**%**	**#**	**%**
Homeless	1,962	43.6%	24,020	26.2%
Dependent Living	936	20.8%	26,296	28.6%
Independent Living	1,597	35.5%	41,472	45.2%
TOTAL	**4,495**	**100.0%**	**91,788**	**100.0%**

Table 16: CalOMS Legal Status at Admission, CY 2018

Table 16: CalOMS Legal Status at Admission, CY 2018				
Admission Legal Status	**Alameda**		**Statewide**	
	#	**%**	**#**	**%**
No Criminal Justice Involvement	3,352	74.6%	54,930	59.8%
Under Parole Supervision by CDCR	120	2.7%	2,288	2.5%
On Parole from any other jurisdiction	45	1.0%	890	1.0%
Post release supervision - AB 109	799	17.8%	28,801	31.4%
Court Diversion CA Penal Code 1000	143	3.2%	1,259	1.4%
Incarcerated	*	n/a	389	0.4%
Awaiting Trial	*	n/a	3,221	3.5%
TOTAL	**4,495**	**100.0%**	**91,788**	**100.0%**

Table 17: CalOMS Employment Status at Admission, CY 2018

Table 17: CalOMS Employment Status at Admission, CY 2018				
Current Employment Status	Alameda		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	571	12.7%	12,134	13.2%
Employed Part Time - Less than 35 hours	347	7.7%	7,259	7.9%
Unemployed - Looking for work	1,270	27.2%	25,522	27.8%
Unemployed - not in the labor force and not seeking	2,307	54.7%	46,873	51.1%
TOTAL	**4,495**	**100.0%**	**91,788**	**100.0%**

The information displayed in Tables 18-19 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 18 indicates the percent of clients who left treatment before completion without notifying their counselors (Administrative Discharge) vs. those who notified their counselors and had an exit interview (Standard Discharge, Detox Discharge, or Youth Discharge). Without prior notification of a client's departure, counselors are unable to fully evaluate the client's progress or, for that matter, attempt to persuade the client to complete treatment. Alameda has a low rate of administrative discharges which makes their data more reliable in that persons are interviewed before they leave each level of care. There was a major data change this year at the state level and much data is still not accounted for in the "lift and shift from one data platform to another. Thus, we were told the data for this year of CalOMS was not complete for many counties.

Table 18: CalOMS Types of Discharges, Alameda and Statewide, CY 2018

Table 18: CalOMS Types of Discharges, CY 2018				
Discharge Types	Alameda		Statewide	
	#	%	#	%
Standard Adult Discharges	3,833	74.0%	43,654	49.6%
Administrative Adult Discharges	358	6.9%	33,344	37.9%
Detox Discharges	831	16.0%	8,470	9.6%
Youth Discharges	156	3.0%	2,609	3.0%
TOTAL	**5,178**	**100.0%**	**88,077**	**100.0%**

Table 19 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. This is the only statewide data commonly collected by all counties for use in evaluating treatment outcomes for clients

with SUDs. The first four rating options are positive. “Completed Treatment” means the client met all their treatment goals and/or the client learned what the program intended for clients to learn at that level of care. “Left Treatment with Satisfactory Progress” means the client was actively participating in treatment and making progress, but left before completion for a variety of possible reasons other than relapse that might include transfer to a different level of care closer to home, job demands, etc. The last four rating options indicate lack of satisfactory progress for different types of reasons.

More than 50 percent of the clients completed treatment which is a much higher rate than statewide and a very positive indication of treatment engagement and retention once the client is in treatment. And for those who did leave before completing treatment 23.4 percent still showed improvement in their SUD symptoms. Again, this is significantly better than statewide data.

Table 19: CalOMS Discharge Status Ratings, Alameda and Statewide, CY 2018

Table 19: CalOMS Discharge Status Ratings, CY 2018				
Discharge Status	**Alameda**		**Statewide**	
	#	**%**	**#**	**%**
Completed Treatment - Referred	2,690	52.0%	20,190	22.9%
Completed Treatment - Not Referred	97	1.9%	6,070	6.9%
Left Before Completion with Satisfactory Progress - Standard Questions	1,210	23.4%	12,220	13.9%
Left Before Completion with Satisfactory Progress – Administrative Questions	140	2.7%	7,259	8.2%
Subtotal	*4,137*	*80%*	*45,739*	*52%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	823	15.9%	16,253	18.4%
Left Before Completion with Unsatisfactory Progress - Administrative	191	3.7%	24,781	28.1%
Death	*	n/a	96	0.1%
Incarceration	*	n/a	1,208	1.4%
Subtotal	*1,041*	*20%*	*42,338*	*48%*
TOTAL	**5,178**	**100.0%**	**88,077**	**100.0%**

Performance Measures Findings—Impact and Implications

Overview

Access to Care PM Issues

- Services show access to new levels of care as required by DMC-ODS in most levels of care, except those where certification has not yet occurred or there have been documented billing delays.
- There have been challenges will smooth transitions to residential treatment as well as discharges post WM to other levels of care. Both of these are the focus of performance improvement projects and should be better reflected next year in their performance data. Due to lack of residential certifications, the performance data was not very helpful in tracking these issues in this first year of service delivery.
- Penetration rates for African American and White clients are high, but efforts are needed with Asian ethic groups related to access to care and fears related to stigma. This was part of the Cultural Competence Plan.
- MAT and Detention Health access and engagement efforts were excellent for treatment of SUD and showed in PMs as well as focus groups and other data.

Timeliness of Services PM Issues

- Timeliness of NTP services is excellent and offered appts is excellent as well.
- Timeliness of transitions in care from residential and WM can be improved similar to other counties.
- Use of clinician's gateway can enhance timeliness tracking and measures but support for the IT system and training for contractors in use of these tools and understanding of performance measures and quality metrics in general is needed.

Quality of Care PM Issues

- Quality of care in non-profit NTP HAART and Santa Rita Jail are models for others in MAT and outpatient services and case management.
- QA Plan and use of data was reflected in PMs
- More use of data dashboards linked to performance measures in quality work would help programs understand the quality of care system and their role in in better.

Client Outcomes PM Issues

- Both CalOMS and TPS showed client improvement and satisfaction as a result of services and these were priorities in the QI/QM Plan as well.

INFORMATION SYSTEMS REVIEW

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

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

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

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

ISCA Table 1: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	0%
Contract providers	100%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 1.98 percent.

The budget determination process for information system operations is:

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

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

☐ Yes ☒ No ☐ In Pilot phase

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported technology staff changes (in FTEs) for the baseline years are shown in ISCA Table 2.

ISCA Table 2: Summary of Technology Staff Changes

ISCA Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2	2	0	1

DMC-ODS self-reported data analytical staff changes (in FTEs) for the baseline year are shown in ISCA Table 3.

ISCA Table 3: Summary of Data and Analytical Staff Changes

ISCA Table 3: Summary of Data and Analytical Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2	1	0	1

The following should be noted regarding the above information:

- DMC-ODS staffing numbers reported in ISCA Tables 2 and 3 are less than adequate levels to support SUD technology and data analytical support roles.
- As Health Agency IT division also supports mental health program, that uses the same practice management and EHR systems as DMC-ODS. There is a high degree of interchangeability of staff skills and knowledge between the two programs for experienced and subject matter expert staff members.
- Mental Health program reports 42 FTE positions supporting technology and an additional eight FTE positions provide data and analytical support.
- DMC-ODS is in planning phase with County Human Resources to create additional technology positions.

Current Operations

- DMC-ODS continues to rely on two legacy IS systems to support clinical program operations - see Table 4.
- Contract provider agencies deliver almost all client direct services and are required to enter client data directly into legacy systems. Those providers who have their own local EHRs can use electronic batch file transfer process to upload direct services into legacy system too.

- DMC-ODS provides formal classroom training for all administrative and clinical users', including contract providers, before receiving their user ID and password. Legacy systems trainings are conducted weekly, monthly, or as-needed basis. Staff training attendance is tracked via Training Database.
- AC3 database (Community Health Record) is now operational. The database includes housing, homeless, jail, social services, and EMS (Emergency Medical System) information for over 40,000 clients served by Alameda County departments. One Detox treatment program, Cherry Hill was given access to AC3 database. Their treatment staff can access "Clients Shared Care Plan" document to answer questions: Who is working with my client? Where consent to treat was capture? How to respond to a client in crisis. This is a unique strength of Alameda County.

ISCA Table 4 lists the primary systems and applications the DMC-ODS county uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third-party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

ISCA Table 4: Primary EHR Systems/Applications

ISCA Table 4: Primary EHR Systems/Applications				
System/ Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
INSYST	Practice Management, Claim Processing	The Echo Group	28	BHCS
Clinicians Gateway	Clinical EHR	Platton Technologies	11	BHCS

Priorities for the Coming Year

- RFP System Replacement project: Replace INSYST system with new EHR.
- APTTUS - Phase II will be completed and go-live within 6-8 months.
- Increase Care Coordination by expanding DMC-ODS system to include Drug Court, Withdrawal Management programs and new County Jail SUD programs. Developing templates and security configurations.
- Phase 2, DMC-ODS implementation. Ongoing refinement of tools, templates and reporting available within Waiver compliant EHR. Taking input from contract providers for system improvements, including additional alerts and reports.
- Develop Salesforce community web portal for MHS/SUD Provider data review for monthly attestation.

- Develop forms and applications for Salesforce (CRM).
- Implement ANSI x12 – EDI 274 dataset for NACT data submissions.
- Develop reports for Timeliness monitoring.
- Windows 10 Implementation.
- AC3/Thrasys – Community Health Record (CHR)/Data Warehousing.
- AC3/Thrasys – CHR Power BI Dashboards and KPI Development.
- Network Adequacy Reporting Tool (NACT) – for both MHS & SUD.
- Mobile desktop support: Schedule weekly clinic visits to support off-site County staff.
- Develop process and technology tool to maintain and update staff and provider information for Final Rule (Provider Directory and NACT).
- Maintaining and recruiting IT staff.
- Configure firewall and network appliance to allow users outside of our firewall access to network resources.
- Implement beneficiary E-Signature via signature pads – start with a pilot project for Medication Consent template in MHS. Will expand to treatment plans and ROI templates, including tracking in CG.
- Adopt ImaVisor document management module for use by contractor agencies outside of County firewall with 42CFR Part 2 security requirements.
- Adopt MH and SUD Assessment forms to meet Final Rule requirements, including new SOGI (Sexual Orientation, Gender Identify) data tracking requirements.
- Create secure data portal for distributing reports via ShareFile.

Major Changes since Prior Year

- Successfully updated INSYST operating system to the latest - 10.4 version.
- Successfully submitted NACT Quarterly Data Submission for Q1 & Q2, 2019.
- Published Provider Directory and Rendering Service Providers on the Public Website to meet NACT requirements.
- DMC-ODS implementation. Continued refinement and addition of templates and treatment plans to support program needs and state-reporting requirements.
- Successfully collecting and reporting ASAM data to DHCS.

Other Significant Issues

- Rollout of Yellowfin, a business intelligence application, pilot project to support contract provider agencies was initiated during the past year, however pilot project has been further delayed. Yellowfin provides advance-level reporting and dashboards to support clinic operations.
- Double data entry is necessary for contract provider agencies who have a local in-house EHR system.

Plans for Information Systems Change

- Actively searching for a new system, project plan in place and project team assigned and active.
- To support search for a new system ACBH (Alameda County Behavioral Health) engaged Xpio Health for their project management and healthcare operations expertise.
- The project began during Fall 2019. As of early December, Xpio began to conduct interviews with ACBH executives, senior managers, and staff subject matter experts to identify and support current and future program and operational requirements.
- Tentative plans, as of December 2019, are to complete RFP development process and release it by late-Spring 2020.

Current Electronic Health Record Status

ISCA Table 5: EHR Functionality

ISCA Table 5: EHR Functionality					
		Rating			
Function	System/ Application	Present	Partially Present	Not Present	Not Rated
Alerts	Clinicians Gateway (CG)	X			
Assessments	CG	X			
Care Coordination	CG	X			
Document imaging/storage				X	
Electronic signature—client				X	
Laboratory results (eLab)				X	
Level of Care/Level of Service	CG	X			
Outcomes	CG/OA	X			
Prescriptions (eRx)				X	
Progress notes	CG	X			

Referral Management	CG	X			
Treatment plans	CG	X			
Summary Totals for EHR Functionality:		**8**	**0**	**4**	**0**

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

- Clinicians Gateway (CG) is a legacy EHR system that originally supported California Short-Doyle/Medi-Cal mental health program. ACBH contracted with CG to modify clinical workflow processes, add new functionality and edits to implement DMC-ODS waiver requirements.

Clients' Chart of Record for county-operated programs (self-reported by DMC-ODS):

☐ Paper ☐ Electronic ☒ Combination

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

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

ISCA Table 6: ASAM LOC Referral Data, CalOMS, and TPS Summary of Findings			
	Yes	**No**	**%**
ASAM Criteria is being used for assessment for clients in all DMC Programs.	x		100
ASAM Criteria is being used to improve care.	x		
CalOMS being administered on admission, discharge and annual updates.	x		
CalOMS being used to improve care. Track discharge status. Outcomes.	x		
Percent of treatment discharges that are administrative discharges.			35
TPS being administered in all Medi-Cal Programs.	x		

Highlights of use of outcome tools above or challenges:

- More than half of the clients in CalOMS showed improvement.
- TPS was a positive overall rating for the first year though there was some variability with some provider sites.

Drug Medi-Cal Claims Processing

- DMC-ODS claim submissions to DHCS for FY 2018-19 were generally submitted timely.
- Claims were underrepresented due to PED sites not being approved yet

Special Issues Related to Contract Agencies

- Double data entry is generally required for agencies who have their own local EHRs, as they also are required enter data into CG and INSYST.
- Providing the Detox Treatment program access to AC3 database (Community Health Record) provides previous treatment history and engagement information for Cherry Hill. Detox staff can access “Clients Shared Care Plan” that includes data across Alameda departments to include housing, homeless, jail, social services, and EMS information.

NETWORK ADEQUACY

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

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

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

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

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

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

CalEQRO reviewed separately and with Alameda county staff all documents, data and maps submitted to DHCS. CalEQRO also reviewed the special form created by CalEQRO for alternative access standard zip codes and efforts to resolve these access issues. There were two zip codes with approved alternative access standards. These two zip codes have low populations in Medi-Cal and using services and are in a remote area of the county near Livermore. They were all in the eastern areas of the county and Alameda is working with an existing NTP who is trying to establish a new site to meet the requirements for this area. CalEQRO met with this NTP provider (Heart) and did a focus group at the site. Clients felt the provider was flexible and open to take home options to improve challenges with access for those who live at a distance.

The county identified the closest providers for youth, adult, and NTP services for all zip codes in their NACT form and those with alternative access standards (AAS) were in the eastern and central areas of the county. Many contracts were added with surrounding counties providers for convenience such as Contra Costa and Santa Clara and also San Francisco. The two AAS zip codes with longer time/distance standards impacted 39 people based on the April data. Average of 48 minutes driving time for clients who lived in these zip codes and distances were 17.21 miles average but in heavy traffic. Closest DMC-ODS provider is in Manteca (Aegis).

Plan of Correction to Meet NA Standards

To meet the required standards Alameda County was working with a local NTP provider to expand and add a new site in the needed area of the county. The providers who serve clients in this area are also trying to be flexible where clinically appropriate with task home doses There are also two FQHC clinics where MAT services may be able to be purchased or arranged for. There are also some FQHCs with DMC-ODS certification. There were some technical questions on licensing, certification, and billing related to the NTP and FQHC providers which CalEQRO will refer to DHCS. Per Alameda leadership the opening of a freestanding NTP in Dublin, Livermore/Pleasanton was not viable due to no landlord being willing to rent to an NTP program, and the proposed provider did fiscal analysis and did not recommend free standing site due to low client presence in the area, so an alternative is being developed with telehealth prescribing or partnership with an FQHC for MAT services which is now being worked on.

CalEQRO will follow up on this action plan for this zip code area with AAS in the following review.

In addition, Alameda County monitors transportation needs of members to support access to care. Many programs have a variety of supports for clients to assist with

transportation in addition to trying to use the health plan transportation. Clients none the less reported that transportation was a challenge particularly for methadone which is a daily service seven days per week and very early. This was shared with the County.

DHCS provided a timely response to the Alameda County Alternative Access Application.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Alameda County PIPs Identified for Validation

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

Clinical PIP— Recovery Coaches for Withdrawal Management

Date PIP Began: 10/1/19 **Status of PIP:** Active and ongoing

Brief Description of the problems the PIP is designed to address: Many clients were leaving WM and not engaging in any services after discharge. Soon thereafter they would return having relapsed and returned to drug and alcohol use. Current methods of discharge planning and support/engagement is not working. One Recovery coach is being hired and trained as an intervention to engage with clients being admitted to WM to support them in seeing the need for ongoing support and work on recovery and not just momentary withdrawal from drug use.

PIP Question:

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

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

Does providing recovery coaches to follow-up with WM clients who are assessed as needing outpatient/intensive outpatient services result in a 20% increase in engagement with outpatient/intensive services and 20% improvement in outcomes post-discharge?

Indicators:

Alameda listed the following PIP indicators:

1. Percent of WM clients discharges connected to OP/IOP (Outpatient/Intensive Outpatient) within 30 days of discharge;
2. Percent engaged in OP/IOP at least 30 days following intake;(retention)
3. Percent engaged in OP/IOP services at least 60 days following intake;(retention)
4. Percent successfully discharged from OP/IOP services (CalOMS);
5. Percent who return to WM;

Interventions:

Alameda cited the following interventions:

1. Addition of Recovery Coach during WM Intake; who will provide a set of support services including transportation, MI (Motivational Interviewing), reminders, help with childcare, logistics;
2. Contact after 72 hours of admission and regularly thereafter
3. Regular contact in OP for at least 60 days following intake
4. Document intervention strategies and needs

Results/Impact upon Clients:

Alameda cited the following client outcomes:

1. Only first quarter of PIP had progressed. No data had yet been analyzed and available.

Technical Assistance Provided: Several sessions provided in the development to document the training of the recovery coach and the exact interventions.

PIP Score: **52 %**

Non-Clinical PIP—Improving Timely Access to Residential Treatment

Date PIP Began: 8/1/19 **Status of PIP:** Active and ongoing

Brief Description of the problems the PIP is designed to address: The goal of the PIP is to improve the effectiveness and efficiency of the referral process from request to

the placement into residential treatment. This includes the timeliness from request to assessment to admission, the drop out and no-show rate, and to make sure there is efficient use of the vacant residential treatment beds.

PIP Question:

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

Does implementation of 1) improved processing procedures for individuals wanting access to residential treatment, 2) 3 way calling protocol for intake appointments at the access call center, and 3) a bed availability mobile resource application improve timeliness of access to residential treatment by 20% above current baselines and improve bed utilization of residential treatment beds by 20%?

Indicators:

Alameda County listed the following PIP indicators:

1. Percentage of residential beds utilized by clients;
2. Average time from referral screening to first schedule treatment service appointment;
3. Average time from referral screening to first residential treatment service appointment;
4. Percent of three-way calls between residential treatment providers, referral counselors, with the intent to schedule a residential services intake appointment for the beneficiary; and
5. Percent of providers who update their bed availability at least once per day.

Interventions:

Alameda cited the following interventions:

1. Modification of procedures for clients who have requested services while intakes are being scheduled and linked to care;
2.Addition of three-way calls to link clients to assessments at the residential treatment centers;
3. Add mobile residential beds application for tracking resources to help staff have immediate knowledge of vacant bed resources for clients requesting care.

Results/Impact upon Clients:

Alameda cited the following client outcomes:

1. There are no data analysis yet based on this PIP. Therefore, I cannot do the outcomes analysis. The data analysis will be done when they have their next review

and there is data on results from multiple quarters or if they ask for help before the next review.

Technical Assistance Provided: BHC provided several Go to Meeting sessions, reviewed drafts and gave comments, discussed merits of interventions based on experience of other counties, indicators, methods of data captures, use of data for baseline, importance of at least quarterly tracking, though monthly would be better. Recommended continued consultation if improvements were not evident to consider what other changes could be made to improve impacts. Asked for regular updates to lead reviewer who will be the same next year.
.

PIP Score: **60 %**

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

PIP Table 1: PIP Validation Review

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

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

PIP Table 2: PIP Validation Review Summary

PIP Table 2: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	13	15
Number Partially Met	0	0
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating Clinical: 13 x 2 + 0 /50=52% Non-clinical: 15 x 2 +0 /50=60%	**52%**	**60%**

PIP Findings—Impact and Implications

Overview

Both PIPs address typical issues common to the DMC-ODS programs in their initial years of start-up related to timeliness of residential treatment with the introduction of new authorization processes, and also continuity of care post withdrawal management trying to link clients to outpatient and aftercare treatment. The designs include interventions used by other DMC-ODS counties to improve these issues and systems.

Access to Care Issues related to PIPs

Both PIPs link to treatment access. The clinical PIP works to improve access to outpatient and intensive outpatient after WM. The non-clinical PIP was to improve access to residential treatment in an improved timely manner. Many counties have had problems with the processes involved with the assessment and determination of medical necessity and placement into residential care delaying actual access into treatment and discouraging clients who are often ambivalent about committing to abstinence and working on recovery.

Timeliness of Services Related to PIPs

The non-clinical PIP is focused on the timelines problem that Alameda has related to promptly placing clients into residential treatment. Delays caused by a variety of factors

in the intake and screening processes need careful re-thinking to facilitate prompt engagement.

Quality of Care Related to PIPs

Continuity of care related to services post WM is critical to avoiding relapse and moving towards recovery. This is the focus of the clinical PIP and a positive metric linked to quality and sustained wellness. It is one of the measures CMS is promoting as a voluntary measure nationwide for SUD.

Client Outcomes Related to PIPs

The indicators measured in both PIPs will be good indicators for outcomes for improvement in continuity of care, and also in access to residential treatment when it is most in need. This should be also reflected in improved CalOMS outcomes and TPS findings.

CLIENT FOCUS GROUPS

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

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

Focus Group One: Adult Residential Group

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

There were 14 clients, and three were 18 to 24-year old's, nine were 25 to 59-year old's, and two were seniors. Thirteen spoke English and one was bilingual. Seven were white, four were Latino, two African American, and one was Latino/Native American. Eight were male, and six were female.

Number of participants: 14

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

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.6	4-5
2. I got my assessment appointment at a time and date I wanted.	4.8	4-5
3. It did not take long to begin treatment soon after my first appointment.	4.8	3-5
4. I feel comfortable calling my program for help with an urgent problem.	4.6	3-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.6	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.6	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.7	3-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.6	3-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.5	2-5

The following comments were made by some of the 14 participants who entered services within the past year and who described their experiences as follows:

- CURA program is amazing because of its counselors and has helped so much with recovery. I would recommend to others.
- They save lives and have given me what I needed to succeed, best program I have seen and been in.
- They give clients jobs who have lived it and it builds confidence and trust and there is a full safety net of support, kindness, respect and attention.

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

- More one on one quality time with counselors would be good. They seem to have so much paperwork and less time now.
- Some people really need more than 90 days to make the transition to abstinence stick and especially during the transition to the community. Can out counselors stick with us for another 90 days while we transition, that would be ideal.
- Special help with child custody is sometimes needed, complex and hard but so important to success.

- Had been calling access for a month asking for a specific program, but when said I would go anywhere and I got CURA a few days later and is has been good.
- Took three weeks from Santa Rita to CURA but started treatment the same day and will stay till I can make it in the community.
- If relapse given 5$ cash and BART ticket back to WM but not put on street, and then can come back.

Recommendations for improving care included the following:

- GED classes to help with job options, computers especially.
- Acupuncture for pain and cravings on site.
- More Recovery Residences for women .
- Support MAT and choice of medications as part of program.
- Want to call my family when I need emotional support not just twice per week.
- Trouble with transferring my Medi-Cal.
- More family visits and involvement in recovery plan .
- Help with housing and stability after discharge, support should not end at the door.

Interpreter used for focus group 1: No

Focus Group Two: Latino/Hispanic Adult Group

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

Only two clients presented for the group and the staff said there was a problem because the main Spanish speaking counselor was gone the last month, so no one was available who knew the clients well to organize it. Nonetheless, the group went forward with the two adult participants.

Number of participants: 2

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

explained that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement.

Participants described their experience as the following:

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

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

- Counselor allows me to give opinions and express feelings, deal with my anger and abuse, work on issues of jealousy and male chauvinist issues.
- I had one year and two months sober and then relapsed and they helped me become sober again and get my son back. I have been clean again for five months. This has made a big difference in my life.

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

- I called on a Thursday and was able to start services on Monday.
- One counselor needs to listen more and not just talk about problems.
- I appreciate the couple therapy and anger management too.
- We can come in if we need help when things are urgent or there is a crisis.

Recommendations for improving care included the following:

- Work with the whole family and don't let denial of the reality of addiction get in the way of moving ahead. Ignoring it leads to a dark road.

- Keep a wide support network to look at the whole person, show respect and be honest

Interpreter used for focus group two: Yes

Focus Group Three: Adult NTP Group

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

Large diverse group of 15 met in community room at HAART Oakland with CFM and two review staff to share their experiences of the program. Group was a mix of new and long-term clients of mixed racial background and co-ed representation. There were also several seniors, but most were adults 22-60 years of age.

Number of participants: 15

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

Participants described their experience as the following:

Question	Average	Range
1. I easily found the treatment services I needed.	4.0	3-5
2. I got my assessment appointment at a time and date I wanted.	4.0	3-5
3. It did not take long to begin treatment soon after my first appointment.	4.2	3-5
4. I feel comfortable calling my program for help with an urgent problem.	4.4	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.5	4-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.3	4-5

Question	Average	Range
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.6	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.2	3-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.5	4-5

The following comments were made by some of the 6 participants who entered services within the past year and who described their experiences as follows:

- Counselor worked with me and my Probation Officer to get me started and helped me a lot.
- They really care about you here not like some other programs.
- I can come by and talk about new problems and they give me time.
- You don't feel like a number here, it is not just about the money.
- Wish I found this place earlier in my life, things would have been easier.
- I found some friends here too and it feels more like a community for treatment.

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

- This is the best MAT program in the County everyone should come here.
- I wish my counselor had more time as they are great and can help with lots of things besides medication and abstinence.
- The director needs to supervise all new staff members, so they are as good as the ones who have been here a long time.
- I hate it when my counselor leaves. Can we pay them more, so they don't leave?

Recommendations for improving care included the following:

- Keep adding more time for groups and individual support especially help with housing and when we transition to less meds or to the new ones.
- More social support groups here so we can build community too.
- More ways to keep our counselors and doctors and nurses. It is hard when they leave.

Interpreter used for focus group three: No

Client Focus Group Findings and Experience of Care

Overview

Focus groups yielded rich picture of programs improving client's SUD conditions and also some areas of improvement. Generally based on comments from participants, access to treatment was working well if clients asked for next available service option versus a specific program and as expected it could take longer with a release from a detention setting. Transitions in care to outpatient and recovery residence levels needed some work with support services and it appeared that clients were not being followed with case management or recovery supports until they were stable at the next level of care.

Access Feedback from Client Focus Groups

- As reflected in comments general requests for service were easier to meet than access to a specific program site;
- Bilingual programs had more challenges with access and staffing than others;

Timeliness of Services Feedback from Client Focus Groups

- Timeliness was impacted by asking for specific programs or general access to care;
- Timeliness was an issue related to recovery residence for women which is frequently the step-down from residential linked to outpatient care.

Quality of Care Issues from Client Focus Groups

- MAT options in the residential setting may need more support and education and encouragement to be fully available to residents.
- For clients who have used opioids for chronic pain, some access to acupuncture could help prevent relapse as part of overall treatment approach and Medi-Cal does cover this, but would require coordination
- Family involvement plays a role with client motivation for treatment and recovery and should be considered as additional element in treatment planning.

Client Outcomes Feedback from Client Focus Groups

- Programs were moving clients towards positive outcomes with counseling and groups, but some clients felt they needed more time especially during transitions to community settings

- Outcomes and relapse risks heightened if recovery residences linked to outpatient were not available to persons coming out of residential with supports during transitions.
- Therapeutic alliances with counselors were strong and needed to be valued as part of the success in treatment process and successful outcomes, especially in the process of transfers.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	PM
Alameda was working to increase access to underserved populations and high-risk populations. They had done an update to their cultural competence plan and were working to implement new standards to address access issues for specific groups particularly the Asian communities.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
Planning effort, RFP, contracts and continued adjustments to the network showed clear efforts to expand and adapt to needs of clients with SUD in all areas of the community and particularly specific high-risk groups such as criminal justice and those impacting the emergency department.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
Excellent efforts with HIE, housing, law enforcement, education, mental health, hospital and primary care systems, and the health plans to link coverage and access systems.		

Timeliness of Services

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

KC Table 2: Timeliness of Care Components

KC Table 2: Timeliness of Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
Tracking systems in place with clinician gateway and new dashboards are good for tracking access and timeliness but need refinement and stabilization to confirm accuracy and consistency. Contractors asked for additional TA.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	PM
Methadone dosing is tracked from first walk into clinic site, access not routinely making referrals which is a recommended change.		
2C	Tracks and Trends Access Data from Initial Contact to First Non-Methadone MAT Appointment:	PM
This service is newly being implemented at other programs besides than at HAART which was doing a good job tracking access to care. Time to first dose of buprenorphine takes longer as client must first be tapered off opioids to begin new medications. Staff were trained and monitoring induction appropriately, but limited to one medical provider at this first review.		
2D	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	M
Mean is over state average and definition and understanding still not solid with staff includes pregnant women, medical conditions such a head injuries and heart issues, and self-declared. More work needed here, but tracking is built into clinician gateway and dashboards.		
2E	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	M
Tracked for residential and WM but transitions to lower levels of care not high at this time. PIP focusing on intervention using recovery navigator.		
2F	Tracks Data and Trends No Shows	NM
Not able to track at this time except in terms of referrals from Access never showing up at programs to whom they had been referred.		

Quality of Care

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

KC Table 3: Quality of Care Components

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
Despite needing more staff to accomplish the key tasks associated with the DMC managed care and quality duties, the commitment to these values and goals is clear in the organization from entry staff to management. It was evident in program design, problem solving approaches, fiscal priorities, and case conference discussions.		
3B	Data is used to inform management and guide decisions	M
Few counties have committed to having the entire network on the same computer system for treatment plans, assessments, notes, and authorizations and it will be a positive thing for both clients and staff over time. Just difficult for initial years with design and training and refinement of complex software in a rapidly changing/evolving environment. To achieve the full benefits of this, more staffing is needed in development and the help desk and training functions.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	PM
The provider network clearly respected and valued to senior DMC managers and saw them as committed and communicating on an ongoing basis. They did want more inclusion whenever possible in the decision making, problem solving process for SUD network expansion and also how to address new state mandates.		
3D	Evidence of an ASAM continuum of care	M
Alameda did an excellent job completing required levels of care for the Waiver and going beyond requirements in several areas such as the ED and Jail systems. Areas still needing expansion are youth residential and more MAT in remote areas of the county.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
Alameda has several NTPs and is expanding to outpatient MAT programs as well. In addition, outpatient medications are available at the Emergency Department as well as Santa Rita Detention Facility with counseling and other SUD treatments. FQHCs also have X-waivered prescribed who provide SUD medications including buprenorphine to clients assigned to their clinics with Medi-Cal.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	PM
The program has instituted regular ASAM trainings for staff and have very valuable case conferences with Dr David Mee-Lee to better understand how to apply those principles in clinical care monthly. This includes the contract providers and is extreme well received by the clinical staff. Nonetheless, as is typical with this major system change, there was evidence that some of the staff used to older models of care were still promoting program driven concepts of care such as “graduation” from residential and resistance to MAT as appropriate treatment. Thus, training and engagement of staff needs to continue to show the benefit of more science-based treatment approaches.		
3G	Measures clinical and/or functional outcomes of clients served	PM
Alameda participated in the October 2019 TPS survey and had overall positive results with a range of outcomes from different providers and sites which they will use for quality improvement. They had just received their data from UCLA at the time of the review and were just beginning to use it for QI. CalOMS was also used to show outcomes and progress in care in terms of both program completion and program progress in treatment goals.		
3H	Utilizes information from client perception of care surveys to improve care	PM
As noted above Alameda participated in TPS but did not have time to do follow up yet on the data which had just arrived from UCLA on their specific programs.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Excellent leadership team with commitment to quality and client service needs;
- Solid planning efforts leading to RFPs and contracts for 33 new and expanded contracts across the ASAM continuum of care;
- Above and beyond access activities in the Emergency Department and Santa Rita Detention Center for high-risk populations.

Opportunities:

- Refinement and re-design of access and authorization systems to link clients to residential treatment and WM services more rapidly and reduce dropouts and inefficient use of valuable treatment beds;
- Access call center linkage of clients with opioid use disorder to MAT services specifically NTPs such as HAART with a full range of treatment options as well as counseling/residential care;
- Addition of a residential treatment program for adolescents.

Timeliness of DMC-ODS Services

Strengths:

- Clinician's Gateway and new dashboard software established the infrastructure to track timeliness of services and other key metrics and support the managed care provider network, and it was made available to all contractors and county staff;
- First offered and routine appointments based on preliminary year one data appear to be within state standards systemwide.

Opportunities:

- Residential timeliness data which is the focus of a PIP is being working on for improvement through a set of interventions for improvement;
- Urgent conditions are over the state standard and also appear to need some study and refinement of the definition and process of linkage to services to be within the required standard.

Quality of Care in DMC-ODS

Strengths:

- Establishing Clinician's Gateway and Dashboards regularly shared to improve communication and coordination of care with the full provider network was a very positive actions, only a few counties have taken this step, though many see this as a critical system need;
- Solid QI/QM leadership and plan including cultural competence focus on underserved and high-risk populations with standards and goals;
- Expanded ASAM continuum of care with more attention to MAT needs of acute care patients in the emergency departments and detention centers.

Opportunities:

- Expanded staffing is needed to successfully execute the Clinician Gateway/Dashboard initiatives as well as the QI/QM Managed Care work for SUD in a county as large as Alameda with the size of your provider network and complexity of the IT initiative; staffing levels similar to Riverside and San Diego are needed to support this important work;
- Continue to complete annual updates to the Cultural Competence Plan until DHCS provides the new definitions and standards that have been requested.

Client Outcomes for DMC-ODS

Strengths:

- CalOMS data related to discharge status show that more than 50% of the clients served have improved in services and completed programs they were admitted to;
- Planning processes used in the DMC-ODS tracked needs of ethnic populations and set goals and standards of improvements for the future.

Opportunities:

- TPS data from the first year of surveys can be analyzed by program site to look at outliers both high and low as well as comments from clients for improvements and best practices;

- To support the success of residential transitions a master plan for recovery residences including for women and families would be helpful as a tool for the future to enhance long-term outcomes;
- Helpline for IT system support is backed up and not functioning for clinical and program staff in real time when they need it to do critical work; resources urgently needed to address core infrastructure in this area.

Recommendations for Alameda DMC-ODS:

1. Add IT staff capacity to the Clinician Gateway help desk as well as the project overall linked to the dashboard, training and management functions as this is a very positive commitment to quality and efficiency, but does take up front resources to support your provider network adequately and also assist with efficient support on their many billing and documentation related questions;

2. Continue efforts to examine and improve access and timeliness issues linked to placement in residential treatment to reduce wait times, dropouts, and underutilization of residential treatment beds and intake appts;

3. Access Call Center staff, with appropriate training and supervision, should refer persons with opioid use disorders and alcohol use disorders to NTPs and MAT resources as well as to counseling/residential treatment;

4. Continue efforts to add an adolescent residential treatment provider with other counties to address this gap in the continuum for youth;

5. Include more contract agencies in the Quality Improvement and Quality Assurance processes including PIPs and financial claiming processes/work groups to support these functions since they are core to service delivery; and

6. Add additional staff to Quality Assurance/Improvement functions to assist with chart reviews and training at the contract agency level. With 16 programs new to Medi-Cal billing and the level of staff turnover described there is significant risk of audit problems without more hands-on chart reviews at least for the next two to three years while agencies develop more internal capacity and staffing.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: County Highlights

Attachment E: Continuum of Care Form

Attachment F: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: On-site Review Agenda

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

Table A1—CalEQRO Review Sessions - 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 performance measures
Quality Improvement Plan, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care coordination with DMC-ODS
ASAM fidelity and structure of the continuum of care
Medication-assisted treatments (MATs)
MHP coordination with DMC-ODS
Youth Services and coordination
Criminal justice coordination with DMC-ODS
Clinic managers group interview – contracted and county
Residential Treatment Center Site visit and focus group with residents
NTP site visit staff interview and focus group with clients
Clinical line staff group interview – county and contracted
Access Call Center site visit and Focus group with line staff
Client/family member focus groups such as adult, youth, special populations, and/or family
Site visits such as residential treatment (youth, perinatal, or general adult), WM, access center, MAT induction center, and/or innovative program
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

Attachment B: Review Participants

CalEQRO Reviewers

Rama K Khalsa, PhD Lead Reviewer
Jan Tice, Second Reviewer
Bill Ullom, IS Reviewer
Diane Mintz, CFM Consultant
Erin Johnson, Research Asst

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

Sites for Alameda County DMC-ODS Review

DMC-ODS Sites:

County Behavioral Health and Recovery Services

2000 Embarcadero Cove, Oakland, CA

1900 Embarcadero Cove, Oakland, CA

Contract Provider Sites:

La Familia Outpatient, 1319 Fruitvale Ave, Oakland, CA

Access Call Center, 3155 Kearney St, suite 150, Fremont, Ca 94538

CURA Residential, 37437 Glenmoor Drive, Fremont, CA.

HAART, 20094 Mission Blvd, Hayward CA.

Table B1 - Participants Representing Alameda County DMC Review			
Last Name	**First Name**	**Position**	**Agency**
Arrieta	Rudy	QM Director (Retired)	ACBH
Ball	Angela		Horizon
Buchanan	Toki	Network Office	ACBH
Capece	Karen	Division Director, Utilization Management	ACBH
Carlisle	Lisa	CYASOC Director	ACBH
Chau	Mandy	Finance	ACBH
Claassen	Emily		ACBH
Coady	Kim	Interim QA Administrator	ACBH
Duvall	Cammie	QA Auditor	ACBH
Diedrick	Sheryl	Information System Analyst	ACBH
Engstrom	John	QI Manager	ACBH
Fletcher	Lena	Network Office	ACBH
Fultz Stout	Laura	Network Office	ACBH
Guinn	John		Cherry Hill
Hobbs	Nathan	Alcohol & Drug Program Administrator	ACBH
Houston	Fonda	Network Office	ACBH
Jones	Kate	AOASOC Director	ACBH
Judkins	Andrea	Senior FFS	ACBH
Kasdin	Lucy	Health Care for the Homeless	HCSA
Kemp	Angelito		CPINC
Kline	Steve	Information Systems	ACBH
Lai	Sophia	Sr. Program Specialist QI	ACBH
Lopez	Rickie	Network Office Director	ACBH
Louie	Jill	Budgeting Officer	ACBH

Table B1 - Participants Representing Alameda County DMC Review			
Last Name	**First Name**	**Position**	**Agency**
Loveseth	Sharon	SUD Program Specialist – QA	ACBH
Ly	Theresa	SUD Program Specialist	ACBH
McCray	Dennis		CPINC
Meinzer	Chet	ISM	ACBH
Moore	Danielle	Network Office	ACBH
Moore	Lisa	Provider Relations Director	ACBH
Murillo	Jacqueline	DMC-ODS Consultant	ACBH
Pallotta	Lani	Network Office	ACBH
Phipps	Brion	Quality Assurance Specialist	ACBH
Sanders	Tony	Interim QA Associate Administrator	ACBH
Schulz	Henning	Division Director – Adult Case Management	ACBH
Serrano	Cecilia	Finance Director	ACBH
Shallcross	Lori		ACBH
Smith	Freddie	Division Director	ACBH
Tribble	Karyn	Director	ACBH
Vargas	Wendi	Assistant Director of Network Office	ACBH
Virrey	Rommel	Finance	ACBH
Wagner	James	Deputy Director	ACBH
Wilson	Javarre	Ethnic Services Manager	ACBH

Attachment C: PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
DMC-ODS: Alameda County	
PIP Title: Recovery Coaches for Withdrawal Management Services	
Start Date 10/1/19: **Completion Date** 12/31/20 **Projected Study Period** (#of Months): **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** 12/10/19: **Name of Reviewer**: Rama Khalsa	**Status of PIP – Active and Ongoing** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): Clients were leaving the WM and not connecting to any services after discharge and then being re-admitted at a high rate after discharge within the next 30 days. Thus it is a very expensive revolving door with poor outcomes. Key intervention is addition of a recovery coach to follow clients from admission through outpatient treatment for 60 days, and provide MI and transportation, logistics, remove barriers to participation, encouragement etc.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1 Was the PIP topic selected using stakeholder input? Did <County> develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☒ High volume services ☐ Care for an acute or chronic condition ☒ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	☒ Met ☐ Partially Met ☐ Not Met	

Demographics: ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Unable to Determine	
	Totals 0	**3** Met **0** Partially Met **0** Not Met **1** UTD
STEP 2: Review the Study Question(s)		
(1) Will adding the recovery coach in the PIP improve client satisfaction, engagement, retention and positive treatment outcomes?	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	
	Totals 0	**0** Met **0** Partially Met **0** Not Met **1** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals 0	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:*	☒ Met ☐ Partially Met ☐ Not Met	

(1)	☐ Unable to Determine	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☒ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Listed in the chapter
	Totals 0	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling used
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees?	☐ Met ☐ Partially Met ☐ Not Met	

_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☒ Not Applicable ☐ Unable to Determine	
	Totals 0	**0** Met **3** NA **0** Partially Met **0** Not Met **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☐ Provider ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Outcomes tool ☒ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met	

Did the plan include contingencies for untoward results?	☐ Unable to Determine	
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Title: Role: *Other team members:* Names:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 0		**6** Met **0** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:* See chapter description	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	
Totals 0		**0** Met **0** Partially Met **0** Not Met **1** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	First quarter data analysis not yet available
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met	

Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Not Applicable ☒ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? *Indicate the time periods of measurements*: quarterly *Indicate the statistical analysis used*: pre/post *Indicate the statistical significance level or confidence level if available/known:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Analysis not completed yet
	Totals 0	**0** Met **0** Partially Met **0** Not Met **4** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated? quarterly* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Quarterly data not yet available for analysis

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

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	Not yet available

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Good design and start. Positive model focused on common problem but initial data not yet available to test first intervention		
Recommendations: Document intervention carefully and do thorough analysis and stay in touch for TA		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	

PIP item scoring

13 Met

0 Partially Met

0 Not Met

3 Not Applicable
11 UTD

PIP overall scoring

((13 x 2) + 0) / (25 x 2) = 52% score of PIP

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

GENERAL INFORMATION

DMC-ODS: Improving Timely Access to Residential treatment and care

Start Date: 8/1/19 **Completion Date: 12/31/20** **Projected Study Period** 16: **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: December 10, 2019 **Name of Reviewer**: Rama Khalsa	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted

Brief Description of PIP: PIP is to improve timeliness and engagement of clients and efficiency of process linking clients into residential care. There have been problems with this process linking access to assessments at residential care to vacant beds and having clients accept the placements. PIP proposes 3 sets of interventions to improve the current problems of timeliness, drop-outs, inefficient use of beds, lack of knowledge of where the empty beds are, helping clients link to assessments into care promptly and then go into care.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments

1.1 Was the PIP topic selected using stakeholder input? Did Alameda develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	PIP team includes SUD client input but to the extent there is no improvement from the interventions more input may be needed.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data clearly showed problems in timeliness and efficient use of beds and engagement.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This is a key issue for the Waiver related to an important level of care.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 0		**4** Met **0** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Will the 3 interventions reduce timeliness problem by 20% and improve efficient use of residential beds instead of leaving them vacant.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 0	**1** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☒ Referral ☐ Self-identification ☒ Other: ASAM Level of Care Results	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals 0	**2** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* See report narrative for indicators related to timeliness reduction from request to placement, bed utilization, coordination of care via three- way calling	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client-focused. ☒ Health Status ☒ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals 0	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling – not applicable
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals 0	**0** Met **0** Partially Met **0** Not Met **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Bed days, timeliness data, 3 way call success
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ASAM ☒ Claims ☐ Provider ☒ Other: Call log connections for appointments	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☒ Outcomes tool ☒ Level of Care tools ASAM ☒ Other: monthly claims log, daily client requests access call data linked to appts	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	.
6.6 Were qualified staff and personnel used to collect the data? *Project co-leaders :Lead data staff Sophia Lai* Name: Sophia Lai PhD Title: QI Director Role: Oversight of data analysis for PIPs *Other team members:* Names:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals 0	**6** Met **0** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:* *See report section on interventions*	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	First quarter data not available to do analysis of impact of interventions
	Totals 0	**0** Met **0** Partially Met **0** Not Met **1** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data from the first quarter was still being analyzed and was not available
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	"First quarter data not yet available
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: -Claims - encounter data during brief stay in residential WM and for treatment intake within 7 and 14 days post-discharge quarterly measurement Indicate the statistical analysis used: percentages- Indicate the statistical significance level or confidence level if available/known: _____% __x___Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	"

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interventions:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
Totals 0		**0** Met **0** Partially Met **0** Not Met **4** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Data from the first quarter was not available for analysis by CalEQRO
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	"
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	"

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	“
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	“
	Totals 0	**0** Met **0** Partially Met **0** Not Met **5** UTD

ACTIVITY 2: SCORING

PIP Item Scoring: **PIP Overall**

15 Met **((15 x 2) + 0) / (25 x 2) = *60% score of PIP***

0 Partially Met

0 Not Met

3 Not Applicable **10 Unable to Determine**

ACTIVITY 3: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	Not available

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

Conclusions:

Data was not available to do analysis of first quarter on the intervention

Recommendations:

Continue interventions and do analysis of each quarter of data before next review. Consult quarterly with lead reviewer.

Check one:

☐ High confidence in reported Plan PIP results

☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

☒ Confidence in PIP results cannot be determined at this time

Attachment D: County Highlights –

See information on Santa Rita Jail Services: Expanding Access to MAT in County Criminal Justice Settings (https://addoctopmfreeca/org/Resource-Library/Expanding-Access-to-MAT-in-County-Criminal-Justice-Settings)

Attachment E: Continuum of Care Form

Continuum of Care –DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Treatment Capacity:

County: **Alameda County** Review date(s): **December 10-12, 2019**

Person completing form**: Theresa Ly**

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

Percent of all treatment services that are contracted: 100%

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

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

All SUD treatment providers are required to provide case management services to coordinate care within the DMC-ODS and to provide access to and care coordination with other services such as mental health, primary care, social services, and other systems involved in a beneficiary's care. The Call Center also provides appropriate external resources (for example, referrals to housing resources, mental health resources, social services resources as requested or indicated) at time of screening and referral.

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

Monthly estimated billed hours of case management: **182**

Comments:

Case management is integrated into all DMC-certified programs (including OTP programs as of July 1, 2019). In addition, three of our four access points (Drug Court, SUD Helpline, and Criminal Justice Case Management program) provide care navigation services for designated clients. The case management hours above do not include these care navigation services.

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

Pick 1 or more as applicable and explain below:

1) Included with Access sites for linkage to treatment
2) Included with outpatient sites as step-down
3) Included with residential levels of care as step down

4) Included with NTPs as stepdown for clients in remission

Total Legal entities offering recovery services: **7**
Total number of legal entities billing DMC-ODS: 7
Choices: **Alameda Health Systems (AHS), Bi-Bett, Horizon, La Familia, Options, Second Chance, City of Fremont**

Comments:

Recovery Services are available at all outpatient/intensive outpatient sites (adult and adolescent) as a step down.

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

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

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

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

Comments:

N/A

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

Number of sites: 1
Total number of legal entities billing DMC-ODS: 0
Number of beds: 27
Estimated billed hours per month: 869
Pick 1 or more as applicable and explain below:

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

Choice(s): Freestanding

Comments:

All Level 3.2 WM is provided at Cherry Hill Detox/Withdrawal Management. Cherry Hill is still awaiting DMC certification, so it is not yet billing DMC. The number of beds at Cherry Hill Detox can fluctuate to some extent based on need. For this program, the contractor's maximum daily occupancy is 32.

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

Total legal entities in county: 7
In county NTP: Sites 7 Slots: 2,654
Out of county NTP: Sites 12 Slots: Enter number of slots.
Total estimated billed hours per month: 9280
Are all NTPs billing for non-methadone required medications? __x__yes ____no
Comments:

All NTP providers are able to bill for non-methadone medications (buprenorphine, suboxone and naloxone); however, NTP providers have not been billing for these medications very much, citing client disinterest in these medications.

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

Total legal entities: 3 Number of sites: 5
Total estimated billed hours per month: N/A

Comments:

La Familia & AHS have been selected to provide MAT services in their outpatient treatment sites, however they will not be starting these services until December 1, 2019. In addition, our newest outpatient provider (Asian American Recovery Services – Healthright 360) will offer MAT services at their Union City clinic, which is anticipated to open February 2020.

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

Total legal entities: 7 Total sites: 12
Total number of legal entities billing DMC-ODS: 7
Average estimated billed hours per month: 8,630

Comments:

We are in contract negotiations with an 8th entity to open an Outpatient/Intensive Outpatient program in Union City (Asian American Recovery Services – Healthright 360). Three adolescent outpatient clinics also provide services in addition to what is provided in their clinics at community sites, 19 high schools, continuation schools, and Juvenile Hall.

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

Estimated billed hours per month: see average estimated bill hours per month below
Total legal entities: 7 Total sites for all legal entities: 12

Total number of legal entities billing DMC-ODS: 7
Average estimated billed hours per month: 9,113

Comments:

See comment above. Adolescent services at community sites, however, do not include IOS services.

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

Total sites for all legal entities: N/A
Total number of legal entities billing DMC-ODS: N/A
Total number of programs: N/A
Average client capacity per day: N/A

Comments:

Alameda county does not contract for level 2.5 partial hospitalization programs

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

Total sites for all legal entities: 15
Total number of legal entities billing DMC-ODS: 15
Number of program sites: 15
Total bed capacity: 183
Average estimated billed bed days per month: 2,503

Comments:

Sites and legal entities are inclusive of adult 3.1 residential treatment providers and perinatal 3.1 residential treatment providers. Total bed capacity reflects bed capacity to cover 3.1, 3.3 and 3.5 levels of care.

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

Total sites for all legal entities: 2
Number of program sites: 2
Total number of legal entities billing DMC-ODS: 1
Total bed capacity: 40
(Can be flexed and combined in some settings with 3.5)

Comments:

Total bed capacity reflects bed capacity to cover 3.1, 3.3 and 3.5 levels of care

Level 3.5: Clinically Managed, High-Intensity Residential Services – 24-hour

structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.

Total sites for all legal entities: 15
Number of program sites: 15
Total number of legal entities billing DMC-ODS: 8
Total bed capacity: 183
(Can be flexed and combined in some settings with 3.5)

Comments:

Sites and legal entities are inclusive of adult 3.1 residential treatment providers and perinatal 3.1 residential treatment providers. Total bed capacity reflects bed capacity to cover 3.1, 3.3 and 3.5 levels of care.

3 of the 15 program sites were recently ASAM 3.5-certified, and ACBH anticipates they will start providing and billing for 3.5 level of care services approximately December 2019.

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

Number of program sites: N/A
Total number of legal entities billing DMC-ODS: N/A
Number of legal entities: N/A
Total bed Capacity: N/A

Comments:

ACBH does not contract for 3.7 ASAM services

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

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

Comments:

ACBH does not contract for level 4 ASAM services

Recovery Residences – 24-hour residential drug free housing for individuals in outpatient or intensive outpatient treatment elsewhere who need drug-free

housing to support their sobriety and recovery while in treatment.

Total sites for all legal entities: 8 sites (3 legal entities)
Number of program sites: Enter total number of program sites.
Total bed capacity: 77

Comments:

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

The Follow programs are pending DMC certification:

- Cherry Hill Residential Withdrawal Management – for 3.2 Withdrawal Management
- Horizon, Project Eden (East County) – for 1.0 outpatient, 2.1 intensive outpatient and recovery support services
- Options, San Leandro - for 1.0 outpatient, 2.1 intensive outpatient and recovery support services
- Lifelong, Project Pride – for perinatal 3.1 and 3.5 Residential Treatment
- HealthRight360 – for 1.0 outpatient, 2.1 intensive outpatient and recovery support services (application not yet submitted)

Attachment F: Acronym List Drug Medi-Cal EQRO Reviews

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

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

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