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2020-21
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

ALAMEDA DMC-ODS REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
March 8-10, 2021

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ALAMEDA DMC-ODS REPORT

Beneficiaries Served in Fiscal Year (FY) 2019-20: 4,063.
Alameda Threshold Language(s): Spanish, Cantonese, Vietnamese, Mandarin, Tagalog
CalEQRO obtained the DMC-ODS threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070
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
Alameda Seat: Oakland
Alameda Review Process Barriers: See the unusual circumstances notes below in the review special characteristics.

Review Special Characteristics

This review took place during the COVID-19 pandemic when the Governor's Executive Order established restrictions on in-person gatherings and other public safety precautions. In response, CalEQRO worked with Alameda to design an alternative to the usual in-person on-site review format. The review was a hybrid review with three days of video sessions and one client focus group. It did not include in-person sessions as is the usual process, but all customary data was submitted, and additional supplemental questions for clarifications of some areas were provided. In addition, the Director participated in much of the review as did many senior staff and over forty-two stakeholders not counting the clients who participated in the focus group session. In addition, Alameda took advantage of technical assistance in a number of quality issues and topics before and during the review and followed up with a request for additional assistance after the review.

Introduction

Alameda 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. In this report, "Alameda" shall be used to identify the Alameda DMC-ODS program unless otherwise indicated.

During this FY 2020-21 Alameda review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to DMC access, timeliness, quality, and outcomes related to the second-year implementation of Alameda's DMC-ODS services. CalEQRO reviews are retrospective, therefore data evaluated is from FY 2019-20.

How Beneficiaries Access Care

There are some best practices important to DMC-ODS programs in how they organize their access to care. To understand whether a county is doing these, it is important to know how they have organized their access systems. In addition, the special terms and conditions (STCs) of the 1115 Waiver have specific requirements for the 24-hour beneficiary access line (BAL) or as many describe it their “Access Call Center”. The Access Call Centers play different roles in different counties in the linkage of clients to treatment depending on the size of the county and the design of the access points. To evaluate this element of quality, it is important first to know how this DMC-ODS has chosen to organize its access system to bring beneficiaries into the treatment system via screenings, assessment, and engagement.

Alameda DMC-ODS has developed their access system with the following elements:

Alameda has a central 24-hour access line with ASAM screening known as the beneficiary access line (BAL), operated by Center Point, a contract agency. This agency and the system overall had made some improvements since the first review with two additional staff, addition of a three-way calling system to make direct appointments for clients with providers for initial assessments, and better coordination with residential providers reducing vacant bed capacity and increasing referrals for MAT for those with opioid use disorders. Implementation of new procedures was evident especially with referrals to MAT and three-way calling, as well as motivational interviewing and ASAM training from the group interview with line staff.

In addition to the BAL, Alameda also has other access points in the Forensic case management and Drug Court programs, the ED Bridge connection to their services, and direct connections to contract agencies who then coordinate with the BAL and appropriate agencies depending on the level of care (LOC) needed by the person seeking services. There is special county oversight in areas related to urgent requests and residential requests because of the timeliness linked to those levels of care.

In terms of access to expanded capacity, Alameda added outpatient non-methadone MAT to two agencies, added 23 recovery residence beds in partnership with Alameda Probation, obtained DHCS certification for the 3.2 withdrawal management (WM) residential program, and in December 2020 opened an Asian American outpatient and intensive outpatient SUD treatment program in the Union City area which includes special outreach and engagement services. This was part of their plan for expanding services for this underserved population.

In addition, after some challenging issues in Santa Rita jail due to COVID-19 impacts related to the virus, the unique SUD treatment program highlighted in last year’s review, which includes MAT, counseling, and case management, has been re-established and is operating successfully in partnership with the DMC-ODS and the Highland Hospital ED Bridge program. Group interviews of these stakeholders and data from them provided in the review sessions was helpful in documenting the unusual network of services and

protocols between detention, probation, the DMC-ODS, and the Highland acute care system.
Finally, the other area of expanded access was the linkage of Alameda DMC-ODS staff to Project Roomkey housing for those with COVID-19 and their assignment to do support and outreach to those with SUD. Their effort was to engage and use motivational interviewing to encourage treatment engagement and referral and if this was not possible, a harm reduction strategy, with an open invitation for treatment at a later time, when the person may feel more willing to consider a change. Counselors have served 460 individuals in these housing situations and continue to be available to assist in the public health emergency in engaging those who also have SUD. There was also a long-term goal of providing more mobile services to make engagement in treatment less challenging for hard-to-reach populations.

Because the community impact of COVID-19 was severe, Alameda County made a major effort to let the community know behavioral health services were available with a major media campaign ranging from buses, TV, and radio. Materials were shared on this effort. Part of this was re-doing their website and some feedback was provided on this related to the Access line and other issues related to SUD services.

Continuum of Care Overview

The Special Terms and Conditions (STCs) require an implementation plan with phased levels of care based on the ASAM continuum, expanding over time treatment options for clients to access based on their individual needs. Each year the CalEQRO reviews in depth the current services and capacity and plans for changes in the services by levels of care or capacity including consideration of locations, special needs, age groups, etc.

As stated in the Access section, Alameda has added to its ASAM continuum of care by contracting with two new outpatient MAT providers, adding 23 Recovery Residence beds, residential capacity, and the outpatient and intensive outpatient Asian American program. In addition, there is a youth program which has applied to move to a larger program site seeking Provider Enrollment Division (PED) approval. Youth is one of the underserved populations in the DMC-ODS and Alameda is eager to do this expansion for the program. They want to do other youth expansion activities as well.

The Alameda continuum of care has all the DHCS required levels of care and Alameda is tracking demand with their current data system and access call system requests, new admissions, and placements.

Case Management/Care Coordination Model

Case management and coordination of care in a managed care model based on the ASAM continuum of care is a critical service. DMC-ODS programs have approached this element of the care system in vastly different ways. Because it has such a major impact on the clients and their outcomes, it is important to understand how the DMC-ODS has chosen to organize this service as part of the continuum of care. In many ways, it is the

glue that makes the system work as a whole for the client versus siloed program elements. CM services include advocacy, linkage, support, and practical assistance based on a foundation of a therapeutic alliance with the client with SUD. Given the levels of impairment and stages of change experienced, many clients need these CM supports especially in early stages of treatment to be successful in initiation and engagement, and ultimately in progress and positive outcomes.

Alameda has a provider-based case management system where the contractors have this as a component of their contracts. Nonetheless, this past year, a special position was added as an adjustment to the WM residential provider called a recovery navigator. This position is similar to a peer navigator who functions as a special case manager to link the individuals leaving WM to the next level of care. This was part of a PIP that was disrupted by COVID-19 and not conclusive; however, the clients who had the peer navigator were more successful in linking to their lower level of care in most circumstances. Many of those involved felt this model needed to be tested as “glue” between levels of care as a primary function. Other staff said they had too many other duties or functions. Thus, there is still exploration of a better model for two areas often needing extra case management (CM) for vulnerable populations - first engagement from the BAL to first appointment, and second, the help between levels of care.

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 contracted with 30 separate counties and seven Partnership 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.

This report presents the FY 2020-21 EQR findings of Alameda's FY 2019-20 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 16 performance measures (PMs) for ongoing implementation of the DMC-ODS Waiver as defined by DHCS. The 16 PMs are listed at the beginning of the PM chapter, followed by tables that highlight the results.

Performance Improvement Projects[2]

Each DMC-ODS county is required to conduct two PIPs—one clinical and one non-clinical — during the 12 months preceding the review. These are special projects intended to

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

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.

The CalEQRO staff provide trainings and technical assistance to the County DMC-ODS staff for PIP development. 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 meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of Alameda 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 Substance Use Disorder (SUD) program that administered the survey so that quality activities can follow the survey results for services at that site. CalEQRO reviews the UCLA analysis and outliers in the results to discuss with the DMC-ODS leadership any need for additional quality improvement efforts.

CalEQRO also conducts 90-minute client focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries. The client experiences reported on the TPS are also compared to the results of the in-person client focus groups conducted on all reviews. Groups include adults, youth, parent/guardians from various

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

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 reviews also include meetings during in-person or virtual sessions with line staff, supervisors, contractors, stakeholders, agency partners, local Medi-Cal Health Plans, primary care, and hospital providers. Additionally, CalEQRO conducts site visits, when possible, 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. In the case of a desk review, site visits and virtual sessions are not conducted; instead, written documentation submitted by the county is used to assess the Key Components and make recommendations.

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

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

PRIOR YEAR REVIEW FINDINGS

In this section, the status of last year's (FY 2019-20) EQRO review recommendations are presented, as well as changes within the DMC-ODS's environment since its last review.

Status of Prior Year Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made a number of recommendations for improvements in the DMC-ODS's programmatic and/or operational areas. During this current FY 2020-21 desk review, CalEQRO and DMC-ODS staff discussed the status of those prior year recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the DMC-ODS has either:

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

Not Met is assigned when the DMC-ODS performed no meaningful activities to address the recommendation or associated issues.

Prior Year Key Recommendations

Recommendation #1: Add IT staff capacity to the Clinician's Gateway (CG) help desk as well as the project overall linked to the dashboard, training, and management functions as this is a 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.
Status: Met

- Alameda County Behavioral Health (ACBH) is in the process of hiring new permanent IS staff in both the Help Desk Unit as well as the CG team administrative support. Current vacancies are expected to be filled imminently.
- In the interim, temporary staffing is used to provide Help Desk support to users of the EHR and other Information Systems products.
- The Data Services Team (DST) has been meeting with the Privacy Officer and Quality Improvement Unit to expand access to YellowFin dashboards with

aggregate SUD data for community-based organizations (CBOs), balancing data availability with privacy considerations. ACBH anticipates this expansion in 2021.

Recommendation #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 appointments.
Status: Met

- In August 2019, ACBH launched a Non-Clinical PIP to improve access and timeliness for residential treatment, specifically focusing on reducing wait times, dropouts, and under-utilization of residential treatment beds and intake appointments.

- In partnership with the beneficiary access line provider (Center Point) and the residential treatment programs, ACBH has implemented the following interventions or actions for the Non-clinical PIP:

    - In August 2019, ACBH modified the residential treatment procedures 1) to increase efficiency for the beneficiary access line to connect referrals to residential treatment and 2) to allow residential treatment providers to serve beneficiaries who contact them directly for service.

    - In June 2020, ACBH implemented a three-way call among the beneficiary, beneficiary access line, and residential treatment provider to increase connection to residential treatment programs upon referral. In July 2020, ACBH made this process mandatory in its FY 2020-21 contracts to ensure provider compliance.

    - In October 2020, ACBH developed Yellowfin dashboards to monitor residential treatment bed capacity and timely access for beneficiaries referred to residential treatment.

- As a result, residential bed utilization was increasing prior to COVID; from July 2019 to February 2020, ACBH achieved 68 percent bed utilization in residential treatment beds, improving from FY 2018-19 bed utilization of 52 percent.

    - In Fiscal Year 2019-20, 83 percent (173-209) of callers who received residential intake appointments through the beneficiary access line participated in a three-way call appointment with the residential treatment provider. 69 percent (211/306) of all callers screened for residential treatment participated in the three-way call.

    - The number of beneficiaries who were unable to immediately connect to residential treatment due to limited residential treatment capacity decreased after November 2019, but progress on this measure abated because of COVID-19 reductions in residential treatment capacity.

Recommendation #3: Access Call Center staff, with appropriate training and supervision, should refer persons with opioid use disorders and alcohol use disorders to Narcotic Treatment Programs (NTPs) and MAT resources as well as to counseling/residential treatment.
Status: Met

- In July 2020, Center Point trained Beneficiary Access Line counselors to increase referrals of beneficiaries to NTPs and MAT, reinforcing this message at subsequent weekly staff meetings.

- As a result, there has been an increase in referrals to NTPs from an average of one per month in FY 2019-20 to eight per month in FY 2020-21.

- Center Point changed the BAL internal procedures so that counselors are required to inquire about MAT awareness and service history for opioid users and to automatically refer beneficiaries to MAT service providers. In July-August 2020, the BAL provider implemented a new process to track and report the number of opioid use disorder callers who accept or decline MAT referral.

- In December 2020, ACBH developed a referral flow chart with NTP providers with intake days and times so that beneficiary access line counselors can improve MAT referrals. This includes referrals to the ED Bridge program for beneficiaries who need immediate MAT induction.

- These efforts build upon improvements made to the ASAM LOC screening tool so that the BAL counselors can better identify clients experiencing opioid withdrawal symptoms.

Recommendation #4: Continue efforts to add an adolescent residential treatment provider with other counties to address this gap in the continuum for youth.
Status: Met

- In March 2020, ACBH procured a contract with Advent Group Ministries in Morgan Hill (Santa Clara County) to provide adolescent residential program services. This program is in the process of obtaining Drug Medi-Cal certification having resubmitted its application to PED in November 2020.

- ACBH is currently simplifying the referral process and promoting local awareness about this resource.

- This program has served one Alameda County beneficiary in March-April 2020.

Recommendation #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.
Status: Met

- Through partnership with SUD Operations, the Quality Improvement Unit has incorporated 133% more SUD contract agencies into the monthly joint Mental Health & Substance Use Disorder Quality Improvement Committee (QIC). Prior to 2020, there were three regular SUD contracted providers in attendance (Options Recovery Service, Second Chance, and La Familia Counseling Services). In 2020, four additional SUD contracted providers began attending joint QIC meetings regularly (City of Fremont, East Bay Community Recovery Project, Humanistic Alternatives to Addiction, Research and Treatment [HAART], and Horizon Services.

- The two Performance Improvement Workgroups have also increased the number of SUD contracted agencies engaged in Quality Improvement activities:

    - The Clinical PIP is implemented by the WM provider (Horizon Services – Cherry Hill), which has also been integral in developing the interventions. This group has been meeting monthly or bimonthly since June 2019.

    - The Non-Clinical PIP is implemented in partnership with both the SUD helpline provider (Center Point) and the seven residential services providers (La Familia, Bi-Bett, Magnolia House Recovery Services, Horizon Services, HealthRIGHT 360, CURA, EBCRP-Lifelong). This workgroup has been discussing PIP development and implementation at bimonthly meetings since October 2019.

- Since July 2020, QA has worked with SUD contract providers to reduce the administrative burdens of compliance by improving Clinical Documentation, Clinical Quality Review Teams (CQRT), Clinician's Gateway, Audits, and QA Trainings. The Interim Quality Assurance (QA) Administrator has met regularly with The Collaborative (an organization comprised of mental health and substance use community-based providers in Alameda County, formerly known as Alameda Council of Community Mental Health Agencies or ACCMHA), as well as the Alliance of Drug and Alcohol Providers (Alameda County's SUD providers collective) to gather additional feedback from SUD providers concerning these processes (November 2020). In January 2021, QA staff collaborated with SUD providers to revise the Client Plan document to be more user-friendly and limited to necessary compliance items. QA anticipates completing this overall effort in October 2021.

- Since February 2020, the Utilization Management (UM) Program has worked with contracted residential treatment providers to redesign the InSyst PSP 131 report used to invoice ACBH. As the unit assigned to render prior authorization for residential treatment services, UM has met with contracted providers through SUD Provider meetings and Alliance of Drug and Alcohol Providers (SUD contractors' organization) meetings to add authorization entries (i.e., approvals, denials) to the report. This revision will enable residential treatment providers to identify any issues and/or trends with authorization requests and/or high denial rates due to services not meeting medical necessity. Implementation of this new report is anticipated in 2021.

Recommendation #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.
Status: Met

- QA has successfully hired additional staff to support SUD providers with chart reviews and training over the last year, including:
    - Two FTE Clinical Review Specialist Supervisors to support audits and trainings (January 2020)
    - One FTE Program Specialist for Site Certification (March 2020), which allows Clinical Review Specialists who had been supporting the Site Certification function to return to chart reviews and provider training.
    - Two provisional FTE Clinical Review Specialists to support audits, Clinical Quality Review Teams (CQRT), and provider trainings (December 2020).
    - In addition, QA has added two positions which are vacant due to COVID-19 delays with County Human Resources for recruitment and hiring. These positions will be filled once lists of qualified candidates are certified:
        - 1 FTE Behavioral Health Clinician II was reclassed from temporary to permanent in August 2020.
        - 1 Program Specialist was reclassed to Supervising Program Specialist in July 2020; this position will support SUD providers by updating policies and procedures, as well as updating documentation manuals.

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Changes to the Environment

Alameda, similar to other counties, experienced both fires and continues to have impacts from the COVID-19 pandemic as well as stress created by the deaths of African Americans by police which created protests and outcries of the public for more social justice for citizens of all racial groups. Alameda county is a truly diverse county where there has been a history of conflict with law enforcement causing social and political conflict. The County Board and Health Agency developed community engagement, outreach, and communication strategies to offer support and recognition of these issues and offer support and services.

Past Year's Initiatives and Accomplishments

- Rapid response to COVID-19 with deployment of video and phone services as well as some mobile services to community members directly and through contract agencies, increased take-home doses of methadone, flexible service models to promote client and staff safety and health.

- Media campaign and engagement of community in education and support related to SUD and Mental Health (MH) to encourage treatment as a service for coping with new stressors in the community and for health and wellness.

- Support and engagement of individuals in Project Roomkey housing with SUD issues numbering over 426 at the time of the review and continuing and linking them when possible, to services.

- Expanded training and communication between Behavioral Health and Probation with delivery of service trainings for all Probation Officers by the Director of Behavioral Health over several days with special tools to enhance communication and coordination.

- Numerous service expansions were accomplished including residential expansion, MAT contracts for non-methadone services with two new contractors, an outpatient and intensive outpatient program specializing in treatment for Asian and Pacific Islanders in Union City Area, additional staff in Center Point Access program, and 23 beds of recovery residences for families using AB 109 funds.

Alameda Goals for the Coming Year

- Expand service capacity: Continue to improve awareness of and utilization of contracted Adolescent Residential program, Asian American Recovery Services, and continue to expand MAT and where possible consider mobile service options to make services easier to access for community members and those that are more vulnerable or difficult to reach and unhoused.

- Continued refinement and expansion of protocols and models of care with Santa Rita Jail MAT, DMC contract agency partners, Probation, Drug Court, Highland Hospital ED Bridge program, Wellpath, Options Recovery Services and re-entry initiatives into the community. Includes Department of Justice grant on co-occurring disorders, with care coordination focused on African American men.

- Improve infrastructure for billing and clinical chart documentation with DMC practice guidelines.

- Develop Overdose Prevention Data Tracking and Strategy Plan

- Increase Community and Stakeholder outreach, engagement, and information processes.

- ACBH plans to strengthen access to the SUD system, especially for unhoused residents.

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 12 performance measures to use in the annual reviews of all DMC-ODS counties. Data were available from DMC-ODS claims, eligibility, provider files, the Treatment Perception Survey (TPS), CalOMS, and the ASAM level of care data for these measures.

1. CalOMS Treatment Data Collection Guide:

   http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

2. TPS:
   http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf

3. ASAM Level of Care Data Collection System:

   https://www.dhcs.ca.gov/individuals/Documents/MHSUDS_Information_Notice_18046.pdf

The first six PMs are used in each year of the Waiver for all DMC-ODS counties and statewide. The additional PMs are based on research linked to positive health outcomes for clients with SUD and related to access, timeliness, engagement, retention in services, placement at optimal levels of care based on ASAM assessments, and outcomes.

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 levels of care, 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 Withdrawal Management (WM) episodes and no other treatment to improve engagement.

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

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

HIPAA Guidelines for Suppression Disclosure

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

Year Two of Waiver Services

This is the second year that Alameda has been implementing DMC-ODS services. Performance Measure data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file (FY 2019-20), and from UCLA for TPS, ASAM, and CalOMS data from FY 2019-20. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. Thus, there may be a claims lag for services in the data available at the time of the review. CalEQRO used the time period of FY 2019-20 to maximize data completeness for the ensuing analyses. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. CalEQRO included in the analyses all claims for the specified time period that had been either approved or pended by DHCS and excluded claims that had been denied.

DMC–ODS Clients Served in FY 2019-20

Clients Served, Penetration Rates and Approved Claim Dollars per Beneficiary

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

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

Alameda served 4,063 clients in FY 2019-20 which is an increase of eight percent from the previous year. 82 percent of total clients served are in the ages 18-64 group. Alameda's total penetration rate is on par with large-sized counties and the Statewide average but the rate for clients ages 12-17 is low.

Table 1: Penetration Rates by Age, FY 2019-20

Alameda				Large Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages12-17	41,652	75	0.18%	0.34%	0.32%
Ages 18-64	226,946	3314	1.46%	1.55%	1.33%
Ages 65+	58,001	674	1.16%	0.97%	0.81%
TOTAL	**326,598**	**4,063**	**1.24%**	**1.27%**	**1.10%**

Table 2 below shows Alameda's average approved claims per beneficiary served overall and by age groups. The amounts are compared with statewide averages for DMC-ODS counties. Alameda's total average approved claim ($4,489) is on par with the Statewide average ($4,515).

Table 2: Average Approved Claims by Age, FY 2019-20

Alameda			Statewide
Age Groups	Average Approved Claims	Total Approved Claims	Average Approved Claims
Ages 12-17	$2,625	$196,861	$2,046
Ages 18-64	$4,452	$14,752,385	$4,613
Ages 65+	$4,881	$3,289,764	$4,837
TOTAL	**$4,489**	**$18,239,010**	**$4,515**

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 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 2019-20

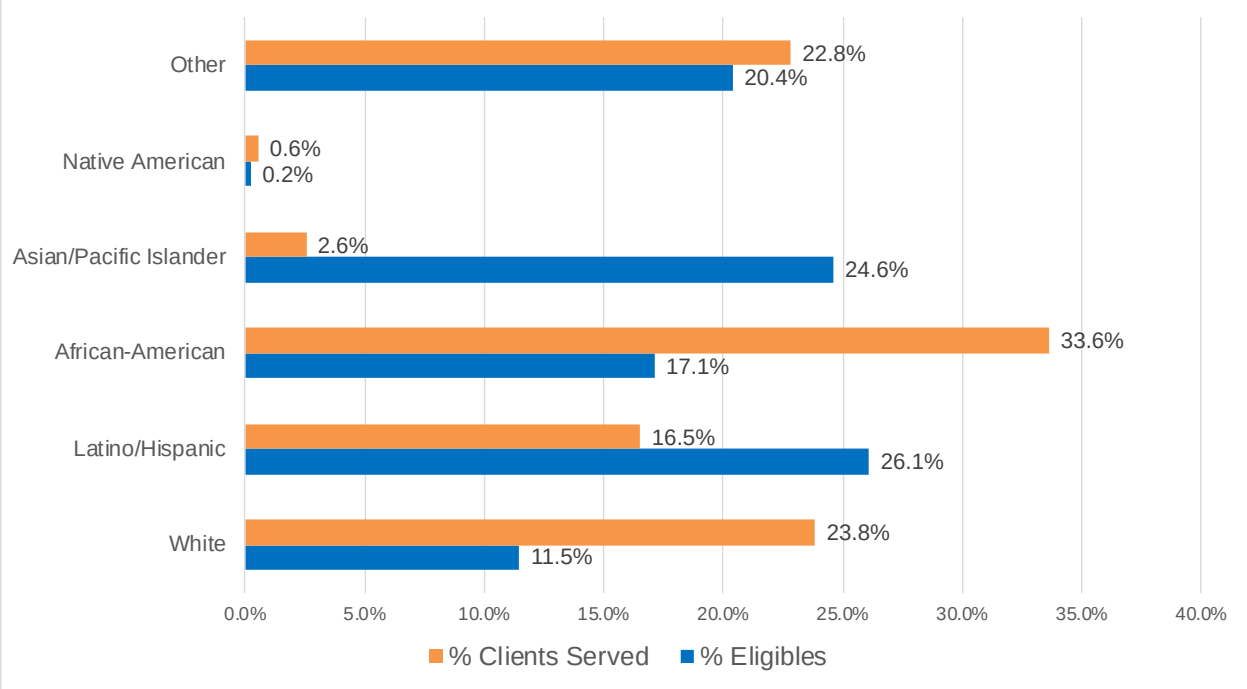


Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. The two largest race/ethnicity groups in Alameda are Latino/Hispanics and Asian/Pacific Islanders, followed by Other, Whites and African Americans. Latino/Hispanics and Asian/Pacific Islanders are under-served relative to their population size, but African Americans and Whites receive proportionally more services.

Native Americans have the highest penetration rate although the number of clients served is small. Penetration rates for Whites and African Americans are high but Hispanic/Latinos and Asian/Pacific Islanders have considerably lower rates.

Table 3: Penetration Rates by Race/Ethnicity, FY 2019-20

Alameda				Large Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	37,499	969	2.58%	2.61%	2.08%
Latino/Hispanic	85,267	672	0.79%	0.85%	0.76%
African American	55,960	1,367	2.44%	1.65%	1.44%
Asian/Pacific Islander	80,432	104	0.13%	0.20%	0.19%
Native American	807	23	2.85%	3.07%	1.91%
Other	66,636	928	1.39%	1.54%	1.38%
TOTAL	**326,601**	**4,063**	**1.24%**	**1.27%**	**1.10%**

Table 4 below shows Alameda's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. The ACA group has the largest number of clients served, followed by the Disabled group. However, Disabled clients have a higher penetration rate than ACA clients. Eligibility categories with a high concentration of youths (Foster Care, Other Child, MCHIP) all show lower penetration rates than Statewide averages.

Table 4: Clients Served and Penetration Rates by Eligibility Category, FY 2019-20

Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Penetration Rate	Penetration Rate
Disabled	39,838	1,351	3.39%	1.88%
Foster Care	1,120	*	n/a	2.46%
Other Child	24,770	48	0.19%	0.34%
Family Adult	51,068	616	1.21%	1.15%
Other Adult	63,728	123	0.19%	0.13%
MCHIP	18,065	*	n/a	0.24%
ACA	126,991	2,023	1.59%	1.74%

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

Table 5 below shows Alameda's approved claims per penetration rates by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Clients in the Disabled group have the highest average approved claim, followed by Other Adults and Family Adults. Alameda's average approved claims are higher than Statewide averages in most eligibility categories.

Table 5: Average Approved Claims by Eligibility Category, FY 2019-20

Alameda				Statewide
Eligibility Categories	Average Number of Eligibles per Month	Number of Clients Served	Average Approved Claims	Average Approved Claims
Disabled	39,838	1,351	$4,641	$4,513
Foster Care	1,120	*	n/a	$1,578
Other Child	24,770	48	$2,556	$1,943
Family Adult	51,068	616	$4,301	$3,792
Other Adult	63,728	123	$4,321	$4,042
MCHIP	18,065	*	n/a	$2,039
ACA	126,991	2,023	$4,239	$4,667

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

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 2019-20. Narcotic Treatment Programs (NTP) serve the most clients, followed by Outpatient Services and Residential Treatment. The average approved claim is highest in Residential Treatment, followed by NTP.

Table 6: Percentage of Clients Served and Average Approved Claims by Service Categories, FY 2019-20

Service Categories	# of Clients Served	% Served	Average Approved Claims
Narcotic Tx. Program	2,356	49.1%	$4,209
Residential Treatment	640	13.3%	$6,653
Res. Withdrawal Mgmt.	*	n/a	$1,879
Ambulatory Withdrawal Mgmt.	-	-	-
Non-Methadone MAT	247	5.1%	$596
Recovery Support Services	79	1.6%	$2,167
Partial Hospitalization	-	-	-
Intensive Outpatient Tx.	399	8.3%	$1,251
Outpatient Services	1,071	22.3%	$3,024
TOTAL	**4,797**	**100.0%**	**$4,489**

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

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

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

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

On average, Alameda clients receive their first dose of methadone within a day after completing assessment, which is similar to the Statewide experience.

Table 7: Days to First Dose of Methadone by Age, FY 2019-20

Alameda				Statewide		
Age Groups	**Clients**	**%**	**Avg. Days**	**Clients**	**%**	**Avg. Days**
Ages 12-17	-	-	n/a	*	n/a	n/a
Ages 18-64	2,039	88.6%	<1	37,884	90.8%	<1
Ages 65+	*	n/a	n/a	*	n/a	n/a
TOTAL	**2,301**	**100.0%**	**<1**	**41,714**	**100.0%**	**<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). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

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.

Alameda County did not offer outpatient MAT services in FY 2019-20. However, all OTP providers are able to bill for non-methadone medications (buprenorphine, disulfiram, and naloxone) although some have not been consistently billing for these medications.

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

Table 8 displays 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 the EQRO.

247 Alameda clients received non-methadone MAT services in FY 2019-20 and 55 had three or more services. As such, Alameda has a lower rate of clients receiving regular non-methadone MAT services than the State average.

Table 8: DMC-ODS Non-Methadone MAT Services by Age, FY 2019-20

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
Ages 18-64	237	6.4%	53	1.4%	6,504	6.8%	3,036	3.2%
Ages 65+	*	n/a	*	n/a	*	n/a	*	n/a
TOTAL	**247**	**6.08%**	**55**	**1.35%**	**6,658**	**6.3%**	**3,095**	**2.9%**

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). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Transitions in Care Post-Residential Treatment – FY 2019-20

The DMC-ODS Waiver emphasizes client-centered care, one element is the expectation that treatment intensity should change over time to match the client's changing condition and treatment needs. This treatment philosophy is in marked contrast to a program-driven

approach in which treatment would be standardized for clients according to their time in treatment (e.g., week one, week two, etc.).

Table 9 shows two aspects of this expectation: 1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. The table shows the percentage 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 the table are the percent of clients who had follow-up treatment from 31-365 days.

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

7.2 percent of Alameda clients had a care transition following residential treatment within seven days, which is similar to the Statewide experience. Overall, 22.3 percent of Alameda clients had a transition admission following residential treatment in FY 2019-20, which is a higher rate than the Statewide average.

Table 9: Timely Transitions in Care Following Residential Treatment, FY 2019-20

Alameda (n= 753)			Statewide (n= 30,303)	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	54	7.2%	2,312	7.6%
Within 14 Days	73	9.7%	3,161	10.4%
Within 30 Days	104	13.8%	3,987	13.2%
Any days (TOTAL)	**168**	**22.3%**	**6,016**	**19.9%**

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 Jan 10, 2020 through Dec 10, 2020. Improved performances are noted in Average Volume (calls increased from 616 in FY 2018-19 to 760), Time to Answer Calls (reduced from 15 seconds to five seconds) and Percent of Calls Referred to Treatment (increased from 58 percent to 76 percent).

Table 10: Access Line Critical Indicators, January 10, 2020 through December 10, 2020

Alameda	
Average Volume	760 calls per month
% Dropped Calls	4%
Time to answer calls	5 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	76% of callers are linked to treatment through the Access Line
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 number 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 $12,973 in approved claims per year. The table lists the average approved claims costs for the year for Alameda HCBs compared with the statewide average. 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 repeatedly 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.

The 2.6 percent of Alameda's clients are considered high cost, but this rate is about half the State average in percent. Alameda's average approved claim per high-cost beneficiary is also lower than the Statewide average by almost $2,000.

Table 11a: High-Cost Beneficiaries by Age, Alameda, FY 2019-20

Alameda						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	75	-	-	-	-	-
Ages 18-64	3,314	105	3.2%	$17,588	$1,846,747	12.5%
Ages 65+	674	*	n/a	n/a	n/a	n/a
TOTAL	**4,063**	**107**	**2.6%**	**$17,531**	**$1,875,793**	**10.3%**

Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Table 11b: High-Cost Beneficiaries by Age, Statewide, FY 2019-20

Statewide					
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**
Ages 12-17	5,018	22	0.4%	$18,095	$398,083
Ages 18-64	91,813	5,377	5.9%	$19,374	$104,171,358
Ages 65+	10,592	41	0.4%	$18,713	$767,217
TOTAL	**107,423**	**5,440**	**5.1%**	**$19,363**	**$105,336,659**

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

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.

Due to DMC certification and time needed to configure the billing system, claims for the WM program were submitted in November 2020. Claims data in Table 12 is incomplete.

Table 12: Residential Withdrawal Management with No Other Treatment, FY 2019-20

Alameda			Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	12	8.3%	7,836	3.4%

Use of ASAM Criteria for Level of Care Referrals

The clinical cornerstone of the DMC-ODS Waiver is use of ASAM Criteria for initial and ongoing level of care placements. Screeners and assessors are required to enter data for each referral, documenting the congruence between their findings from the screening or assessment and the referral they made. When the referral is not congruent with the LOC indicated by ASAM Criteria findings, the reason is documented.
Alameda recorded high congruence between ASAM LOC referrals and level of care placements in both initial screening (94.5 percent) and follow-up assessment (92 percent) in FY 2019-20. The congruence was lower in initial assessment (78.2 percent) due to patient preference or clinical judgement.

Table 13: Congruence of Level of Care Referrals with ASAM Findings, FY 2019-20

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	2,953	94.5%	2,340	78.2%	5,149	92.0%
Patient Preference	92	2.9%	452	15.1%	153	2.7%
Level of Care Not Available	34	1.1%	*	n/a	14	0.2%
Clinical Judgement	16	0.5%	161	5.4%	258	4.6%
Geographic Accessibility	*	n/a	*	n/a	*	n/a
Family Responsibility	*	n/a	*	n/a	*	n/a
Legal Issues	*	n/a	*	n/a	*	n/a
Lack of Insurance/Payment Source	15	0.5%	*	n/a	*	n/a
Other	*	n/a	14	0.5%	*	n/a
Actual Referral Missing	-	0.1%	-	-	-	-
TOTAL	**3,125**	**100.0%**	**2,994**	**100.0%**	**5,594**	**100.0%**

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

Initiating and Engaging in Treatment Services

Table 14 displays results of measures for two early and vital phases of treatment: initiating and then engaging in treatment services. They are part of a set of newly adopted measures by CalEQRO for counties in their second year of DMC-ODS implementation. An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them. Research suggests that those who are able to engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. Several federal agencies and national organizations have encouraged and supported the widespread use of these measures for many years.

The method for measuring the number of clients who initiate treatment begins with identifying the initial visit in which the client's SUD is identified. Since CalEQRO does this through claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a client that is not preceded by one within the previous 30 days. This second day or visit is what in this measure is defined as "initiating" treatment. Alameda's adult clients had a good rate (92.09 percent) of initiating services in FY 2019-20 and youth clients also had a better rate (83.56 percent) of initiating services than the Statewide average.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 15th and 45th day following initial DMC-ODS service. Alameda adult clients had a good service engagement rate at 85.17 percent; however, youth clients had a lower rate at 68.85 percent.

Table 14: Initiating and Engaging in DMC-ODS Services, FY 2019-20

	Alameda				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	4,070		73		93,923		4,825	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	3,748	92.09%	61	83.56%	82,854	88.2%	3,877	80.4%
Clients who then engaged in DMC-ODS services	3,192	85.17%	42	68.85%	64,689	78.1%	2,744	70.8%

Table 15 tracks the initial DMC-ODS service used by clients to determine how they first accessed DMC-ODS services and shows the diversity of the continuum of care. For service entry, NTP/OTP was the leading modality in FY 2019-20 with 2,335 clients,

followed by Outpatient Treatment (917 clients) and Residential Treatment (560 clients). These were also the State's leading DMC-ODS service modalities.

Table 15: Initial DMC-ODS Service Used by Clients, FY 2019-20

	Alameda		Statewide	
DMC-ODS Service Modality	**#**	**%**	**#**	**%**
Outpatient treatment	917	24.1%	34,506	34.9%
Intensive outpatient treatment	-	-	4,484	4.5%
NTP/OTP	2,335	61.3%	35,276	35.7%
Non-methadone MAT	-	-	225	0.2%
Ambulatory Withdrawal	-	-	20	-
Partial hospitalization	-	-	26	-
Residential treatment	560	14.7%	17,509	17.7%
Withdrawal management	-	-	6,042	6.1%
Recovery Support Services	-	-	660	0.7%
TOTAL	**3,812**	**100.0%**	**98,748**	**100.0%**

Asterisks and n/a, if included, indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation). Totals at the bottom of each column reflect the total of the actual numbers for all the above cells including the ones which are asterisked.

Retention in Treatment

Table 16 is a measure of how long the system of care is able to retain clients in its DMC-ODS services, and counts the cumulative time that clients were involved across however many types of service they received sequentially without an interruption of more than 30 days. Defined sequentially and cumulatively in this way, research suggests that retention in treatment and recovery services is predictive of positive outcomes. To analyze the data for this measure, CalEQRO first identified all the discharges during the measurement year (in this case CY 2018), defined as the last billed service after which no further service activity was billed for over 30 days. Then for these clients, CalEQRO identified the beginning date of the service episode by counting back in time to the date before which there was no treatment for at least 30 days. The claims data used for these calculations covers 18 months of utilization data, going back six months prior to the year in which discharges are counted. Clients in outpatient programs are counted as having seven days per week if they had at least one outpatient visit in a week.

The mean (average) length of stay for Alameda clients was 142 days (median 90 days), compared to the statewide mean of 133 (median 87 days). 50.4 percent of clients had at least a 90-day length of stay; 30.9 percent had at least a 180-day stay, and 20.8 percent had at least a 270-day length of stay.

Length of stay data show Alameda clients stay in treatment about the same duration of time as the Statewide average.

Table 16: Cumulative Length of Stay (LOS) in DMC-ODS Services, FY 2019-20

	Alameda		Statewide	
Clients with a discharge date	3,268		100,971	
Length of stay (LOS) for clients across the sequence of all their DMC-ODS services	**Mean (Average)**	**Median (50th percentile)**	**Mean (Average)**	**Median (50th percentile)**
	142	90	133	87
	#	%	#	%
Clients with at least a 90-day LOS	1,646	50.4%	49,332	48.9%
Clients with at least a 180-day LOS	1,010	30.9%	28,635	28.4%
Clients with at least a 270-day LOS	679	20.8%	17,711	17.5%

Residential Withdrawal Management Readmissions

Table 17 measures the number and percentage of residential withdrawal management readmissions within 30 days of discharge. Data in Table 17 is incomplete due to late submission of claims related to DMC certification lag time and billing system configuration. This claims data appears to be incomplete.

Table 17: Residential Withdrawal Management (WM) Readmissions, FY 2019-20

	Alameda		Statewide	
Total DMC-ODS admissions into WM	6		10,104	
	#	#	#	%
WM readmissions within 30 days of discharge	*	n/a	999	9.9%

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

Diagnostic Categories

Table 18 compares the breakdown by diagnostic category of the Alameda and statewide number of beneficiaries served and total approved claims amount, respectively, for FY 2019-20. Alameda clients' leading diagnosis was Opioid, followed by Alcohol User Disorder and Other Stimulant Abuse. These diagnosis codes were also the top three diagnoses in the State.

Table 18: Percentage Served and Average Cost by Diagnosis Code, FY 2019-20

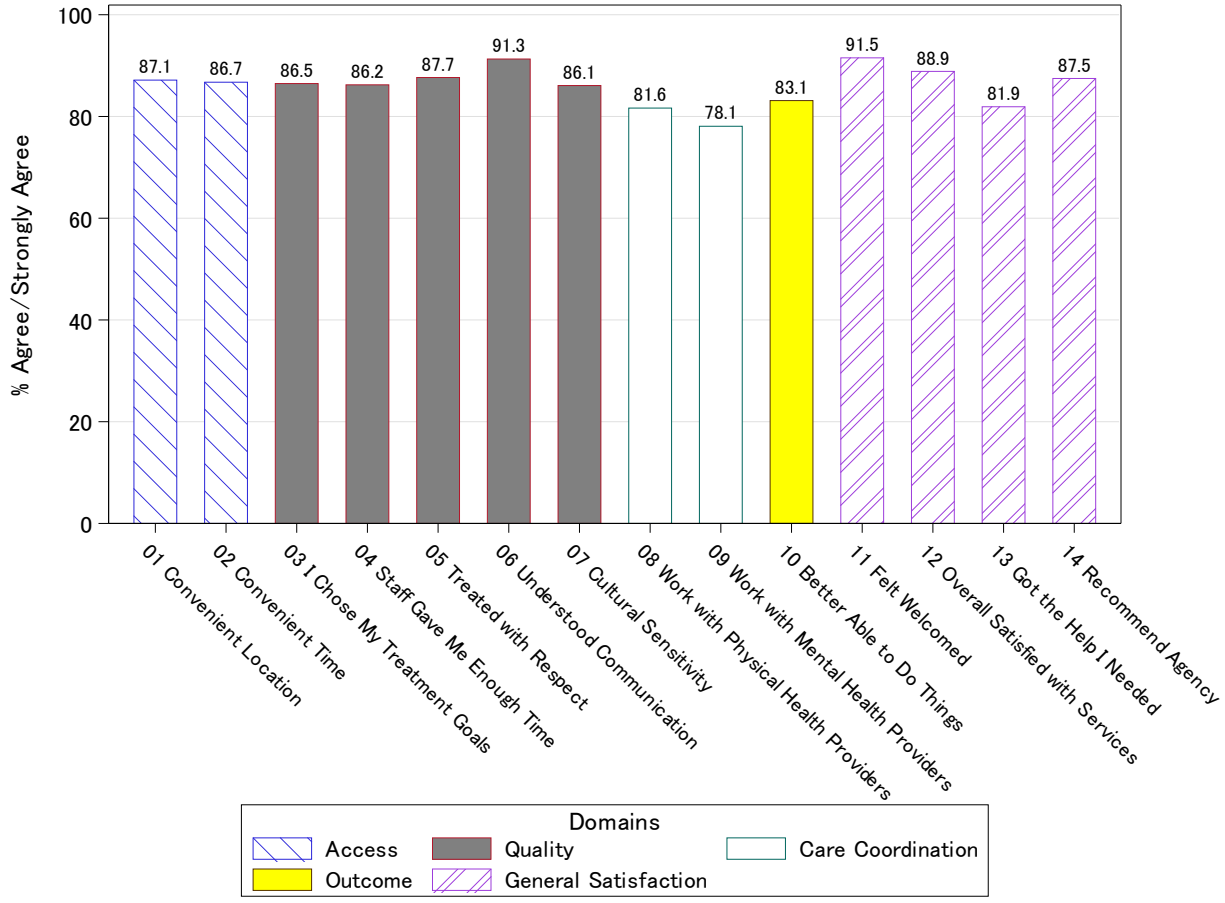
Diagnosis Codes	Alameda		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	14.8%	$4,887	17.1%	$5,317
Cannabis Use	4.6%	$3,075	9.0%	$2,328
Cocaine Abuse or Dependence	4.6%	$4,809	1.9%	$5,273
Hallucinogen Dependence	0.2%	$3,746	0.23%	$5,151
Inhalant Abuse	-	-	0.03%	$6,809
Opioid	61.4%	$4,679	45.7%	$5,084
Other Stimulant Abuse	13.8%	$4,987	24.4%	$4,723
Other Psychoactive Substance	-	$2,747	0.11%	$6,172
Sedative, Hypnotic Abuse	0.4%	$5,327	0.52%	$5,095
Other	0.2%	$1,136	0.90%	$3,259
Total	**100.0%**	**$4,489**	**100.0%**	**$4,776**

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 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 clients rated most TPS measures favorably, and higher scores were noted in the Quality and General Satisfaction domains. Lower scores were found in Care Coordination which appears to be the experience shared by clients across active DMC-ODS counties. Probably due to the COVID-19 pandemic, Alameda had significantly less participants in the 2020 adult TPS as compared to 2019 (over 950 respondents).

Figure 2: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA (N =418)



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 19-21 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. FY 2019-20 CalOMS data showed Alameda clients having a higher homeless rate than the Statewide average, a lower level of criminal justice involvement and a comparable employment rate.

Table 19: CalOMS Living Status at Admission, FY 2019-20

Admission Living Status	Alameda		Statewide	
	#	%	#	%
Homeless	1,897	44.2%	32,027	28.7%
Dependent Living	807	18.8%	28,474	25.5%
Independent Living	1,587	37.0%	51,036	45.7%
TOTAL	**4,291**	**100.0%**	**111,537**	**100.0%**

Table 20: CalOMS Legal Status at Admission, FY 2019-20

Admission Legal Status	Alameda		Statewide	
	#	%	#	%
No Criminal Justice Involvement	3,232	73.4%	68,737	61.7%
Under Parole Supervision by CDCR	204	4.7%	2,255	2.0%
On Parole from any other jurisdiction	76	1.8%	1,676	1.5%
Post release supervision - AB 109	543	12.7%	30,671	27.5%
Court Diversion CA Penal Code 1000	143	3.3%	2,111	1.9%
Incarcerated	50	1.2%	711	0.6%
Awaiting Trial	41	1.0%	5,324	4.8%
TOTAL	**4,289**	**100.0%**	**111,485**	**100.0%**

Table 21: CalOMS Employment Status at Admission, FY 2019-20

Current Employment Status	Alameda		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	515	12.0%	13,156	11.8%
Employed Part Time - Less than 35 hours	309	7.2%	8,637	7.7%
Unemployed - Looking for work	1,228	28.6%	33,128	29.7%
Unemployed - not in the labor force and not seeking	2,239	52.2%	56.616	50.7%
TOTAL	**4,291**	**100.0%**	**111,537**	**100.0%**

The information displayed in Tables 22-23 focus on the status of clients at discharge, and how they might have changed through their treatment. Table 22 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 had a significantly higher standard adult discharge rate than the Statewide average in FY 2019-20, which is an indication of good treatment outcome with 74.4 percent of clients with a standard adult discharge.

Table 22: CalOMS Types of Discharges, FY 2019-20

Discharge Types	Alameda		Statewide	
	#	%	#	%
Standard Adult Discharges	4,716	74.4%	49,577	42.1%
Administrative Adult Discharges	736	11.6%	55,467	47.1%
Detox Discharges	726	11.4%	10,420	8.8%
Youth Discharges	163	2.6%	2,415	2.1%
TOTAL	**6,341**	**100.0%**	**117,879**	**100.0%**

Table 23 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.

The 76 percent of Alameda clients had a positive discharge status in FY 2019-20 which was higher than the Statewide rate of 46 percent, either completing treatment or leaving before treatment completion but with satisfactory progress.

Table 23: CalOMS Discharge Status Ratings, FY 2019-20

Discharge Status	Alameda		Statewide	
	#	%	#	%
Completed Treatment - Referred	2,719	43.2%	20,317	17.6%
Completed Treatment - Not Referred	97	1.5%	6,759	5.8%
Left Before Completion with Satisfactory Progress - Standard Questions	1,692	26.9%	17,115	14.8%
Left Before Completion with Satisfactory Progress – Administrative Questions	266	4.2%	8,734	7.6%
Subtotal	*4,774*	*75.8%*	*52,925*	*45.8%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	1,071	17.0%	16,693	14.4%
Left Before Completion with Unsatisfactory Progress - Administrative	433	6.9%	44,609	38.6%
Death	*	n/a	235	0.2%
Incarceration	*	n/a	1,058	0.9%
Subtotal	*1,524*	*24.2%*	*62,595*	*54.1%*
TOTAL	**6,298**	**100.0%**	**115,520**	**100.0%**

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

Performance Measures Findings: Impact and Implications

Access to Care

- Alameda continues to expand the DMC-ODS and eight percent more clients received services in FY 2019-20 than the previous year even with COVID-19 impacts.
- Clients in the 12-17 age group have a low penetration rate when compared to Large-size counties and the Statewide averages.
- Latino/Hispanics and Asian/Pacific Islanders are under-represented in their use of DMC-ODS services although they are the two largest race/ethnicity groups in Alameda. African Americans and Whites use more services proportional to their population size.
- More clients received non-methadone MAT services, but the rate still appears low. Two outpatient programs started offering non-methadone MAT services in

FY 2020-21 and Alameda is exploring adding outpatient MAT services at a new program in Union City. Alameda also anticipates adding MAT services to residential treatment programs in FY 2021-22.

- Telehealth and telephone support from peers are deployed by Alameda CBOs during the COVID-19 pandemic to improve clients' access to services.

Timeliness of Services

- Alameda clients have timely access to NTP services, usually receiving their first dose of methadone within a day after completing assessment.

- Clients discharged from residential treatment transition to another level of care at a higher rate than the Statewide experience.

Quality of Care

- Both adult and youth clients have good service initiation and engagement rates.

- Clients who participated in the 2020 adult TPS gave high ratings in Quality and General Satisfaction measures and domains.

- Client ASAM LOC referrals and placements show high congruence match to patient needs in initial screening and follow-up assessments.

Client Outcomes

- CalOMS data show Alameda clients having a high standard adult discharge rate and positive discharge improvement status which are both indicative of good treatment outcomes.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA)

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

ISCA Table 1 shows the percentage of DMC-ODS budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous two-year period, as well as the similar-size DMC-ODS and statewide averages.

ISCA Table 1: Percentage of Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19
Alameda	4.83%	1.98%	N/A
Large Size Group	N/A	3.09%	3.94%
Statewide	N/A	2.40%	3.16%

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

The following business operations information was self-reported in the ISCA tool and validated through interviews with key DMC-ODS staff by CalEQRO.

ISCA Table 2: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the DMC-ODS uses an ASP model to host EHR system which provides 24-hour operational support.	☐ Yes	☒ No
There is at least one person within the DMC-ODS organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No
If no one within the DMC-ODS organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The DMC-ODS performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

ISCA Table 3 shows the percentage of services provided by type of service provider.

ISCA Table 3: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	0%
Contract providers	100%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in ISCA Table 4.

ISCA Table 4: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	2	0	0	0
2019-20	2	2	0	0
2018-19	N/A	N/A	N/A	N/A

DMC-ODS self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in ISCA Table 5.

ISCA Table 5: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	3	0	0	1
2019-20	2	1	0	1
2018-19	N/A	N/A	N/A	N/A

The following should be noted with regard to the above information:

- The ACBH IS team supports both Mental Health and SUD as they share the same EHR and practice management system.
- The total number of FTE positions in ACBH IS has decreased due to budget challenges related to the COVID-19 pandemic.
- An InSyst SUD Billing and Claiming Analyst vacancy was recently filled.
- Whole Person Care funding of a data analyst position will end in June 2021.
- Data analytics staff are not specifically assigned to MH or SUD, the SUD FTE represents the estimated amount of work.

Summary of User Support and EHR Training

ISCA Table 6 provides the number of individuals with log-on authority to the DMC-ODS EHR. The information was self-reported by DMC-ODS and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

ISCA Table 6: Count of Individuals with EHR Access

Type of Staff	Count of DMC-ODS Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	44	41	85
Clinical Healthcare Professional	32	393	425
Clinical Peer Specialist	0	0	0
Quality Improvement	7	7	14
Total	83	441	524

ISCA Table 7: EHR User Support

EHR User Support	Status	
DMC-ODS maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
DMC-ODS utilizes an ASP model to support EHR operations which is hosted at IS vendor Data Center and staffed 24/7.	☐ Yes	☒ No
DMC-ODS also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
DMC-ODS also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

ISCA Table 8: New Users EHR Training

New Users EHR Training				
Training Category	**QI**	**IT**	**ASP**	**Local Super Users**
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☒	☒	☐	☒

ISCA Table 9: Ongoing EHR Training and Support

Ongoing EHR Training and Support	Status	
DMC-ODS maintains a formal record of EHR training activities to evaluate quality of training material.	☒Yes	☐ No
DMC-ODS routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
DMC-ODS maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

- Contract providers are encouraged to train their CG users using the train-the-trainer model but if needed, ACBH IS staff will provide webinar training.

- All CBO InSyst data input and clinical users are required to attend formal classroom training. Due to current COVID-19 constraints, webinar training is offered weekly based on request and demand.

Telehealth Services Delivered by County

DMC-ODS county-operated clinics and program currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 10: Summary of DMC-ODS Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	25
Number of county-operated telehealth sites	0
Number of contract providers' telehealth sites	25

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☒ To serve beneficiaries temporarily residing outside the county
- ☐ To serve special populations (i.e., children/youth or older adult)
- ☒ To reduce travel time for healthcare professional staff
- ☒ To reduce travel time for beneficiaries
- ☐ To support NA time and distance standard
- ☒ To address and support COVID-19 contact restrictions

Summarize DMC-ODS use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and DMC-ODS provider staff.

- Many outpatient providers migrated to telehealth services during the pandemic. Currently, 17-18 percent of all services in the DMC-ODS system are performed via telehealth or telephone.

- Telehealth is deployed to support meeting time and distance standards and further serve beneficiaries with mobility issues. Between October 2019 to September 2020, 25 CBO sites have provided telehealth services to 625 clients for a total of 4,963 encounters.

Identify from the following list of California-recognized threshold languages that are directly supported by the DMC-ODS or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☒	Cambodian
☒	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☒	Mandarin	☒	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☒	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 11: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Options Recovery Services	5
La Familia	4
Horizon Services Inc.	3
HealthRight360	2
Magnolia Women's Recovery	2
Second Chance Inc.	2
Bi-Bett	1
City of Fremont	1
CURA	1
H.A.A.R.T.	1
Highland Hospital	1
Lifelong Medical Care	1
New Bridge Foundation Inc.	1
Total:	25

Current DMC-ODS Operations

- Alameda uses two legacy systems to support DMC-ODS clinical operations and billing and both systems are supported by the ACBH IS team.
- Clinician's Gateway is the EHR and InSyst is the practice management system.
- YellowFin is Alameda's application for business intelligence reporting, and it is integral to support a data warehouse which includes data from the EHR and practice management system along with over thirty external data sources. YellowFin is managed by the Data Services Team in ACBH IS.

- Salesforce COVID-19 Hotel application has been developed for DMC-ODS county staff for use in the COVID-19 SUD hotels.
- Alameda County's Social Health Information Exchange is AC Care Connect and ACBH is participating in its development.
- ACBH has selected a vendor to implement a new billing system and contract negotiations are currently under way.

ISCA Table 12 lists the primary systems and applications the DMC-ODS uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Drug Medi-Cal and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

ISCA Table 12: Primary EHR Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Hosted By
InSyst	Practice Management – Registration and Claiming	Echo	29	County
Clinician's Gateway	Clinical – EHR	Krassons, Inc	12	County
RxNT	E-Prescribing	Networking Technology, Inc	9	Vendor & County
YellowFin	Business Intelligence	YellowFin	9	ACBH-IS
Salesforce	Tracking COVID-19 clients in hotels	Salesforce Team in SF	2	SAS

The DMC-ODS Priorities for the Coming Year

- Finalize contract negotiations with the selected vendor for a new billing system. Project planning is scheduled for March through June 2021 with an estimated completion date of July 2023.
- Migrate ACBH active directory to the County's domain to support better management of user permissions.
- Upgrade the eCura managed care system.

- Develop a Customer Relationship Management (CRM) system for substance use disorders and homeless clients at the COVID-19 hotels for contact tracing and management.
- Expand e-prescribing and medical staff functionality to Clinician's Gateway's SUD environment.
- Recruitment of IS staff to fill vacancies.
- Develop YellowFin public facing dashboards for contract provider access.
- Expand beneficiary e-signature via signature pads and tracking in Clinician's Gateway.
- Create a secure data portal for distributing reports to users via ShareFile.
- Collaborate with HCSA on the Alameda County Care Connect and integrated Community Health Record system to support data file uploads from ACBH-IS is a current but especially important process.

Major Changes since Prior Year

- Migrated to multi-factor authentication for additional system security.
- Migrated the Confidentiality, Security, and Usage Agreement and Electronic Signature Agreement to an electronic form so that staff could submit it from home during shelter-in-place.
- Assisted several hundred County employees with hardware and software requests so that they could work from home during the COVID-19 pandemic.
- Created dashboards for: Telehealth, Productivity, SUD DMC, Timeliness and Plan Administration.
- Upgraded all 3Par array storage systems to solid state drives.
- Developed templates and security configurations to support increased care coordination in expanded DMC-ODS system to include drug court, withdrawal management programs and new county jail SUD programs.
- Upgraded all ACBH workstations and laptop devices to Windows 10.
- Continued implementation of Apttus services, a contract lifecycle management system for Mental Health, SUD, services as needed and FFS contracts.
- Started work to develop reports for Timeliness monitoring.

- Started work to implement a provider portal that has a public access component as well as a secured community login for providers to view their information.

Plans for Information Systems Change

- A new billing system has been selected but not yet in implementation.

DMC-ODS EHR Status

ISCA Table 13 summarizes the ratings given to the DMC-ODS for EHR functionality.

ISCA Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Clinician's Gateway	☒	☐	☐	☐
Assessments	Clinician's Gateway	☒	☐	☐	☐
Care Coordination	Clinician's Gateway	☒	☐	☐	☐
Document Imaging/ Storage		☐	☐	☒	☐
Electronic Signature—DMC-ODS Beneficiary		☐	☐	☒	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	Clinician's Gateway	☒	☐	☐	☐
Outcomes	Clinician's Gateway	☒	☐	☐	☐
Prescriptions (eRx)	Clinician's Gateway	☒	☐	☐	☐
Progress Notes	Clinician's Gateway	☒	☐	☐	☐
Referral Management	Clinician's Gateway	☒	☐	☐	☐
Treatment Plans		☐	☐	☒	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		8	0	4	0
FY 2019-20 Summary Totals for EHR Functionality:		8	0	4	0

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

- Increased care coordination:
    - Expand CG to include Drug Court portal services, WM programs and new County Jail SUD programs. Developed templates and security configurations.
    - Expand access for CBO co-occurring programs in County Jail to allow viewing of client face-sheets in CG Mental Health Services database.
    - Created Drug Panel Test Report and Court Report templates for standardized communication of programs with Drug Court.
- Streamline workflow:
    - Streamlined workflow by creating a pre-populated ALOC Review template (ASAM Level of Care follow-up document).
    - Streamlined workflow for WM site by creating specialized Intake template and a specialized ALOC for the case manager.
    - Created specialized ALOC for out-of-county OTP programs to enter ASAM State Minimum data only.
    - Created Outreach and Engagement template to allow CG do documentation and automatic transfer of outreach activities to InSyst, eliminating InSyst data entry. Adapted Discharge Plan per requests.
- Added medical staff functionality:
    - Expanded e-Prescribing CG SUD to accommodate SUD Psychiatrist & Addiction Medicine MD prescribing and accommodate MAT prescribers in SUD outpatient programs.

- Online annual agreements for staff:
    - Migrated the Confidentiality, Security, and Usage Agreement and Electronic Signature Agreement to an electronic form so that staff could submit it from home during shelter-in-place.

Contract Provider EHR Functionality and Services

The DMC-ODS currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

ISCA Table 14 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the DMC-ODS's EHR system, by type of input methods.

ISCA Table 14: Contract Providers' Transmission of Beneficiary Information to DMC-ODS EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to DMC-ODS EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and DMC-ODS EHR system	0%	Not used
Electronic batch files submitted to DMC-ODS for further processing and uploaded into DMC-ODS EHR system	80%	Daily
Direct data entry into DMC-ODS EHR system by contract provider staff	20%	Daily
Electronic files/documents securely emailed to DMC-ODS for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to DMC-ODS for data entry input by DMC-ODS staff into EHR system	0%	Not used

ISCA Table 15: Type of Input Method for NTP/OTP Providers

Type of Input Method For NTP/OTP Providers	Status	
NTP/OTP providers enter data on dosing and counseling services directly into DMC-ODS billing system.	☒ Yes	☐ No
NTP/OTP providers enter dosing and counseling services into local EHR and submits batch file for upload into DMC-ODS EHR system.	☐ Yes	☒ No
NTP/OTP providers enter dosing and counseling services into local EHR and produces EDI 837 transaction claim file which is submitted to DMC-ODS who then submits claim file to DHCS for adjudication.	☐ Yes	☒ No

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. ISCA Table 16 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the DMC-ODS.

ISCA Table 16: EHR Vendors Supporting Contract Provider to DMC-ODS Data Transmission

EHR Vendor	Product	Count of Providers Supported
EPIC	EPIC	2
Netalytics	Methasoft	2
Welligent	Welligent	2

Special Issues Related to Contract Agencies

- All Alameda DMC-ODS services are provided by CBOs.
- CBO users register clients and open/close episodes including CalOMS data in InSyst. NTP programs enter service encounters and dosing data directly into InSyst.
- Clinical documentation including notes, medical necessity, ASAM screening and assessment and drug testing are entered into CG. 20 percent of the data is

entered directly into the EHR and 80 percent is sent via electronic batch file uploads.

- Finalized progress notes and entered services are transferred nightly from CG to InSyst for outpatient, IOT and residential services.
- In 2020, DST, Privacy, and Quality Management/Quality Improvement leads formed a Data Governance Committee that meets biweekly to review external data requests for the purpose of supporting clinical operations decisions while ensuring compliance with health privacy/security requirements.
- This group has collaborated to expand YellowFin dashboards and reports to CBOs with appropriate privacy/security configurations.
- This group has also partnered with a CBO outpatient/recovery residence provider to develop a monthly customized automated report to support their quality improvement efforts and state reporting needs.

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

ISCA Table 17: Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey

Findings Related to ASAM Level of Care Referral Data, CalOMS, and Treatment Perception Survey	Yes	No
ASAM Criteria is used for assessment for clients in all DMC Programs.	x	
ASAM Criteria is used to improve care.	x	
ASAM screening is entered directly into the EHR.	x	
ASAM assessment is entered directly into the EHR.	x	
TPS is administered in all Medi-Cal Programs.	x	
CalOMS is administered on admission, discharge, and annual updates.	x	
CalOMS is used to improve care by tracking discharge status and other outcomes.	x	

Highlights or challenges of use of outcome tools above:

- The county-developed screening based on ASAM criteria is incorporated into CG.
- TPS data is analyzed by age, gender, and race/ethnicity of clients to identify quality improvement opportunities.

- CalOMS discharge code results are included on client discharge summary forms and provide some direction to providers on further follow-up needed. SUD also uses some CalOMS data elements in YellowFin dashboard reports, which is shared with providers to review outcomes at a systems level. In addition, ACBH creates a monthly Power report with CalOMS data, such as the Completion Status Report, which SUD uses to determine overall trends in treatment completion and referrals to another level-of-care.

Overview and Key Findings

Operations and Structure

- While ACBH has added staffing to the CG Help Desk to support contract providers in their use of the EHR in the past year, both technology and data analytics staff levels to support DMC-ODS operation remains lean, and conversion to new billing system will be exceedingly difficult without new resources.

- A vendor has been selected to implement a new billing system and contract negotiations are ongoing.

- Enhancements and modifications were made in CG in the last year in support of telehealth, care coordination and workflow streamlining.

- YellowFin reports and dashboards are used successfully to provide decision support to SUD leadership. The most frequently used SUD dashboards are Timeliness, Case Management, Engagement, Length of Stay, Transfers in Care and Residential Treatment Capacity.

Key Findings

- Alameda has a long list of technology projects prioritized for the coming year, including the implementation of a new billing system. It will be critical to have adequate staffing to resource these projects to ensure their successful completion.

- A Data Services priority in 2021 is to improve CBOs' access to data. The scope of work includes how CBOs request data and the approval process, configuration of CBO data at the agency and reporting unit levels to respect privacy and security concerns, and an audit trail on report permissions and access. When this project is completed, contractors who are interested will have access to critical performance data and a subset of critical reports and dashboards.

- The SUD online Provider Directory is updated monthly but information is difficult to search or filter. ACBH has plans to revamp its SUD web portal that will support user-friendly content presentation and information searches.

NETWORK ADEQUACY

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate Network Adequacy as required by state law. The first document to be reviewed is the NACT which outlines in detail the DMC-ODS provider network by location, service provided, population served and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an Alternative Access Standards (AAS) request would be submitted for approval by DHCS.

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, the time and distance requirements are 30 minutes and 15 miles for substance use disorder services, and 30 minutes and 15 miles for NTP/OTP services. The two types of care that are measured for DMC-ODS NA compliance with these requirements are outpatient and intensive outpatient SUD services and NTP/OTP services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with DMC-ODS staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted one client and family member focus group, seven stakeholder interviews with staff and contractor providers, and discussed access and timeliness issues to identify problems for beneficiaries in these areas and in the county.

Findings

There was one zip code, 95391, which has a need for an AAS in Alameda County for time and distance. This zip code includes part of San Joaquin county and includes three Alameda beneficiaries are outside the time and distance requirements and others who appear to be residing in San Joaquin county according to Alameda county staff. They are willing to offer services in Alameda county and are concerned that some are permanent residents of San Joaquin who have not yet changed their Medi-Cal to their county of residence. They are willing to assist them accessing SUD services if they need them and are considering special outreach to these few beneficiaries to offer services and information, but first they are working with DHCS to discuss the appropriate options. The services in question are NTP/OTP services for youth and adults.

Nonetheless the NTP closest in network provider is Aegis in Manteca at 28 minutes from this zip code, and the closest out of network provider is Axis in Pleasanton at 34 minutes and Axis in Livermore at 30 minutes from this zip codes. Axis is an FQHC which provides MAT for opioid use disorders and alcohol use disorders, but at this time cannot provide methadone. These are times for access to NTP services for adults. The proposed AAS is 20.6 miles for Aegis for adults. The proposed AAS for youth is 34.2 miles for HAART, the only youth serving NTP in the region. Alameda is awaiting the decision from DHCS on these proposals.

Alameda has asked for the proposed AAS request to be approved. There has not been interest from new providers to open sites in eastern Alameda county due to low demand and the start-up and ongoing operational costs.

Plan of Correction/Improvement by DMC-ODS to Meet NA Standards or Enhance Access for Medi-Cal Patients

Alameda is still working with DHCS on their AAS request and has also been working with DHCS on their capacity issues as in the Network Adequacy Capacity Findings Report.

Alameda works with the local health plans on transportation access and has also supplemented this with bus vouchers and other supports to access including now video and phone sessions. All of the contract agencies which provide the SUD services in Alameda quickly shifted to video and phone sessions and worked with clients to upgrade their phones when possible if they were getting them through homeless services or other low-income sources or plans. Details of these health plan services are made available to staff at the contract providers. Funds for additional supports from bus vouchers and case management supports were also available when needed, though COVID-19 limited some of the personal transportation services.

Access for those with physical disabilities as required by the Americans with Disabilities Act (ADA) was also reviewed. Per Alameda this is a fundamental contract requirement for health services contracts and many facilities needed modifications of their facilities over

the last decade to reach an acceptable level to be able to serve these populations. Periodic inspections are required as well, and grievances on these issues are taken seriously by the contract division and quality assurance staff if submitted. Alameda's Medi-Cal beneficiary data indicates a higher-than-average percent of persons with disabilities in their services and that includes those with serious mental illness. Per staff, this area has required extra training and support as ASAM assessments are now directing more co-occurring clients into SUD treatment LOC than before the Waiver. Additional skills are required in the SUD treatment programs to adequately serve these clients successfully, as well as ongoing coordination and access to mental health care, particularly medication and case management.

Alameda county does serve Native American clients within its programs but does not have any Native American clinics within its jurisdictions. They were aware of programs in the north bay and surrounding areas for coordination as needed.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as “a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner.” CMS’ EQR Protocol: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each DMC-ODS that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

CMS revised the protocols in October of 2019. On the first page of the new protocol a PIP is defined by: "A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or the MCP/system level. "

Alameda DMC-ODS PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. Alameda submitted two PIPs which were reviewed and validated as shown below.

PIP Table 1: PIPs Submitted by Alameda

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Improving Timely Access to Residential Treatment
Non-clinical	1	Recovery Coach Supports for Withdrawal Management

Clinical PIP

PIP Table 2: General PIP Information, Clinical PIP

DMC-ODS Name	Alameda
PIP Title	Improving Timely Access to Residential Treatment
PIP Aim Statement	Does implementation of 1) improved processes for engaging assessed individuals needing residential treatment such as three-way calling for immediate provider connections for intake appointments and a bed availability mobile application, improve timeliness of access to residential treatment by 20%?

DMC-ODS Name	Alameda
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17) * ☒ Adults only (age 18 and above) ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): All adults with all diagnoses calling Access for SUD treatment and screened as needing residential treatment using ASAM screening tool.	

PIP Table 3: Improvement Strategies or Interventions, Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): New intervention for member is direct, immediate linkage on the phone to program provider for intake appointment after screening so they can plan on a time to begin care and talk to the program staff directly. Staff from program can also then send reminders, off assistance for transportation, answer questions for the prospective residential client on the program prior to admission.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Access staff are trained in new three way calling and on new real time access to resource database for residential bed availability with daily updates.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): System of care can update resource levels in real time and share data with care managers across the system, Access Call Center, and also the public if made available to them.

PIP Table 4: Performance Measures and Results, Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of residential capacity utilized daily	18/19	52.4% 22,074	19/20 ☐ NA*	65.1% 45,370	☒ Yes ☐ No	☒ Yes ☐ No Goal was 20% achieved 24.2%
Average time from screening to first treatment appt at residential	18/19	9.09 days	7/20-12/20 ☐ NA*	12 days	☐ Yes ☒ No	☐ Yes ☒ No -32%
Average time from referral to first treatment appt at residential	18/19	16.43 days	7/20-12/20 ☐ NA*	13 days	☒ Yes ☐ No	☒ Yes ☐ No
Percentage of intakes done with three-way calls with clients at residential sites	none	none	7/20-12/20 ☐ NA*	79%	☒ Yes ☐ No	☒ Yes ☐ No):

Was the PIP validated?	☒ Yes	☐ No

Validation phase:

☐ PIP submitted for approval.

☐ Planning phase

☐ Implementation phase

☐ Baseline year

☒ First remeasurement

☐ Second remeasurement

☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: This COVID-19 period was very unstable period for testing this PIP in that residential capacity was reduced, new requirements were added such as COVID-19 testing, quarantines, that delayed access. These events, which were not the fault of the program, but were necessary for safety, complicated the results. The three-way call services and the real time bed capacity additions had been immensely helpful in reducing time for access in other counties in "normal" times, but this was not the environment for this PIP. BHC recommended continuing another year if possible, with refinement of tracking of activities required prior to admission added due to COVID-19, also consider navigator or CM assistance for clients between referral and admission which is common intervention with successful outcomes in other counties, detail the engagement efforts pre-intake, and first week post intake when drop-outs are common. Alameda is considered for third year PIP.
The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: PIP was reviewed several times prior to visit from original concept and then due to concerns related to COVID-19 impacts. The workflow on the admission process to residential with required timelines and authorization process has been a challenge in many counties in relation to obtaining documentation needed in timely manner for medical necessity and treatment plan. This was particularly true for WM residential. Sample tools to assist are available on ASAM website and in the 5th edition of Principles of Addiction Medicine.

Non-clinical PIP.

PIP Table 5: General PIP Information, Non-Clinical PIP

DMC-ODS Name	Alameda
PIP Title	Recovery Coach Supports for Withdrawal Management
PIP Aim Statement	Does providing recovery coach services to WM clients increase engagement with treatment services after discharge by 10% and reduce re-admissions into WM by 10% within 30 days?

DMC-ODS Name	Alameda
Was the PIP state-mandated, collaborative, statewide, or DMC-ODS choice? (check all that apply) ☐ State-mandated (state required DMC-ODS to conduct PIP on this specific topic) ☐ Collaborative (multiple DMC-ODSs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ DMC-ODS choice (state allowed DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Youth only (ages 12-17) * ☒ Adults only (age 18 and above) at Cherry Hill 3.2 WM ☐ Both Adults and Youth *If PIP uses different age threshold for youth, specify age range here:	
Target population description, such as specific diagnosis (please specify): Adults 18 and older admitted to Cherry Hill 3.2 WM discharged with recommended aftercare plans for another level of treatment, either outpatient or residential treatment.	

PIP Table 6: Improvement Strategies or Interventions, Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Early engagement by staff at Cherry Hill with residents to encourage ongoing work on SUD and introducing Recovery Coach as support to help with transitions. Recovery Coach also provides education and relationship building, exploring needs/barriers to make transition for next level of care, and understanding stages of change, and warm hand-off.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers are training on motivational interviewing, risks of relapse, warning signs, stages of change, identification of barriers to transitions, options for motivation and support in transitions, options for transportation, benefits and rewards for engagement, case management skills, etc.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Use of peers to help clients in engagement and linkage between levels of care, finding resources to make it possible to work on SUD, help with benefits, transportation, mobile phones if homeless, shelters, etc.

PIP Table 7: Performance Measures and Results, Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of clients who connect to any SUD treatment within 10 days	12/18-11/19	722 38%	12/19/- 12/20 ☐ NA*	810 32%	☐ Yes ☒ No	☐ Yes ☒ No
Percent of clients who connect to any SUD treatment within 30 days	12/18-11/19	722 43%	12/19-12/20 ☐ NA*	810 36%	☐ Yes ☒ No	☐ Yes ☒ No
Percent of clients readmitted to WM within 30 days	12/18-11/19	722 8%	12/19-12/20 ☐ NA*	810 20%	☐ Yes ☒ No	☐ Yes ☒ No
Percent of clients who connected to treatment who actually saw and worked with the Navigator	There was no client Navi-gator	43 clients with recovery services	7/20-11/20	**With** recovery 56% in trt in 10 days **Without** coach 31% in trt in 10 days Difference=81 %	☒ Yes ☐ No	☒ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated?	☒ Yes	☐ No

Validation phase:

☐ PIP submitted for approval.

☐ Planning phase

☐ Implementation phase

☐ Baseline year

☒ First remeasurement

☐ Second remeasurement

☐ Other (specify):

This had one re-measurement, but environment compromised by COVID-19 impacts complicating intervention of recovery navigator with clients in WM making transitions.

Validation rating:

☐ High confidence

☐ Moderate confidence

☒ Low confidence

☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP: With vaccines and stabilization, repeat PIP with robust intervention using findings related to intense intervention period of initial period prior to and following discharge for intense activity. If needed increase number of clients impacted to measure impact more fully by having more recovery coaches. Hundreds of clients are discharged from Cherry Hill yet only 43 were engaged and so if more can be served by recovery coach the impact can be measured and seen more clearly. Good if you continue to track multiple levels of care.

The technical assistance (TA) provided to the DMC-ODS by CalEQRO consisted of: Besides data consultation in the year prior to the review on the PIP, BHC also recommended a 6-month follow-up consultation with data to discuss validity and see if the impacts are clearer for interventions for those getting the navigation services versus those not connecting with services. It is unrealistic to expect the impact of the recovery coach to effect hundreds of discharges they have no contact. Cherry Hill had 810 discharges. This is an important design issue. Service should be available to all or to all going to a specific program. If all is too great a number, then focus on discharges to specific LOC and measure the impact on all clients served.

CLIENT FOCUS GROUPS

CalEQRO conducted one 90-minute Adult client member focus groups during the Alameda DMC-ODS site review. As part of the pre-site planning process, CalEQRO requested the focus group with six to eight participants each, the details of which can be found in the section below. The groups were conducted through video conference technology in keeping with health safety precautions during the COVID-19 pandemic.

The client/family member focus group is an important component of the CalEQRO review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group include survey questions that are completed by the focus group participants prior to the focus group discussion. Their responses and the subsequent discussion with them 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: Adult Residential Treatment Group

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

This was a Spanish speaking focus group where seven people in the treatment program completed the survey but only five could participate in the live group. There was a translator. All seven people were between 25 and 59 and three had English as a preferred language and four had Spanish. There was one African American, one Caucasian, and five Latinx persons and all seven were male.

Number of participants: five in live group and seven completed surveys.

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.	4.1	4-5
2. I got my assessment appointment at a time and date I wanted.	4.3	3-5
3. It did not take long to begin treatment soon after my first appointment.	3.9	2-5
4. I feel comfortable calling my program for help with an urgent problem.	4.1	2-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	4.1	4-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.3	4-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.1	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.0	3-5
9. I feel like I can recommend my counselor to friends and family if they need support and help.	4.4	4-5

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

- Easy and quick to get into residential for all despite COVID-19 and reduced beds (capacity 20 and only about 12 residents now). Those who responded got in between 1-2 weeks.

- Biggest challenge is not being able to leave the house because of COVID-19 and risk of contamination, and people who provide other services cannot visit like they used to, and family cannot come in.

- “Counselors give good advice and care how you are really doing. They call in regularly by phone, but it is quite different than having them there in person.”

- “This program offers continuing care, like stepping down in treatment. I didn’t get that in other programs I was in.”

- “Glad they respect me and don’t just lecture or preach.”

- “I feel I’m treated well; they ask me what I need and always try to be helpful.”

- “This program is helping with what I need, and I am appreciative of all they do.”

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

- One man said that this is his first time in recovery, and he is surprised and glad they are not preachy. They listen to him and meets his needs. If he needs to sleep, they let him.

- The only Spanish speaker in the group says he is treated the same as everyone and gets what he needs.

- All were offered mental health care in the assessment. A MH therapist calls once a week to offer assistance and support. They will take you to the doctor to get medication. One client does get medication.

- Staff explain what is going on with COVID-19 restrictions and are helping with vaccines.

- One man said that almost everyone who has left while he has been there has gone to Sober Living. But when he was with Kaiser, there was not any step-down help if he did not have a house to go to.

- There are resources to help you find a job so you can live.

- There is a regular schedule and “we learn a lot about addiction.”

Recommendations for improving care included the following:

- Have more communication about feelings, services, stress, what happens next, how to make it, how to think things through.

- More family interaction and support, by phone, video and eventually in person. “It is so motivating, so helpful, so much harder when you feel alone.”

- “It would be a good idea to have a family program, where the family could learn more about addiction and how to be with us in recovery. I think my family would like to learn more about how we can all recover.”

- “Want to be able to go to work or be able to be distracted at the park. Something to breath fresh air and connect even if not close.”

- “I think dealing with more real-world experiences would help the program.”

- “Would like to have more groups and activities. Like AA meetings here.”

- “More Zoom connections with people, community, music, anything.”

- “Be able to work out and get more exercise, helps stress.”

Client Focus Group Findings and Experience of Care

Overview

Group was engaged and eager to share experiences. Group had initial first-time clients and repeat clients present. Overall, positive feedback, and felt the program was helping and had many good elements. Restrictions in terms of community engagement from COVID-19 were limiting some aspects of the program that client found helpful such as family and therapist/counselor contact.

Access Feedback from Client Focus Groups

- Admission to services was reported as relatively easy by residents. No major barriers were reported.
- Residents came from multiple referral sources including self-referral.

Timeliness of Services Feedback from Client Focus Groups

- As noted, no major delays in access were noted by current residents.
- This was surprising in that there was reduced bed capacity from 20 to 12.

Quality of Care Issues from Client Focus Groups

- MH interface and support were noted and appreciated by residents including one person on medications.
- Strong desire for more family therapies, counselor time and interface, and community programming to enhance program were noted.
- Several residents appreciated step-down options to continue support of counselors and clean and sober housing options with assistance with jobs and support services and continued help, comparison to other program was positive in terms on long term needs of chronic illness.

Client Outcomes Feedback from Client Focus Groups

- Desired long-term goals of jobs, housing, connection with family was positive.
- Felt respected and supported by counselors and services were making a difference for them in their coping skills and knowledge of their SUD.

- Program was keeping them involved and educated on COVID-19 and helping with vaccines and health activities as well as SUD.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1: Access to Care Components

KC Table 1: Access to Care Components		
Component		**Quality Rating**
1A	Service Access are Reflective of Cultural Competence Principles and Practices	M
Alameda's Quality Program includes a strong Cultural Competence component with many initiatives in their annual plan which was updated in the fall of 2021. It incorporates many activities linked to local activities to foster equitable access to behavioral health services including SUD for specific ethnic populations. Since Alameda County is one of the most ethnically diverse counties in California. Some of the special initiatives in their plan this year include expanded access efforts for Asian and Pacific islanders as was discussed previously in the report, and a special practice standard program initiative for SUD related to services for African American, Latinx, and Asian Pacific islander clients which includes special media outreach and workforce and facility approaches. This is tracked using data regularly monitored through service utilization and community public health data. They also use the CLAS standards as part of this effort with all of their contract agencies.		
1B	Manages and Adapts its Network Adequacy to Meet SUD Client Service Needs	M
As noted with Yellowfin and other data tools, services by client groups and languages utilization and access to services are monitored overall and by region. Placement of new contract agencies and types of agencies is tailored to meet gaps in the continuum of care and meet cultural and special needs of groups that are		

KC Table 1: Access to Care Components		
Component		**Quality Rating**
underserved in different communities. An example of this is the new Asian Pacific Islander outpatient and intensive outpatient program in Union City.		
1C	Collaboration with Community-Based Services to Improve SUD Treatment Access	M
There are a large number of community groups as well as other county departments and organizations coordinating with the Health Agency and Alameda Substance Use Continuum of Care to enhance access and treatment quality for those with special cultural needs. These unique contract agencies such as the one in Union City are a special asset for connecting to local schools, places of faith, libraries, social services, and senior centers to seek connections for referrals for those with SUD who would be hesitant to go to traditional government offices for help. Leadership in the county is aware that these agencies are needed to connect to the community to have effective service delivery in these important cultural communities within Alameda county. Alameda will be putting the Behavioral Health Equity Initiatives on its redesigned website.		

Timeliness of Services

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

KC Table 2: Timeliness to Care Components

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Appointment	M
This data is tracked for all routine appointments from request to first appointment. The county provided examples of the data, as well as their detailed business rules for the calculation of those metrics. Routine appointments met the DHCS standard of ten business days 90 percent of the time for adults and 95 percent of the time for youth with the mean being 3.6 days for adults and 2.7 days for youth.		
2B	Tracks and Trends Access Data from Initial Contact to First Methadone MAT Appointment	M
Methadone is accessed within two days as a mean 92 percent of the time which meets the DHCS standard which is three days.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	PM

KC Table 2: Timeliness to Care Components		
Component		**Quality Rating**
Urgent is defined by Alameda as a service for: 1) pregnant client requiring WM, 2) client at imminent risk of overdosing in the next few hours or days, 3) client indicating they are running out of anti-craving medication, 4) client indicating urgent need of substance use service. The calculation method is complex and based on days. 48 hours is the standard.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential Treatment	M
Alameda did track and trend this data and provide their methodology it was broader than that of CalEQRO in that it counted Recovery Residence, which is not a billable service but overall, the methods were similar other than CalEQRO just measures Medi-Cal clients. Nine percent of their clients had a follow-up service within 6 days after discharge from residential treatment.		
2E	Tracks and Trends Data on Follow-up and Re-Admission to Residential Withdrawal Management	M
Alameda also does track re-admissions to WM residential within 30 days, and reports averaging 24 percent re-admissions which is higher than the statewide average. However, it must be noted that Alameda also has a much higher number of WM beds in their continuum of care than most counties even larger counties, so overall, there is more access to WM in Alameda county proportionally than other counties statewide.		
2F	Tracks Data and Trends No Show Data for Initial Appointment	M
Tracking this data has been part of the Non-clinical PIP which focused on timeliness of access to Residential intakes, but also tracked the first intakes to other levels of care as well. The new three-way calling software allowed the Access Call Center to link to the providers to set up appointments with the client requesting services on the line and this enhanced successful first appointments, linkage to providers for information, reminders, and re-schedules if needed, and better customer service.		

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 having an older computer system and working on options for systemic upgrades, Alameda developed a data warehouse and uses a product called Yellowfin to mine data from many sources to create user friendly reports for management and contractors. This endeavor which began several years ago has shown positive results including for the DMC-ODS programs. It is used extensively in meeting the quality and performance requirements of the 1115 Waiver, tracking goals for cultural competence, access, timeliness, revenues, and units of service, and is very graphic making it easy for non-technical staff to understand the dashboards. Additional resources were added to make these systems work to build teamwork, and enhance program performance, and this has been evident in data seen in the two DMC-ODS reviews.		
3B	Data is used to inform management and guide decisions	M
Data is used in decisions and meeting as evidenced by reports reviewed and the Quality Improvement Plan and evaluation. Also, the initiatives in the Cultural Competence Plan update appeared to lead to contract decisions based on data and key indicators of need in specific communities.		
3C	Evidence of effective communication from DMC-ODS administration and SUD stakeholder input and involvement on system planning and implementation	M
Meetings on reviews included multiple stakeholders from outside the DMC-ODS and Agencies which documented joint planning and collaborative activities. They shared initiatives where they were collaborating on community problems related to SUD, overdose prevention, domestic violence, youth needs, health and prevention, early intervention, and coordination with access to treatment during and after jail, prison, and court experiences. Probation was actively helping DMC-ODS with transitions out of the Prison system with MAT medical records to link with care and treatment, the Sheriff's Department, community clinics, Highland Hospital Emergency Department leadership and others were working on joint protocols for safety nets for client care. See the list of attendees in Attachment B.		
3D	Evidence of an ASAM continuum of care	M
Alameda does have most of the ASAM levels of care except partial hospital and levels 3.7 and 4.0 which are not required. However, they do feel they need additional capacity and distribution of services across their large county and more youth services and cultural diversity in some of the services to make them more accessible to more vulnerable groups.		
3E	MAT services (both outpatient and NTP) exist to enhance wellness and recovery:	M

KC Table 3: Quality of Care Components		
Component		**Quality Rating**
There are a large number of NTP/OTP programs as well as two new outpatient non-methadone programs in the county. The county goal is to continue to expand the non-methadone outpatient programs to additional sites as well.		
3F	ASAM training and fidelity to core principles is evident in programs within the continuum of care	M
Alameda has a high level of matching clients to their recommended level of care and tracks and trains staff to understand the importance of this clinical principle. Monthly clinical trainings with Dr Mee-Lee continue on ASAM and case staffing as well. Screenings were rated at 94.5 percent, assessments were rated at 78.2 percent, and re-assessments were rated at 92.0 percent.		
3G	Measures clinical and/or functional outcomes of clients served	M
CalOMS is used for outcomes through tracking discharge status from all programs except recovery support services. Alameda has a low administrative discharge rate (11.6 percent), and a high percentage of clients indicating progress upon discharge compared to statewide (75.8 percent compared to 45.8 percent).		
3H	Utilizes information from client perception of care surveys to improve care	M
TPS ratings were high for satisfaction and client respect and most dimensions. Similar to other counties coordination with MH and healthcare were somewhat lower. Ratings by site were used to engage contractors in quality improvement efforts specific to their issues. It is hoped that next year more surveys will be collected when in person as well as online surveys will be easier to collect as numbers of responses were reduced. Also, an increase in responses from diverse ethnic groups and youth would make the survey more representative.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Added three-way calling to Access Call Center to provide appointments to clients requesting care linking them to providers for intake services.
- Added capacity with two outpatient MAT contractors, residential, outpatient and intensive outpatient for Asian Pacific Islanders in Union City, and 23 additional beds for AB 109 clients.
- Expanded youth services by moving to new expanded site ending PED approval.
- Provided outreach and engagement to persons with SUD living in hotels living in Project Roomkey locations to link them to care in the SUD system.
- Dedicated funding to media campaign to reach community members at risk in the COVID-19 pandemic to office behavioral health services and supports.

Opportunities:

- Continue efforts to establish real time database of residential bed resources and other system of care resources for use in Access Call Center and other “gates” to the system and for ease of access to care.
- Continue efforts to re-design website to be more user friendly and accessible with key information easy to find and in no more than eighth grade language.
- Continue efforts at capacity building for underserved populations and hard to reach groups using mobile services, outreach and special cultural competence initiatives and practice standards.

Timeliness of DMC-ODS Services

Strengths:

- Timeliness tracking of offered and access to routine visits, MAT assessments and dosing, first contacts are incorporated into data systems and dashboards for staff. State standards are met.

- All timeliness services are tracked and monitored.

Opportunities:

- Timeliness of access for residential and residential WM can be improved and should continue to be tracked to see if additional barriers in workflows could be identified.

- Urgent requests, which link to the WM residential LOC and the sobering facility, are over the state standard. It is important to identify the barriers to reducing the time, or make the definition clearer related to the state of withdrawal the client is in for urgent using one of the scales used in other counties.

Quality of Care in DMC-ODS

Strengths:

- Added a recovery navigator to Cherry Hill WM to enhance connections to lower levels of care. For the clients who were assisted by the navigator it increased the connections and timeliness to the next LOC.

- Identified and targets specific ethnic disparities and developed initiatives and goals to improve those disparities as part of quality plan.

- Model NTP and Santa Rita Jail SUD MAT treatment program serve clients and transition them into a range of community programs as part of large collaborative models.

Opportunities:

- Additional stable funding is needed to sustain and support the ED Bridge and Santa Rita collaborative models into the future in partnership with the various programs of the DMC-ODS.

- The excellent work of the DMC-ODS is compromised by not having enough recovery residence beds especially for clients with children coming out of residential programs. The rate of homelessness based on CalOMS data is one of the highest in the state.

Client Outcomes for DMC-ODS

Strengths:

- Achieved a remarkably high CalOMS improvement rate on discharge status showing progress in treatment programs compared to statewide.
- Uses ASAM and ongoing training to enhance quality of placement matching based on clients' needs in care.
- TPS shows client improvement and satisfaction and is used to evaluate individual contractors and sites for areas of improvement and strength.

Opportunities:

- Increasing the numbers of participants in TPS next year to have more diversity and youth will make the survey more useful and representative.

Recommendations for DMC-ODS

1. Develop recovery residence housing master plan including enough for those children in conjunction with partners with incremental goals.
2. Continue efforts to expand SUD service capacity to at-risk and unhoused populations and those with health disparities to targeted expansions and activities.
3. Refine and if needed re-design PIPs to continue working on the important issues linked to system access and transitions in care without hopefully the major confounding issues of COVID-19 making all personal contact impossible. Technical assistance will be available as needed for this and other needs.
4. Plan to add data staff to support the launch of the new data billing system while maintaining the current billing system until all of the cost-reports and audits are completed. This is critical for fiscal to be able to ensure all funds are recouped from current service efforts.
5. Continue efforts to prevent overdoses from drugs and alcohol in partnership with the community and strategic actions to increase awareness of fentanyl and other dangerous drugs.

ATTACHMENTS

Attachment A: CalEQRO Review Agenda

Attachment B: Review Participants

Attachment C: County Highlights

Attachment D: Acronym List Drug Medi-Cal EQRO Reviews

Attachment A: CalEQRO Review Agenda

The following sessions were held during the DMC-ODS 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
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments (MATs)
Criminal justice coordination with DMC-ODS, ED Bridge Program, Santa Rita Jail
Client/family member focus group at a residential program
Probation, Drug Court
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

Attachment B: Review Participants

CalEQRO Reviewers

Rama Khalsa, Lead Quality Reviewer
Jan Tice, Second Quality Reviewer
Caroline Yip, IS Consultant
Diane Mintz, CFM Consultant

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

Alameda's DMC-ODS Review

Video review of all sessions for DMC-ODS.

Most sessions viewed were at locations for Alameda County Behavioral Health and Recovery Services as reflected in the NACT A-2.

Contract Provider Sites – CFM group: La Familia was location for this important client session.

Table B1: Participants Representing Alameda			
Last Name	**First Name**	**Position**	**Agency**
Anderson	Kara	Human Resources Technician	Health Care Services Agency
Aslami	Khatera	Consumer Empowerment Manager	Alameda County Behavioral Health
Ball	Angela	Program Director, Cherry Hill Detox Services	Horizon Services
Becker	Daniel	Clinical Director	Options Recovery Services
Belgasi	Tejasi	Director of Outpatient Services	Asian American Recovery Services
Brown	Kathleen	Sr. Program Coordinator, Substance Use Disorder	City of Fremont
Buenavista	Razelle	Managing Director	Asian American Recovery Services
Caldwell	Jennifer	Program Supervisor	Options Recovery Services
Capece	Karen	Quality Management Program Director	Alameda County Behavioral Health
Carlisle	Lisa	Child & Young Adult System of Care Director	Alameda County Behavioral Health
Chapman	Aaron	Chief Medical Officer	Alameda County Behavioral Health
Chau	Mandy	Interim Financial Services Officer, Data and Cost Reporting Unit	Alameda County Behavioral Health
Coady	Kim	Interim Quality Assurance Administrator	Alameda County Behavioral Health
Collins	Rochelle	Project Director, Project Eden	Horizon Services
Courson	Natalie	IS Deputy Director	Alameda County Behavioral Health
Dawal	Marcus	Assistant Chief Probation Officer	Alameda County Probation Department
Dixon	Amanda	Forensics SUD Case Manager	Center Point
Douglas	James	Assistant Program Manager	Center Point
Eady	Rashad	Program Specialist, QI	Alameda County Behavioral Health
Eaves	Damon	Associate Director, Child & Young Adult System of Care	Alameda County Behavioral Health

Table B1: Participants Representing Alameda			
Last Name	**First Name**	**Position**	**Agency**
Engstrom	John	Sr. Management Analyst, QI	Alameda County Behavioral Health
Fultz-Stout	Laura	Program Contract Manager, Contracts Office	Alameda County Behavioral Health
Grajeda	William	SUD Counselor	Center Point
Guinn	John	Operations Director	Horizon Services
Gums	Angelica	Human Resources Liaison	Alameda County Behavioral Health
Hall	Lorenza	Senior Management Analyst, Data Services Team	Alameda County Behavioral Health
Henry	Krishna N.	Administrative Assistant, QM	Alameda County Behavioral Health
Hering	Marc	Vice President	Center Point
Herring	Andrew	General Emergency Medicine	Alameda Health Systems
Hobbs	Nathan	Substance Use Disorder Continuum of Care Director	Alameda County Behavioral Health
Houston	Fonda	Substance Use Operational Specialist	Alameda County Behavioral Health
Hutchinson	Ricardo	SUD Case Manager	Center Point
Johnson	Luke	MAT Program Coordinator	WellPath
Jones	Katherine	Adult & Older Adult SOC Director	Alameda County Behavioral Health
Jones	Yvonne	Adult Forensic Behavioral Health Director	Alameda County Behavioral Health
Judkins	Andrea	Supervising Financial Services Specialist, Budget & Fiscal Services	Alameda County Behavioral Health
Kelly	Kerry Ann	Medical Director	Wellpath
Kemp	Angelito	Program Manager	Center Point
Kolda	Deanna	Clinical Review Specialist Supervisor, UM	Alameda County Behavioral Health

Table B1: Participants Representing Alameda			
Last Name	**First Name**	**Position**	**Agency**
Lai	Sophia	Senior Program Specialist, QI, Interin Privacy Officer	Alameda County Behavioral Health
Lee	Sun Hyung	TAY Services Interim Division Director	Alameda County Behavioral Health
Lewis	Clyde	EPSDT Coordinator, Child Young Adult System of Care	Alameda County Behavioral Health
Lewis	Stephanie	Crisis Services Division Director	Alameda County Behavioral Health
Lopez	Rickie	Assistant Finance Director	Alameda County Behavioral Health
Louie	Jill	Budget & Fiscal Services Director	Alameda County Behavioral Health
Louis	L.D.	Deputy District Attorney	District Attorney Office, Alameda County
Ly	Theresa	Program Specialist	Alameda County Behavioral Health
MacFarlane	Stacy		
Mehta	Ravi	Compliance Officer	Health Care Services Agency
Meinzer	Chet	Information Systems Manager, Data Services Team	Alameda County Behavioral Health
Momoh	Imo	Deputy Director/Plan Administrator	Alameda County Behavioral Health
Moore	Lisa	Billings & Benefits Support Director	Alameda County Behavioral Health
Mullane	Jennifer	Assistant Director of Adult & Older Adult SOC	Alameda County Behavioral Health
O'Neill	Gavin	Principal Analyst, Manager, Collaborative Courts	Superior Court of California, County of Alameda
Orozco	Gabriel	Management Analyst, QM	Alameda County Behavioral Health
Peterson	Camille	IS Analyst	Alameda County Behavioral Health
Phillips	Anna	Director of Recovery and Wellness	La Familia Counseling
Phillips	Justin	Executive Director	Options Recovery Services
Raynor	Charles	Pharmacy Services Director	Alameda County Behavioral Health

Table B1: Participants Representing Alameda			
Last Name	**First Name**	**Position**	**Agency**
Schulz	Henning	Adult Outpatient Services Division Director, Adult & Older Adult SOC	Alameda County Behavioral Health
Serrano	Cecilia	Finance Director	Alameda County Behavioral Health
Smith	Freddie	Integrated Care Services Division Director	Alameda County Behavioral Health
Suttles	Randy	Assessment Specialist	Center Point
Taizan	Juan	Juvenile Justice Center Health Care Director	Alameda County Behavioral Health
Terovic	Nermina	Program Specialist, QA	Alameda County Behavioral Health
Tribble	Karyn	Director	Alameda County Behavioral Health
Vargas	Wendi	Assistant Director, Contracts Unit	Alameda County Behavioral Health
Velasquez	Edilyn	Interim Director, Contracts Unit	Alameda County Behavioral Health
Wagner	James	Deputy Director, Clinical Operations	Alameda County Behavioral Health
Warder	Rosa	Family Empowerment Manager	Alameda County Behavioral Health
Weston	Diana	Director of Criminal Justice Contracts	Options Recovery Services
Wilson	Javarre	Ethnic Services Manager	Alameda County Behavioral Health
Wong	Jenny	Management Analyst, QM	Alameda County Behavioral Health

Attachment C: County Highlights

Cultural Competence Plan showed excellent effort related to health disparities and initiatives.

http://www.acbhcs.org/ethnicservices/

Attachment D: 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 Outcomes Measurement 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	Integrated Medication Assisted Treatment
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
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
MCBHD	Medi-Cal Behavioral Health 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 Survey on Drug Use and Health (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
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	Web Infrastructure for Treatment Services
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version