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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

ALAMEDA FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 9-11, 2024

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 Drug Medi-Cal Organized Delivery System (DMC-ODS) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Alameda" may be used to identify the Alameda County DMC-ODS program.

DMC-ODS INFORMATION

Review Type —Virtual

Date of Review — January 9-11, 2024

DMC-ODS Size — Large

DMC-ODS Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the DMC-ODS on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	1	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	5	1	0
Quality of Care	8	7	0	1
Information Systems (IS)	6	5	1	0
TOTAL	**24**	**21**	**2**	**1**

Table C: Summary of PIP Submissions

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

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	8
2	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	8

*Medication assisted treatment (MAT), Narcotic Treatment Program (NTP)

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

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

- The DMC-ODS has secured the services of David Mee Lee M.D. (an author of the American Society of Addiction Medicine Criteria) to meet with SUD treatment staff on a monthly basis. This resource is seen as an invaluable tool to promote further skill development for staff which will result in increasingly higher quality treatment for Plan members.

- The DMC-ODS has created a robust partnership with criminal justice in the county and plays a major role in working within the Specialty Courts and supporting SUD services in Santa Rita jail, including three therapeutic housing units in the jail.

- Stakeholder communication has greatly improved, which was validated during CalEQRO's provider focus group. Monthly, quarterly, and annual meetings designed for bidirectional communication are held with stakeholders. The Quality Improvement Committee has integrated Plan members and families into subcommittees and workgroups.

- The Office of the Medical Director/Integrated Care Services is partnering with Bay Area Community Health (BACH) to support behavioral health and primary

health care integration. One aspect of this partnership has resulted in the establishment of the Asian Wellness Project. The Project is designed to reach and engage the Asian/Pacific Islander population which is extremely underrepresented in the DMC-ODS.

- The Quality Improvement Data Analytics Division (QIDAD) is a considerable asset to the DMC-ODS providing valuable information to inform planning and policy development. Since the last review, the DMC-ODS completed a successful initiative to deliver data to their community providers making not only standard data available, but providers can also make specific data requests.

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

- Alameda's no-show rate for first scheduled appointments after screening for residential treatment continues to increase year over year and is currently measured at 66 percent.

- Youth SUD treatment services appear minimal with just 61 youth currently in treatment through the DMC-ODS. There are a significant number of mental health providers (15) on 149 school sites; however, SUD providers are only providing services on 25 school sites. Resistance to SUD services from school sites is a contributing factor to the small number.

- MAT utilization is extremely low, dropping from 200 members last review to 67 members in CY 2022. While there are other entities offering MAT services, it is difficult to determine if MAT is being utilized effectively in the County for those who need it.

- Alameda continues to have a very low percentage of members completing treatment at 17.97 percent, leaving over 80 percent of members discharging prior to completion.

- The 24/7 Access Line does not effectively meet the needs of all members who may call for help. Evening and weekend calls are received by Alameda County Crisis Support (CSS) with messages taken and provided to the DMC Access Call Center to follow-up on the next business day.

Recommendations for improvement based upon this review include:

- Conduct a thorough analysis to determine the root causes of the high no-show rates for residential treatment and take active steps to increase the number of potential clients that attend their first scheduled appointment.

  (This recommendation is a carry-over from FY 2022-23.)

- Determine if the level of SUD services provided on school sites by mental health providers is effectively addressing SUD for the youth. Increase the population of youth participating in SUD treatment in the DMC-ODS.
- Take steps to learn how many Medi-Cal members are receiving MAT from allied health care providers such as Federally Qualified Health Centers (FQHC) and The Bridge Clinic, to get a more accurate picture of MAT utilization and the success of expansion activities in Alameda County.
- Take steps to determine the root causes of the high rate of discharges prior to completion of treatment and take active steps to decrease the number of members discharging prematurely.

  (This recommendation is a carry-over from FY 2022-23.)
- Take active steps to develop a 24/7 access line with SUD trained staff available to provide a brief screen and referral after business hours, comparable to what is provided during business hours.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

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

This report presents the FY 2023-24 findings of the EQR for Alameda DMC-ODS by BHC, conducted as a virtual review on January 9-11, 2024.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. As part of the pre-review process, each DMC-ODS is provided a description of the source of data and a summary report of Medi-Cal approved claims data. These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the DMC-ODS identified as having a significant impact on access, timeliness, and quality of the DMC-ODS service delivery system in the preceding year. DMC-ODSs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- DMC-ODS activities in response to FY 2022-23 EQR recommendations.
- Summary of DMC-ODS-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact Plan member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the DMC-ODS' two contractually required PIPs as per 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii).
- Validation and analysis of each DMC-ODS' NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the DMC-ODS and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county DMC-ODS' reporting systems and methodologies for calculating PMs, and whether the DMC-ODS and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of Plan members' perception of the DMC-ODS' service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and family members.
- Summary of DMC-ODS strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then “<11” is indicated to protect the confidentiality of DMC-ODS members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or corresponding penetration rate (PR) percentages.

DMC-ODS CHANGES AND INITIATIVES

In this section, changes within the DMC-ODS' environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING DMC-ODS OPERATIONS

The DMC-ODS did not experience any significant issues affecting its operations.

SIGNIFICANT CHANGES AND INITIATIVES

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

- As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, Alameda has partnered with one of the managed care plans (MCP), Alameda Alliance for Health, to provide enhanced care management (ECM) to members with serious mental illness (SMI) and SUD. This partnership provides opportunities for the MCP to leverage the knowledge and expertise of mental health and SUD experts leading to enhanced services and collaboration for members in the DMC-ODS and the managed care plan (MCP) systems. The ECM team focuses on ensuring that enrolled eligible ECM members are effectively utilizing the existing DMC-ODS and SMI case management services. Additionally, Alameda will act as an advisor to the MCP on behavioral health issues.

- The DMC-ODS retired their legacy billing and registration system at the end of FY 2022-23 and started implementation of Streamline's SmartCare administrative registration and billing system in its place. Shortly after implementation began, the DMC-ODS paused work on SmartCare because of numerous software issues that are slowly being resolved.
- SmartCare continues to impact many areas in the DMC-ODS including member care. Continued glitches with the implementation have left clinicians unable to access the most recent six months of clinical notes on their clients, making continuity of treatment difficult with no access to previous notes or problem lists. Both current PIPs have been impacted by SmartCare as well, rendering the DMC-ODS unable to collect data to measure effectiveness. As of this review, the DMC-ODS is expected to begin data collection in January 2024.
- The strategic planning initiative continues to be a major focus for Alameda. Plan Administration has collaborated with Information Systems, community-based organizations, and providers. Flexible financing options have been created for

contracted providers to mitigate some of the concerns related to the ongoing implementation of initiatives currently guiding several changes and transitions.

- The forensic division has made considerable progress with program improvements, additional staff and training, and provider engagement.
- Collaboration between the DMC-ODS, the Health Care Service Agency, Clinical Operations, and stakeholders through listening sessions have informed the process of how best to expend the opioid settlement funds.
- To further advance CalAIM and payment reform, Financial Services leadership has completed several process improvement activities and is currently adding additional infrastructure to support the changes.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the county's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

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

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

Recommendations not addressed may be presented as a recommendation again for this review. However, if the DMC-ODS has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Establish new and specific opportunities for providers and line staff to give input into system change and participate in system development.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda has implemented a new dedicated SUD monthly meeting opportunity to engage stakeholders. Providers, including line staff, are able to give input, ask questions, and contribute to ongoing system improvements.
- Alameda continues to hold an annual Provider Planning Meeting.

Recommendation 2: Alameda should conduct thorough analyses and begin interventions to address the root causes to reduce the no-show rate for its residential LOC admission process. They should continue with these efforts to increase prospective client's initial connection to treatment.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Alameda has a plan to identify root causes of the no-show rate for residential treatment using Opioid Settlement funds, however at the time of this review, no meaningful actions had been taken.

Recommendation 3: Alameda should take meaningful steps to identify and address the issue of premature discharge within its system of care. This may include a need to obtain data and provide education or other technical assistance including clinical oversight to reduce client exits prior to the completion of treatment episodes.

☐Addressed ☒ Partially Addressed ☐ Not Addressed

- Alameda began implementation of a clinical PIP (August 2022) to support members within residential treatment by providing care coordination services with the goal of increasing the number of positive discharges. However, due to a variety of factors including those pertaining to disaggregating case management from bundled residential rates and SmartCare issues, data has not been available, and no PIP measurements have been collected since June 2023. CalEQRO notes that the Clinical PIP addresses residential treatment only and is not inclusive of other levels of care.
- Alameda expects to have access to data by the third week in January 2024. The PIP will be extended through 12/2024 to allow appropriate time for services to be rendered and data to be collected.

Recommendation 4: Alameda should explore local cooperatives that are addressing parts of the opioid and overdose epidemic (such as the Bay Area medical association collaborative to support safe prescribing) and consider convening a local comprehensive task force that can enhance efforts to reduce overdose and fatalities by bringing together a multidisciplinary and coordinated set of initiatives and strategies across agencies and the community.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Substance Use Collaborative membership includes Alameda County Behavioral Health, Alameda County Public Health, Mental Health, and SUD providers. The meeting is held to discuss, develop, and implement strategies to address the opioid overdose epidemic.
- Alameda participates in the Health Care Services Opioid Surveillance Task Force. The Task Force is a part of the Alameda County Medication Education and Safety Disposal Coalition. The Board of Supervisors, Healthcare for the Homeless, Emergency Services, County Counsel, representatives from several cities in the county, hospitals, community-based organizations, and community members attend the meetings every other month. Out of this task force, the Alameda Medical Director recently developed a program to obtain and distribute fentanyl and xylazine test strips to the community.

Recommendation 5: Consider expediting the procurement of the clinical component of the Alameda's Electronic Health Record (EHR). The use of older technologies and the integration of that technology with a modern system creates many issues for not just technical staff but for both administrative and clinical staff.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda considered the recommendation; however, they were confident in their decision to move forward with the registration billing software from Streamline. FY 2023-24 started with many changes because of the go live with CalAIM and Alameda's need to replace their legacy registration, billing software, Insyst. To minimize the impact of change for DMC-ODS staff, Alameda did not include implementation of new clinical software.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE DMC-ODS

SUD services are delivered solely by contractor operated providers in the DMC-ODS. Regardless of payment source, 100 percent were delivered by contractor-operated clinics and sites. There are no County-operated sites. Overall, 79.14 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to Plan members 24-hours, 7-days per week that is operated by a contract provider during weekdays and Alameda County Crisis Support Services (CCS) evenings and weekends. Members may request services through the Access Line and CCS. Although there is a centralized access team that is responsible for linking members to appropriate, medically necessary services, with CSS, a message is taken and transferred to the call center on the next business day. Other system entry points include: outpatient clinics, NTPs, non-methadone MAT providers and a withdrawal management site, for a total of 58 program sites throughout the county. The Access Call Center conducts a brief ASAM type screening developed by the County. Once the assessment is complete, members are referred to the appropriate provider for further complete assessment and admission.

In addition to clinic-based SUD services, the DMC-ODS provides telehealth services via video and phone to youth and adults. In FY 2022-23, the DMC-ODS reports having provided telehealth services to 993 adults, 73 youth, and 34 older adults across 24 contractor-operated sites. Among those served, 95 members received telehealth services in a language other than English.

NETWORK ADEQUACY

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

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

In May 2023, DHCS issued its FY 2022-23 NA Findings Report for all DMC-ODSs based upon its review and analysis of each DMC-ODS' Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notices (BHIN).

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

Table 1A: DMC-ODS Alternative Access Standards, FY 2022-23

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

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

Table 1B: Alameda DMC-ODS Out-of-Network Access, FY 2022-23

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- Alameda is partnering with Bay Area Community Health to address the low numbers of Asian/Pacific Islander members accessing services. To increase engagement, the project is targeting areas with high concentrations of this population and adding eastern medicine such as acupuncture, providing a more culturally comfortable environment for accessing health services.
- Alameda has implemented a monthly meeting designed for bi-directional communication with providers to improve all aspects of care including access to services.

ACCESS PERFORMANCE MEASURES

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

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

The Statewide PR is 0.95 percent, with a statewide average approved claim amount of $5,998. Using PR as an indicator of access for the DMC-ODS, Alameda demonstrates more challenges to accessing care than was seen statewide.

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

Table 3: Alameda DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Ages 12-17	46,831	65	0.14%	0.29%	0.25%
Ages 18-64	266,435	2,963	1.11%	1.29%	1.19%
Ages 65+	66,940	386	0.58%	0.56%	0.49%
Total	**380,206**	**3,414**	**0.90%**	**1.04%**	**0.95%**

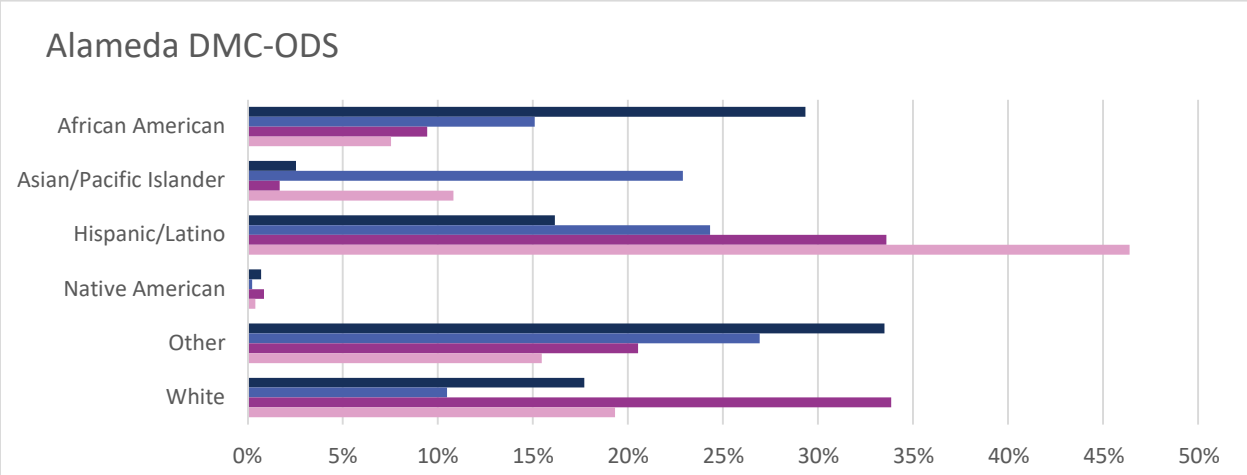
- The total number of members served decreased slightly by 331 members (9 percent) from CY 2021 to CY 2022. The PRs by age are very similar to CY 2021.
- The PRs by age group in CY 2022 are lower than similar-size county and statewide PRs with the exception of adults 65 and older, which is higher than both comparisons.

Table 4: Alameda DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, CY 2022

Racial/Ethnic Groups	# Members Eligible	# Members Served	County PR	Same Size Counties PR	Statewide PR
African American	57,428	1,002	1.74%	1.29%	1.19%
Asian/Pacific Islander	87,077	87	0.10%	0.15%	0.15%
Hispanic/Latino	92,514	552	0.60%	0.74%	0.69%
Native American	901	24	2.66%	2.34%	2.01%
Other	102,435	1,144	1.12%	1.34%	1.26%
White	39,851	605	1.52%	1.89%	1.67%

- The DMC-ODS has higher PRs for African American and Native American members compared to statewide and similar-size counties, and lower PRs than either comparison for all other racial/ethnic groups.
- The “Other” category, which includes both members who identify as more than one race/ethnicity and those for whom more specific data is missing, has the largest number of members served. The DMC-ODS Health Equity division is working to reduce the number of members who are identified as “Other” by more precisely identifying members’ race/ethnicity.

Figure 1: Percentage of Eligibles and Members Served by Race/Ethnicity, CY 2022



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
County % Served	18%	34%	0.70%	16%	3%	29%
County % Eligibles	10%	27%	0.24%	24%	23%	15%
State % Served	34%	21%	0.86%	34%	2%	9%
State % Eligibles	19%	15%	0.41%	46%	11%	8%

- African American, Native American, Other, and White categories are proportionally overrepresented in the DMC-ODS based on eligibles versus members served.
- The proportion of Asian/Pacific Islander members served compared to eligible is very similar to the previous year. To address the low engagement of these members, the DMC-ODS has increased outreach efforts targeting areas of the county with higher populations of Asian/Pacific Islanders.
- Even though Hispanic/Latino members continue to be more proportionally underrepresented in the DMC-ODS than statewide, the number and percentage of members served increased since CY 2021.

Table 5: Alameda DMC-ODS Plan Members Served and PR by Eligibility Category, CY 2022

Eligibility Categories	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Affordable Care Act (ACA)	166,406	1,983	1.19%	1.53%	1.42%
Disabled	37,718	822	2.18%	1.51%	1.37%
Family Adult	68,840	576	0.84%	1.03%	0.94%
Foster Care	968	<11	-	2.08%	1.84%
Medicaid Children's Health Insurance Program (MCHIP)	19,101	-	-	0.20%	0.18%
Other Adult	58,272	44	0.08%	0.10%	0.09%
Other Child	30,135	43	0.14%	0.32%	0.27%

Note: Eligibles may be in more than one aid code category during a year.

- The highest PR is for members who are disabled. The PR for disabled members is well above the statewide and similar-size counties PR, while PRs for all other eligibility categories are lower than both comparisons.
- Statewide the highest PR is seen in the foster care category, but for Alameda it is lower than comparisons.

Table 6: Alameda DMC-ODS Average Approved Claims by Eligibility Category, CY 2022

Eligibility Categories	County AACM	County Size Group AACM	Statewide AACM
ACA	$5,574	$5,742	$6,216
Disabled	$5,865	$5,393	$5,707
Family Adult	$6,693	$5,180	$5,296
Foster Care	$5,857	$2,578	$2,716
MCHIP	$10,429	$3,692	$3,594
Other Adult	$5,838	$3,880	$4,075
Other Child	$7,780	$3,427	$3,194
Total	**$6,027**	**$5,607**	**$5,998**

- The DMC-ODS AACM is similar to the statewide AACM and is 7.5 percent greater than the similar-size county AACM.
- The AACMs for MCHIP and Other Child are more than double the statewide and similar-size county AACMs.

- The CY 2022 AACMs are very similar to CY 2021.

Table 7: Alameda DMC-ODS Services Used by Plan Members, CY 2022

County			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	0	0.00%	56	0.04%
Intensive Outpatient	379	8.95%	14,422	9.58%
Narcotic Treatment Program	1,613	38.11%	37,134	24.67%
Non-Methadone MAT	67	1.58%	7,782	5.17%
Outpatient Treatment	1,076	25.42%	46,441	30.85%
Partial Hospitalization	0	0.00%	13	0.01%
Recovery Support Services	100	2.36%	6,400	4.25%
Res. Withdrawal Mgmt	469	11.08%	10,429	6.93%
Residential Treatment	529	12.50%	27,841	18.50%
Total	**4,233**	**100.00%**	**150,518**	**100.00%**

- The DMC-ODS saw a large decrease in non-methadone MAT services from CY 2021 to CY 2022. In CY 2021, 220 members received this service. In CY 2022, 67 members were served. Alameda noted that the majority of non-methadone MAT services are delivered by FQHCs and private doctors, which would not be reflected in the claims data above.
- NTP services represent a larger proportion of services provided in the DMC-ODS compared to statewide by 54 percent. Residential withdrawal management (WM) exceeds the statewide proportion of services provided by 60 percent. All other DMC-ODS service category proportions are lower than statewide.

Table 8: Alameda DMC-ODS Approved Claims by Service Categories, CY 2022

Service Categories	County AACM	County Size Group AACM	Statewide AACM
Ambulatory Withdrawal Mgmt	$0	$234	$484
Intensive Outpatient	$1,493	$1,207	$1,729
Narcotic Treatment Program	$4,659	$4,279	$4,526
Non-Methadone MAT	$1,651	$1,601	$1,660
Outpatient Treatment	$4,716	$2,304	$2,547
Partial Hospitalization	$0	$2,802	$2,802
Recovery Support Services	$4,925	$1,660	$1,669
Res. Withdrawal Mgmt	$1,892	$2,278	$2,392
Residential Treatment	$11,209	$10,379	$10,178
Total	**$6,027**	**$5,607**	**$5,998**

- The DMC-ODS AACMs for NTP, residential treatment, recovery support services, and outpatient treatment exceed those recorded for similar-size counties and statewide. All other service categories had lower AACMs in the DMC-ODS than seen statewide.

IMPACT OF ACCESS FINDINGS

- African American and Native American PRs are significantly higher than counties of similar size and statewide, indicating members in these populations are able to access SUD services successfully. The PRs in all other categories are lower than similar size counties and statewide, with the Asian/Pacific Islander population being the lowest, indicating the need for more outreach and engagement efforts, currently a focus for Alameda.
- NTPs are the most utilized service at 38.11 percent which is significantly higher than statewide at 24.67 percent. With the NTPs providing mostly methadone, the possibility exists that this number could partially account for the low utilization of non-methadone MAT in the DMC-ODS, suggesting MAT may not be easily accessible through the DMC-ODS.
- The youth PR is very low indicating the need for significant community education and outreach to make youth SUD treatment more visible and easier to access.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 9: Timeliness Key Components

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

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

- The DMC-ODS met or exceeded timeliness standards for first offered service, first delivered service, first offered NTP/OTP, and first offered urgent service. Timely access to care is advantageous to members asking for help given the

limited window of opportunity with regard to the contemplation stage and willingness to seek treatment.

- The no-show rate overall is 26 percent; however, for residential and intensive outpatient, the rates are high at 66 percent and 44 percent, respectively.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the DMC-ODS reported in its submission of the Assessment of Timely Access, representing access to care during the 12-month period of FY 2022-23. Table 10 and Figures 2-4 display data submitted by the DMC-ODS; an analysis follows. These data represent the entire system of care. The DMC-ODS reported urgent services offered in calendar days and the EQRO converted their data to hours.

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

DMC-ODS-Reported Data

Table 10: FY 2023-24 Alameda DMC-ODS Assessment of Timely Access

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	3.2 Business Days	10 Business Days*	94%
First Non-Urgent Service Rendered	8.3 Business Days	10 Business Days**	77%
Non-Urgent MAT Request to First Offered NTP/OTP Appointment	2.3 Business Days	3 Business Days*	82%
Urgent Services Offered	48 Hours***	72 Hours**	84%
Follow-up Services Post-Residential Treatment	3.4 Calendar Days	7 Calendar Days**	69%
WM Readmission Rates Within 30 Days	10%	n/a	n/a
No-Shows	26%	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** DMC-ODS-defined timeliness standards *** Converted to hours from days by EQRO			
For the FY 2023-24 EQR, the DMC-ODS reported its performance for the following time period: FY 2022-23			

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

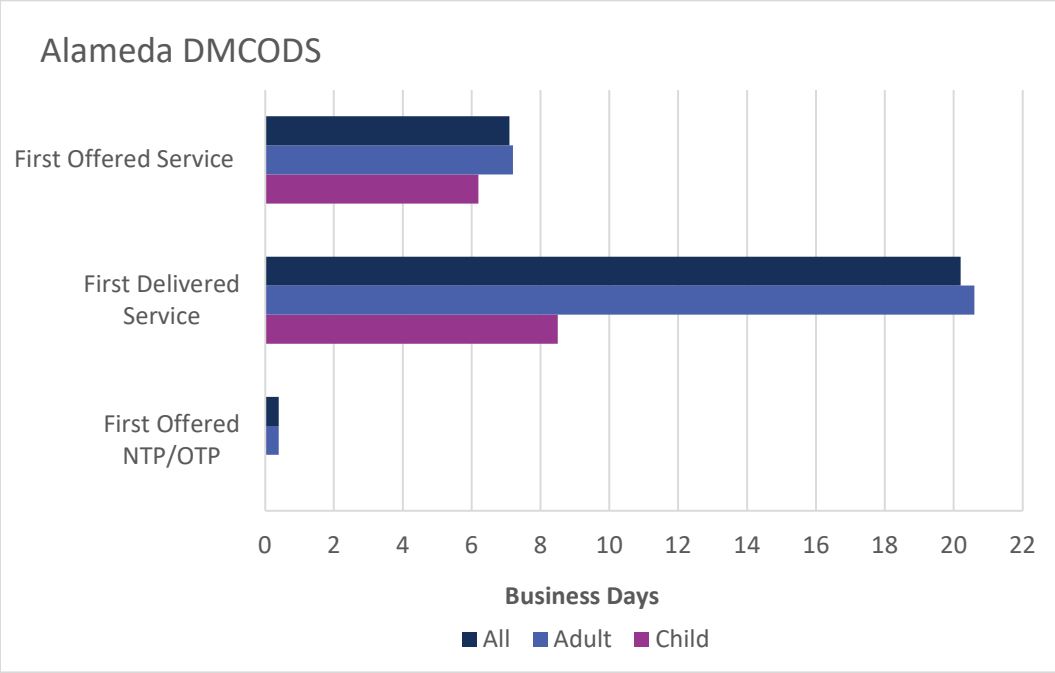


Figure 3: Wait Times for Urgent Services

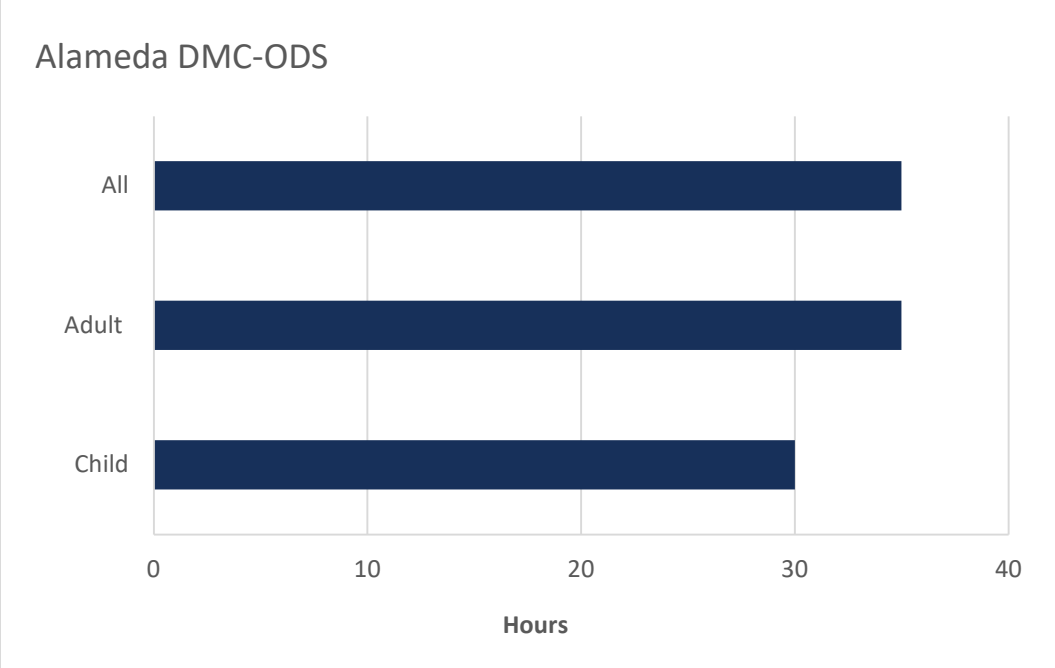
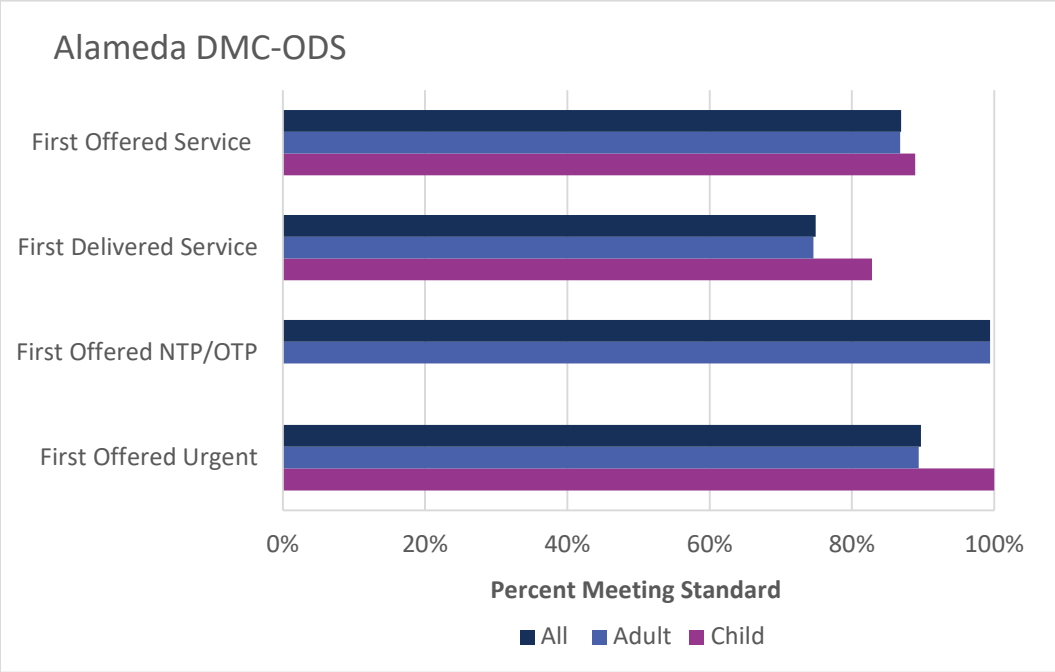


Figure 4: Percent of Services that Met Timeliness Standards



Timeliness from Medi-Cal Claims Data

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the CY 2022 claims.

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

Table 11: Alameda DMC-ODS Days to First Dose of Methadone by Age, CY 2022

County				Statewide		
Age Groups	# of Members	%	Avg. Days	# of Members	%	Avg. Days
12 to 17	0	0.00%	N/A	15	0.04%	12.60
18 to 64	1,349	85.11%	1.27	31,839	87.46%	3.59
65+	236	14.89%	0.00	4,551	12.50%	0.56
Total	**1,585**	**100.00%**	**1.08**	**36,405**	**100%**	**3.19**

- The Alameda average number of days to first dose of methadone is over two days faster than the statewide average.
- The DMC-ODS average days decreased slightly from the previous year while the statewide average increased from 2.94 days to 3.19 days.

Transitions in Care

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

Table 12: Alameda DMC-ODS Timely Transitions in Care Following Residential Treatment, CY 2022

	County N = 515		Statewide N = 27,232	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	51	9.90%	3,243	11.91%
Within 14 Days	83	16.12%	4,515	16.58%
Within 30 Days	110	21.36%	5,706	20.95%

- The DMC-ODS data for CY 2022 in Table 12 are very similar to CY 2021.
- For billed activities, Alameda's timely transitions in care are comparable to statewide, though less than one-quarter of members experienced a transition in care within 30 days. While Alameda's local data for meeting this standard is well above what is reported in approved claims, improving billable contacts is an opportunity for improvement both in the DMC-ODS and statewide.

Residential Withdrawal Management Readmissions

Table 13: Alameda DMC-ODS Residential Withdrawal Management Readmissions, CY 2022

County			Statewide	
Total DMC-ODS admissions into WM	694		13,062	
	#	#	#	%
WM readmissions within 30 days of discharge	101	14.55%	1,148	8.79%

- Alameda's readmission rate decreased by nearly 20 percent from CY 2021 to CY 2022.
- The DMC-ODS rate of WM readmissions within 30 days of discharge is 65 percent higher than statewide. However, the current rate of 14.55 percent is an improvement from CY 2021 which was 17.9 percent.

IMPACT OF TIMELINESS FINDINGS

- Alameda meets or exceeds the DHCS and the DMC-ODS timeliness standards for first offered service, first delivered service, first offered NTP/OTP, and first

offered urgent service, which is exceedingly beneficial to members attempting to access services, given the limited window of opportunity often present in those seeking help for an SUD.

- The DMC-ODS should be commended for the expediency with which the first dose of methadone is administered. It is imperative that members seeking help for an opioid use disorder (OUD) begin treatment immediately upon request. At an average of 1.27 days to first dose, many members receive their first dose the same day they request help.
- The low number of transitions in care from residential to follow-up services, although comparable to statewide numbers, reflects only activities that were billed and may indicate an opportunity for improved engagement in outpatient services.
- Alameda has a high WM readmission rate that may indicate the continuum of care is not being fully utilized as intended.

QUALITY OF CARE

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

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

QUALITY IN THE DMC-ODS

In the DMC-ODS, the responsibility for QI and quality assurance falls within the Quality Improvement Work Plan (QIWP), which describes Alameda's plan for continuous QI of its mental health plan (MHP), DMC-ODS, and overall systems. The QIWP is regularly reviewed, analyzed, and updated by QI with input from the Quality Improvement Committee (QIC) and other stakeholders including Plan members and providers.

The DMC-ODS monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC is comprised of representation by the QI team, health equity, data services, systems of care, stakeholders, and Alameda management and leadership. The county QIC is scheduled to meet monthly. Since the previous EQR, the DMC-ODS QIC met 7 times. Of the 12 identified FY 2023-24 QAPI workplan goals targeting SUD members, the DMC-ODS met three, partially met four, and did not meet three, two of which are still in progress.

QUALITY KEY COMPONENTS

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

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

Table 14: Quality Key Components

KC #	Key Components – Quality	Rating
3A	QAPI are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of an ASAM Continuum of Care	Met
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	Met
3F	ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from the Treatment Perception Survey to Improve Care	Not Met

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

- Alameda has taken meaningful steps to successfully improve communication with contractors. Providers validated this with several positive comments stating communication had greatly improved.
- All ASAM levels of care (LOC) are available through the DMC-ODS and generally admission is within a week or less of request for services. Contractors did comment that at times they must limit the number of beds available due to staffing shortages.
- There is an opportunity for enhanced QI through the use of the TPS. There was no evidence of the TPS being used in QI activities, and feedback suggested results are not shared effectively.

QUALITY PERFORMANCE MEASURES

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

- Members served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment
- High-Cost Members (HCM)
- ASAM congruence
- Initiation and Engagement

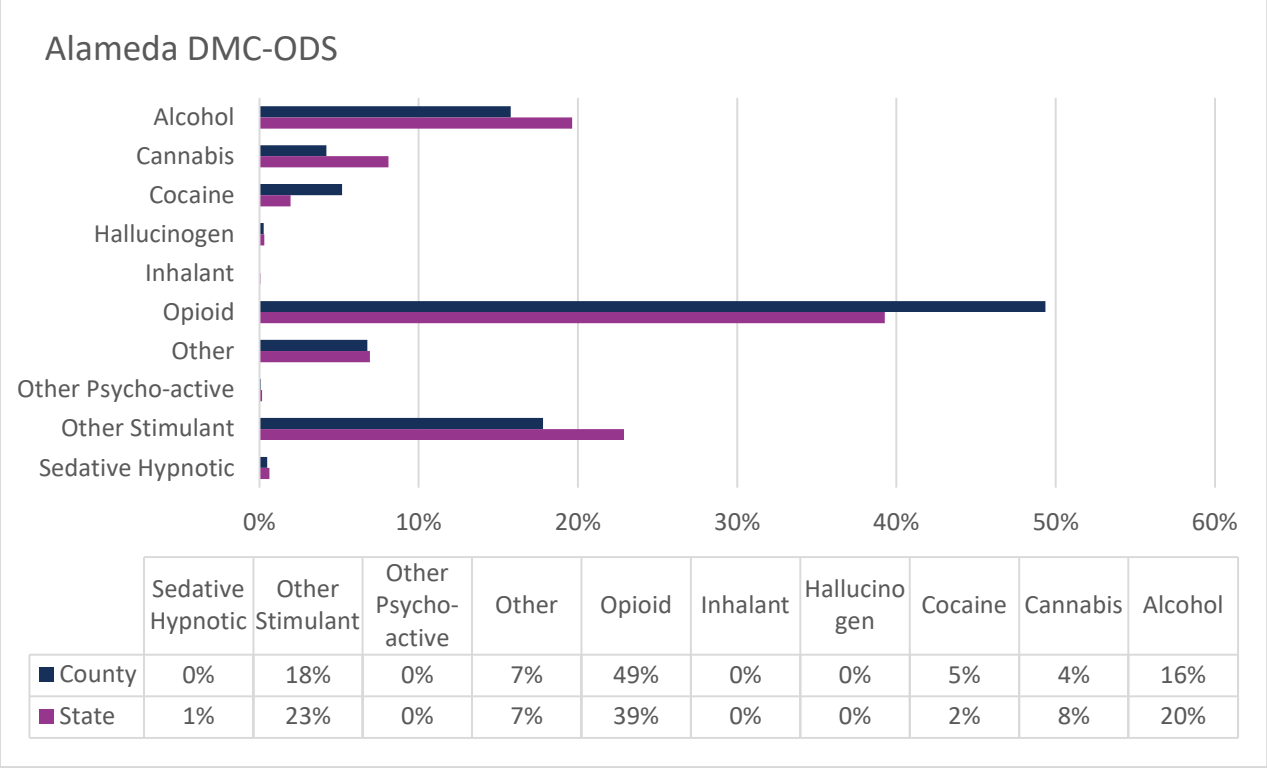
- Length of Stay (LOS)
- CalOMS admission versus discharge for employment and housing status
- CalOMS Legal Status at Admission
- CalOMS Discharge Status Ratings

Diagnosis Data

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SUD treatment services, is a foundational aspect of delivering appropriate treatment. Figures 5 and 6 represent the primary diagnosis as submitted with the DMC-ODS' claims for treatment. Figure 5 shows the percentage of DMC-ODS members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 6 shows the percentage of approved claims by diagnostic category compared to statewide.

Initial assessment and services provided during the assessment process, except for residential treatment, may be provided without an established diagnosis for DHCS-defined periods of time. These deferred diagnoses are included in "Other."

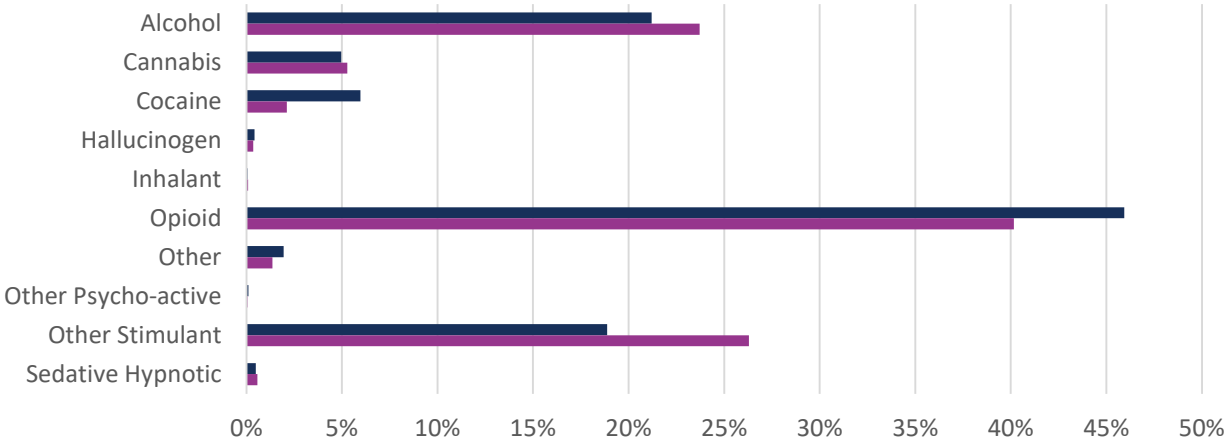
Figure 5: Percentage of Plan Members by Diagnosis Code, CY 2022



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0%	18%	0%	7%	49%	0%	0%	5%	4%	16%
State	1%	23%	0%	7%	39%	0%	0%	2%	8%	20%

- Members with OUD represented 49 percent of members served by the DMC-ODS in CY 2022. The percentage of DMC-ODS members with this diagnosis decreased from 58 percent in CY 2021.
- The next most prevalent diagnosis is other stimulant use disorder, accounting for 18 percent of members. This diagnosis increased from 15 percent in CY 2021.
- Alcohol use disorder (AUD) is the third most common member diagnosis with 16 percent. The percentage increased from 13 percent in CY 2021.
- The percentage of members diagnosed with cocaine abuse is noteworthy as it is 2.5 times the statewide percentage. The diagnosis percentage is the same as CY 2021.

Figure 6: Percentage of Approved Claims by Diagnosis Code, CY 2022



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0%	19%	0%	2%	46%	0%	0%	6%	5%	21%
State	1%	26%	0%	1%	40%	0%	0%	2%	5%	24%

- Claiming patterns in the DMC-ODS are generally congruent with the diagnostic patterns noted in Figure 5.
- Alameda approved claims for treatment of OUD decreased from the previous review cycle of 54 percent to 46 percent.
- Approved claims for treatment of AUD increased from the prior year, as did claims for other stimulants.

Non-Methadone MAT Services

Table 15: Alameda DMC-ODS Non-Methadone MAT Services by Age, CY 2022

County					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 0-17	<11	-	-	-	24	0.56%	13	0.30%
Ages 18-64	62	2.09%	28	0.94%	7,473	7.96%	3,881	4.13%
Ages 65+	<11	-	-	-	428	5.78%	173	2.34%
Total	**67**	**1.96%**	**29**	**0.85%**	**7,925**	**7.13%**	**4,051**	**3.66%**

- Alameda experienced a large decrease in members with at least one non-methadone MAT service, as well as a decrease in those receiving three or more of these services, compared to the prior year. In CY 2021, the number of members who received at least one service was 192, and 38 members received three or more services.
- Because most non-methadone MAT services are delivered outside the DMC-ODS, Alameda reported the EQR data was reasonable.

Residential Withdrawal Management with No Other Treatment

Table 16: Alameda DMC-ODS 3+ Episodes of Residential WM and No Other Treatment, CY 2022

	# Members with 3+ Episodes WM & No Other Services	% Members with 3+ Episodes WM & No Other Services
County	28	6.25%
Statewide	205	2.00%

- Alameda slightly decreased the proportion of members with three or more episodes of WM and no other services from 7.70 percent in CY 2021 to 6.25 percent in CY 2022. Their rate remains notably higher than statewide, however.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. In SUD treatment, this may reflect multiple admissions to residential treatment or residential withdrawal management. HCMs may be receiving services at a LOC not appropriate to their needs. HCMs for the purposes of this report are defined as those who incur SUD treatment

costs higher than two standard deviations above the mean, which for CY 2022 equates to claims of $17,188 or more.

Table 17: Alameda DMC-ODS and Statewide High-Cost Members, CY 2022

	Total Members Served	HCM Count	HCM % by Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
County	3,414	146	4.28%	$28,564	$4,170,391	20.27%
Statewide	105,657	5,724	5.42%	$24,551	$140,532,204	21.84%

- Alameda HCM data in CY 2022 is similar to CY 2021. The percentages of both HCMs by count, and by total claims, are essentially the same for both years.
- The DMC-ODS HCM AACM is higher than statewide. The HCM percentage of members and total claims are lower than statewide.

ASAM Level of Care Congruence

Table 18: Alameda DMC-ODS Congruence of Level of Care Referrals with ASAM Findings, CY 2022 – Reason for Lack of Congruence

	Initial Screening		Initial Assessment		Follow-up Assessment	
ASAM LOC Referrals	#	%	#	%	#	%
Not Applicable /No Difference	2,970	99.50%	2,007	77.28%	3,203	92.55%
Patient Preference	<11	-	400	15.40%	116	3.35%
Level of Care Not Available	<11	-	24	0.92%	<11	-
Clinical Judgement	<11	-	120	4.62%	112	3.24%
Geographic Accessibility	0	0.00%	<11	-	<11	-
Family Responsibility	0	0.00%	<11	-	<11	-
Legal Issues	<11	-	<11	-	<11	-
Lack of Insurance/Payment	<11	-	<11	-	<11	-
Other	0	0.00%	35	1.35%	<11	-
Actual Level of Care Missing	0	0.00%	0	0.00%	0	0.00%
Total	2,985	100.00%	2,597	100.00%	3,461	100.00%

- Alameda has good congruence between the ASAM indicated LOC and referred LOC in all three categories: initial screening, initial assessment, and follow-up assessment.

- Although initial assessment congruence is lower than the other two categories, the differences in designated LOC for the initial assessment were primarily due to patient preference and clinical judgment.

Initiation and Engagement

An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them. Table 20 displays results of measures for two early and vital phases of treatment-initiating and then engaging in treatment services. Research suggests that those who can engage in treatment services are likely to continue their treatment and enter into a recovery process with positive outcomes. The method for measuring the number of Plan members who initiate treatment begins with identifying the initial visit in which the member's SUD is identified. Based on claims data, the "initial DMC-ODS service" refers to the first approved or pended claim for a member 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.

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 14th and 34th day following initial DMC-ODS service.

Table 19: Initiating and Engaging in Alameda DMC-ODS Services, CY 2022

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Members with an initial DMC-ODS service	3,355		61		99,855		4,026	
	#	%	#	%	#	%	#	%
Members who then initiated DMC-ODS services	2,970	89%	58	95%	83,830	84%	3,286	82%
Members who then engaged in DMC-ODS services	2,309	78%	37	64%	63,753	76%	2,202	67%

- Alameda's initiation and engagement for adults overall is higher than statewide.
- From CY 2021 to CY 2022, youth initiation increased 8 percentage points to 95 percent, while engagement dropped from 83 percent to 64 percent over that same period.

Length of Stay

Examining Plan members' LOS in services provides another look at engagement in services and completion of treatment. Table 21 presents the number of members who discharged from treatment in CY 2022, defined as having zero claims for any DMC-ODS services for 30+ days, the average and median LOS for members, and

results indicating what proportions of members had accessed services for at least 90, 180, and 270 days, as well as statewide comparisons for reference.

Table 20: Cumulative LOS in Alameda DMC-ODS Services, CY 2022

	County		Statewide	
Members discharged from care (no treatment for 30+ days)	4,169		139,688	
LOS for members across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	168	83	158	90
	#	%	#	%
Members with at least a 90-day LOS	2,007	48%	69,919	50%
Members with at least a 180-day LOS	1,333	32%	43,096	31%
Members with at least a 270-day LOS	941	23%	27,677	20%

- The average LOS in Alameda increased from 124 days in CY 2021 to 168 days in CY 2022, slightly longer than statewide . The median LOS is the same as in CY 2021 and is lower than statewide.
- The percentage with at least a 90-day LOS stayed the same, while the 180-day LOS increased from 30 percent to 32 percent. The 270-day LOS increased from 18 percent to 23 percent. Thus, more members are staying in treatment longer.

CalOMS Data

CalOMS is one of the few national datasets that asks SUD service users about psychosocial information at both admission and discharge. These are critical outcomes that reflect areas of life functioning expected to be positively influenced by SUD treatment. The measures provided below allow for system evaluation and determine the efficacy of care provided. Additionally, the types of discharges and their ratings reflect the degree to which treatment episodes were considered successful.

Table 21: Alameda DMC-ODS CalOMS Legal Status at Admission, CY 2022

	County		Statewide	
Admission Legal Status	#	%	#	%
No Criminal Justice Involvement	2,660	83.73%	56,511	65.47%
Under Parole Supervision by California Department of Corrections and Rehabilitation (CDCR)	78	2.46%	1,649	1.91%
On Parole from any other jurisdiction	32	1.01%	1,427	1.65%
Post release supervision – AB 109	263	8.28%	19,933	23.09%
Court Diversion CA Penal Code 1000	84	2.64%	1,312	1.52%

Admission Legal Status	County		Statewide	
	#	%	#	%
Incarcerated	17	0.54%	446	0.52%
Awaiting Trial	43	1.35%	5,038	5.84%
Total	**3,177**	**100.00%**	**86,316**	**100.00%**

- Only 16.27 percent of members had criminal justice involvement, which is 52.88 percent lower than statewide. Given the strong collaborative partnership between the DMC-ODS, the specialty courts, and Santa Rita jail, there is likely service activity for this population not covered by CalOMS admission data.
- Post release supervision under AB 109 is the most common legal status for Alameda members who do have criminal justice system involvement.

Table 22: Alameda DMC-ODS CalOMS Discharge Status Ratings, CY 2022

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment – Referred	523	15.31%	19,232	21.62%
Completed Treatment – Not Referred	91	2.66%	5,687	6.39%
Left Before Completion with Satisfactory Progress – Standard Questions	1,555	45.52%	12,302	13.83%
Left Before Completion with Satisfactory Progress – Administrative Questions	128	3.75%	7,046	7.92%
Subtotal	*2,297*	*67.24%*	*44,267*	*49.76%*
Left Before Completion with Unsatisfactory Progress – Standard Questions	857	25.09%	15,497	17.42%
Left Before Completion with Unsatisfactory Progress – Administrative	247	7.23%	28,288	31.80%
Death	-	-	166	0.19%
Incarceration	<11	-	740	0.83%
Subtotal	*1,119*	*32.76%*	*44,691*	*50.24%*
Total	**3,416**	**100.00%**	**88,958**	**100.00%**

- The DMC-ODS recorded 67.24 percent of overall discharges in the favorable subcategory, which while notably higher than the 49.76 percent seen statewide. It includes more than 45 percent of members leaving treatment before completion, well above the 13.83 percent seen statewide.
- Only 18 percent of members actually completed treatment compared to just over 28 percent statewide. Addressing the low treatment completion percentage was a recommendation from the last EQR.

- Members leaving treatment with unsatisfactory progress made up 32.76 percent of total discharges, well below the statewide rate of 50.24 percent.

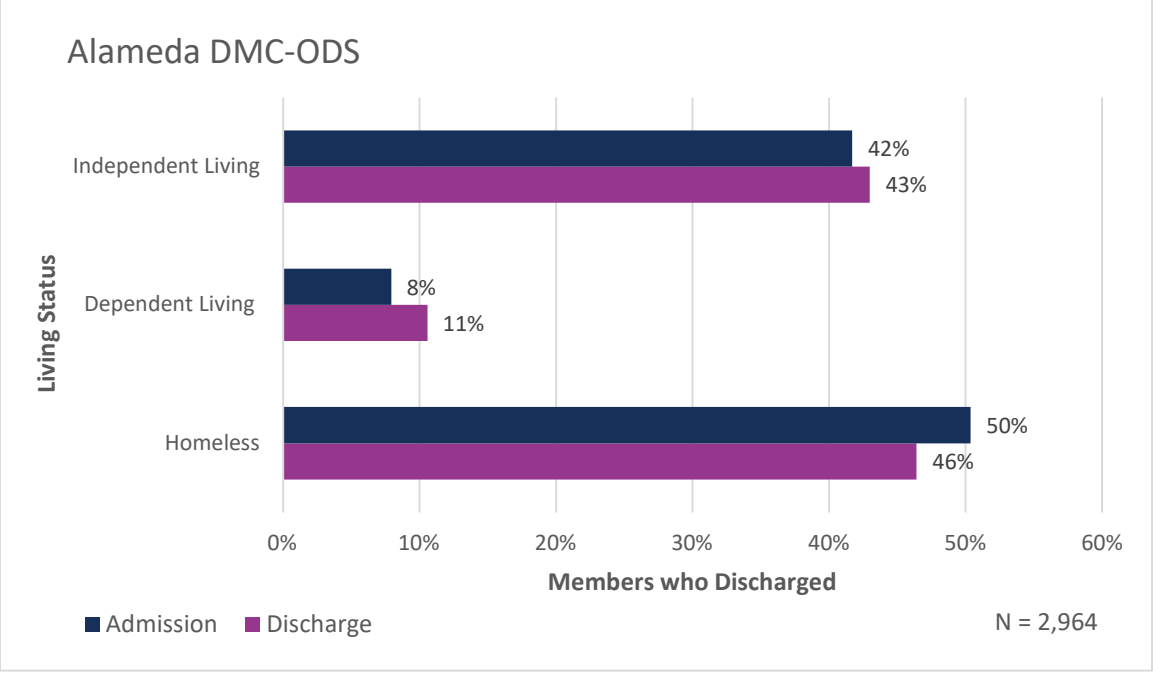
Table 23: Alameda DMC-ODS CalOMS Types of Discharges, CY 2022

Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	2,212	64.75%	44,306	49.81%
Administrative Adult Discharges	390	11.42%	36,240	40.74%
Detox Discharges	752	22.01%	7,075	7.95%
Youth Discharges	62	1.81%	1,337	1.50%
Total	**3,416**	**100.00%**	**88,958**	**100.00%**

- 64.75 percent of discharges were standard adult discharges, exceeding statewide standard adult discharges by 15 percentage points.
- Detox discharges were the second highest and also significantly higher than statewide, to be expected given the high rate of WM utilization.
- Administrative discharges at 11.42 percent were significantly lower than statewide (40.74 percent).

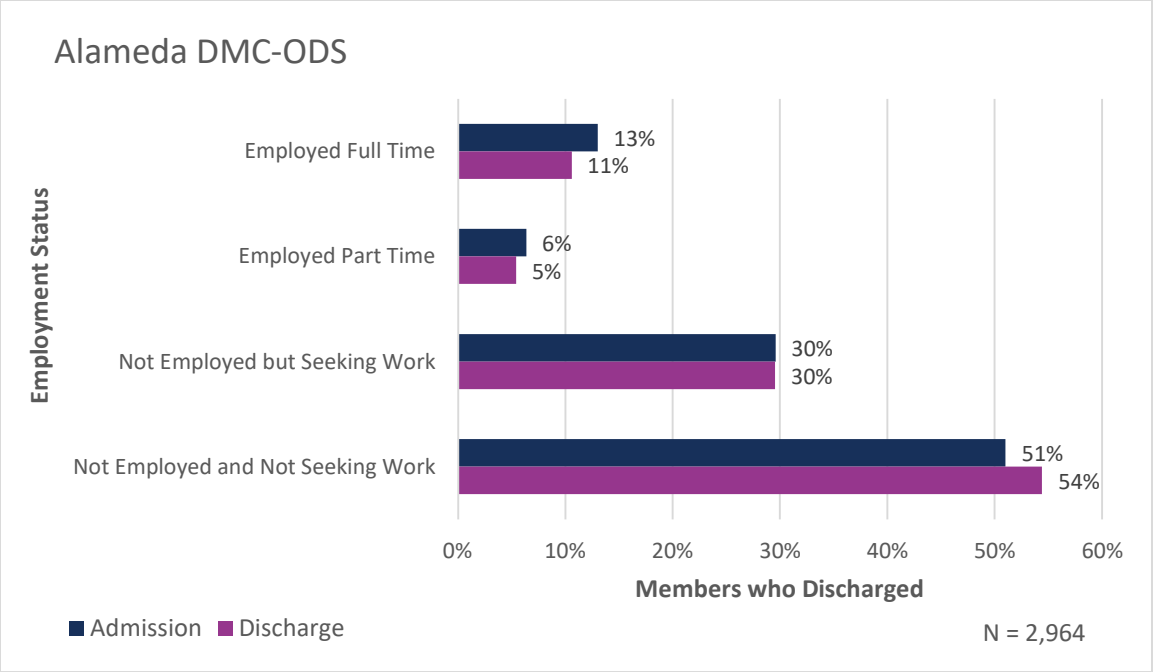
The data presented in Figures 7 and 8 reflect percent change at discharge from admission for both living status and employment status. Both questions are asked in relation to the prior 30 days.

Figure 7: CalOMS Living Status at Admission versus Discharge, CY 2022



- Comparing living status from admission to discharge, Alameda had slightly more people in independent and dependent living situations, and fewer who were homeless. The increase in dependent living could be a result of members continuing in treatment in recovery housing which is a positive outcome.

Figure 8: CalOMS Employment Status at Admission versus Discharge, CY 2022



- By program discharge, fewer Alameda members were employed either part or full time. At discharge, more members were not employed and not seeking work than at admission.
- The percentages of members not employed but seeking work did not change from admission to discharge.

IMPACT OF QUALITY FINDINGS

- Alameda has increased the average LOS to 168 days from 124 days. Research demonstrates that the longer someone participates in SUD treatment, the chances for successful recovery increase. Alameda should continue the activities that are resulting in longer LOS and in combination with the current PIP for enhancing care coordination in residential treatment, the DMC-ODS should continue to see improvement in this area.
- The rates of initiation of services in the DMC-ODS are higher than statewide by 13 percentage points which could be indicative of the efficient coordination between initial requests for help and first delivered services. However, engagement after initiation in the youth population dropped from 83 percent in

CY 2021 to 64 percent in CY 2022, a concern considering that low participation in youth treatment already exists.

- CalOMS discharge data reflects a high percentage (67.24 percent) of positive overall discharges, indicating members are receiving quality treatment and making progress in their recovery. However, only 17.97 percent of members actually completed treatment and over 45 percent leave care early. The low percentage of completions could indicate engagement of the member in treatment waning over time, which could be due to ongoing staffing shortages or staffing changes leaving less staff time dedicated to members, or lack of understanding or presenting the importance of long-term treatment through the continuum of care. Other possible factors should be identified as well.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION

All DMC-ODSs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[1] and 457.1240(b)[2]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and Plan member satisfaction. They should have a direct Plan member impact and may be designed to create change at a member, provider, and/or DMC-ODS system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Care Coordination for Residential Substance Use Disorder (SUD) Services

Date Started: 08/2022

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

Target Population: All adults receiving residential SUD treatment services through the DMC-ODS.

Status of PIP: The DMC-ODS' clinical PIP is still in the implementation stage due to unforeseen circumstances preventing data collection.

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

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

Summary

The focus of this care coordination (case management) PIP is to support members within residential treatment by providing added care coordination services. Members who receive care coordination services see increased positive discharges and better transitions and outcomes overall. In Alameda County, residential treatment facilities had offered care coordination services in addition to services that are included in the daily bundled rate; therefore, there has been no data available to determine how much or how often these services are provided. DHCS recently separated case management from the residential bundled rate allowing for specific claims data on care coordination to be collected.

This PIP is focused on increasing the number of members who engage and benefit from these coordination services, assisting them with smooth transitions to other ongoing care. By increasing care coordination services, Alameda is working to support improved recovery with improvement in member engagement leading to positive progress in treatment.

TA and Recommendations

As submitted, this clinical PIP was validated at low confidence because (1) Alameda has experienced a prolonged inability to collect data due to delays caused by SmartCare implementation and confusion between DHCS, the County, and the providers regarding how to claim case management services in residential treatment. The PIP start date was 8/2022 and while baseline data was collected, there has been no sufficient data collection since June 2023, (2) The PIP is reliant on provider staff to increase case management services at a time when most providers are experiencing staffing shortages, as was validated by the member focus groups. (3) Some providers report they have been conducting more case management than the data reflects because they have not claimed the service. Whether claims increases will indicate increased case management or simply increased claiming of services may render the findings unreliable.

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

- Consider extending the PIP for another year to provide enough time to collect appropriate data given the data collection delays should be resolved by the third week of January 2024. The DMC-ODS was already planning to do this.
- Expand the aim statement to include clear descriptions regarding strategies, timelines, and performance measures.
- Conduct further analysis on the viability of this PIP, given the concern regarding whether the data will reflect an increase in claiming the service vs. an increase in services rendered.

- Engage in a TA discussion regarding progress once three months of data has been collected to review whether the data collection process is operating as planned.
- Seek TA from CalEQRO at any time.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Date Started: 08/2022

Aim Statement: Revised: “Increase timely information sharing from primary care emergency departments (ED) to improve Outpatient and Opioid Treatment Program (OTP) substance use disorder (SUD) providers 1) awareness of their Medi-Cal beneficiary clients’ ED discharges; 2) capacity to provide follow-up services, and 3) rate of timely client follow-up. Implemented interventions aim to increase the percentage of follow-up activities within 30 days of ED visits for SUD conditions by 5% by March 31, 2024.”

Target Population: Adult members visiting an ED with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.

Status of PIP: The DMC-ODS’ non-clinical PIP is still in the implementation phase due to unforeseen circumstances preventing data collection. Alameda is in the process of compiling information from provider feedback sessions. Based on the feedback, Alameda will adjust the ED alert reports and broadcasts.

Summary

The non-clinical PIP is a Behavioral Health Quality Improvement Program (BHQIP) PIP focusing on follow-up with members with an SUD diagnosis after ED visits. Alameda has collaborated with 14 hospitals in the county to receive direct, real-time admission, discharge, and treatment (ADT) data on members who have visited an ED and have a principal SUD diagnosis. Dashboards have been created and push alerts are being sent to SUD providers with the goal of improving timely follow-up for mutually served members.

SUD providers will arrange opportunities for members to provide feedback, and once data is available, the QI and data analytics team will share performance updates with and elicit feedback from the QIC consumer workgroup.

TA and Recommendations.

As submitted, this non-clinical PIP was validated at low confidence because:
(1) Alameda has experienced a prolonged inability to collect data due to delays created by SmartCare implementation, transition to Current Procedural Terminology (CPT) codes for CalAIM, and glitches in receiving, ingesting, and cleaning the ADT data from hospitals, (2) the interventions are the responsibility of contracted providers the County must rely on to participate as planned, and with current reported staffing shortages, the extra work of timely follow-up calls may be difficult to achieve.

No TA was provided this review year.

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

- Extending the PIP for another year to provide enough time to collect appropriate data.
- Engage in a TA discussion regarding progress once three months of data is collected to review whether the data collection process is operating as planned.
- Conduct consistent communication with providers to ensure timely follow-up is occurring.
- Seek TA from CalEQRO at any time.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE DMC-ODS

The EHRs of California's DMC-ODSs are generally managed by county, DMC-ODS IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. Through the end of FY 2022-23, the primary EHR systems used by the DMC-ODS were Echo's Insyst, Krassons Inc's Clinician Gateway, and Networking Technology's RxNT E-prescribing. Insyst was in use for 32 years. Clinician's Gateway has been in use for 15 years. RxNT E-prescribing has been in use for 13 years.

Since the start of FY 2023-24, the DMC-ODS is using SmartCare by Streamline, Krassons Inc's Clinician Gateway, and Networking Technology's RxNT E-prescribing. The DMC-ODS must dedicate staff and resources to the implementation of all components of the EHR.

Approximately 3.52 percent of the DMC-ODS budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under DMC-ODS control.

The DMC-ODS has 1,213 named users with log-on authority to the EHR, including approximately 141 county staff and 1,072 contractor staff. Support for the users is provided by 40 full-time equivalent (FTE) IS technology positions. All IS Technology positions support both DMC-ODS as well as Mental Health Plan technology. Currently 26 positions are filled. The DMC-ODS uses contracted IS FTEs to augment County staff until vacancies are filled.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the DMC-ODS' EHR. At the time of the review, the SmartCare implementation had been suspended and contract providers did not have access to enter services into that application. Clinician's Gateway is available to record progress notes and clinical information. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 24: Alameda DMC-ODS Contract Provider Transmission of Information to DMC-ODS EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between DMC-ODS IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to DMC-ODS IS	☒ Daily ☐ Weekly ☐ Monthly	85%
Direct data entry into DMC-ODS IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	15%
Documents/files e-mailed or faxed to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Plan Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and have their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The DMC-ODS does not have a PHR for its members; however, they have plans to implement a PHR within the next year.

Interoperability Support

The DMC-ODS is a member or participant in an HIE, however the DMC-ODS does not send or receive data through the HIE due to guidance from county legal counsel that 42 CFR Part 2 regulations prohibits such data exchange. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The DMC-ODS receives discharge information directly from several hospital EDs for members with a SUD discharge diagnosis. The DMC-ODS does not participate in any other electronic exchange of information.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 25: IS Infrastructure Key Components

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

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

- Through the end of FY 2022-23, the DMC-ODS submitted claims in a timely manner. As of this review, there had been no claims submitted for FY 2023-24, because of issues with the implementation of the new registration and billing software SmartCare.
- Even though the claims denial rate improved from CY 2021 to CY 2022, the DMC-ODS claims denial rate for CY 2022 is above the statewide average. The denied claims rate dropped from almost 19 percent in CY 2021 to 6.22 percent in CY 2022, which is a notable improvement.
- The DMC-ODS depends on the county IT Department's Operational Continuity Plan in the event of loss of access. The plan includes restoring the system within 24 hours. The plan is not tested annually.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

Table 26 shows the amount of denied claims by denial reason, and Table 27 shows approved claims by month, including whether the claims are either adjudicated or denied. This may also indicate if the DMC-ODS is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Tables 26 and 27 appear to reflect a substantially complete claims data set for the time frame represented.

Table 26: Summary of Alameda DMC-ODS Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible	7,673	$878,483	62.40%
Other Healthcare coverage must be billed first	22,064	$458,946	32.60%
Missing valid diagnosis	162	$34,497	2.45%
Duplicate/same day service without modifier or other info needed for adjudication	225	$19,469	1.38%
Late claim submission	97	$11,997	0.85%
Service location not eligible	18	$4,402	0.31%
Other	3	$98	0.01%
Total Denied Claims	**30,242**	**$1,407,892**	**100.00%**
Denied Claims Rate	**6.22%**		
Statewide Denied Claims Rate	**3.64%**		

- The denied claims rate was higher than statewide at 6.22 percent.

Table 27: Alameda DMC-ODS Claims by Month, CY 2022

Month	# Claim Lines	Total Approved Claims
Jan-22	38,257	$1,600,231
Feb-22	35,601	$1,606,287
Mar-22	39,758	$1,797,876
Apr-22	37,807	$1,740,022
May-22	38,844	$1,749,922
Jun-22	37,446	$1,695,032
Jul-22	38,225	$1,834,334
Aug-22	39,941	$1,939,047
Sep-22	38,137	$1,824,786
Oct-22	38,323	$1,805,040
Nov-22	36,147	$1,756,866
Dec-22	36,939	$1,876,951
Total	**455,425**	**$21,226,395**

- Table 27 shows consistency of claim lines and approved claim amounts throughout CY 2022. The CY 2022 total approved claims is very similar to the total from the previous year.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The DMC-ODS understands the importance of using data as a tool in making decisions and shaping policy. Alameda has a well-developed data warehouse that contains a variety of data sources. The data team employs extensive data checking and validation methods to ensure data integrity.
- As part of County Behavioral Health, the DMC-ODS follows the department's "True North Metrics" to guide ongoing system planning. The True North Metric domains include Quality, Investment in Excellence, Accountability, Financial Sustainability, and Outcome-Driven Goals. In practical terms, following the True North Metrics for the IS team means ensuring that all data measurement tracks back to one or more of the True North domains.
- Since the last review, the DMC-ODS completed a successful initiative to deliver data to their community providers. They conducted outreach to providers that was well received. In addition to standard data sharing, they allow providers to request data and make it available as long as it is appropriate and feasible. This is another example of communication improvement between the DMC-ODS and providers.
- During the previous review, community provider staff reported losing clinical data due to brief outages of the DMC-ODS EHR. Since the last review, IS staff upgraded their technology infrastructure to address clinical data loss, and no further data loss problems were reported through the end of FY 2022-2023.
- Alameda implemented SmartCare at the beginning of FY 2023-24; however, they are not part of the California Mental Health Services Act (CalMHSA) Semi-Statewide EHR initiative. Implementation was paused shortly thereafter because of software issues. As of this review, the planned re-launch was scheduled for the third week of January 2024.
- The DMC-ODS does not engage in data exchange with their MCPs. Alameda County Counsel directed them not to do so based on 42 CFR Part 2. Alameda should consider communicating with other counties that have been successful in legally sharing information.

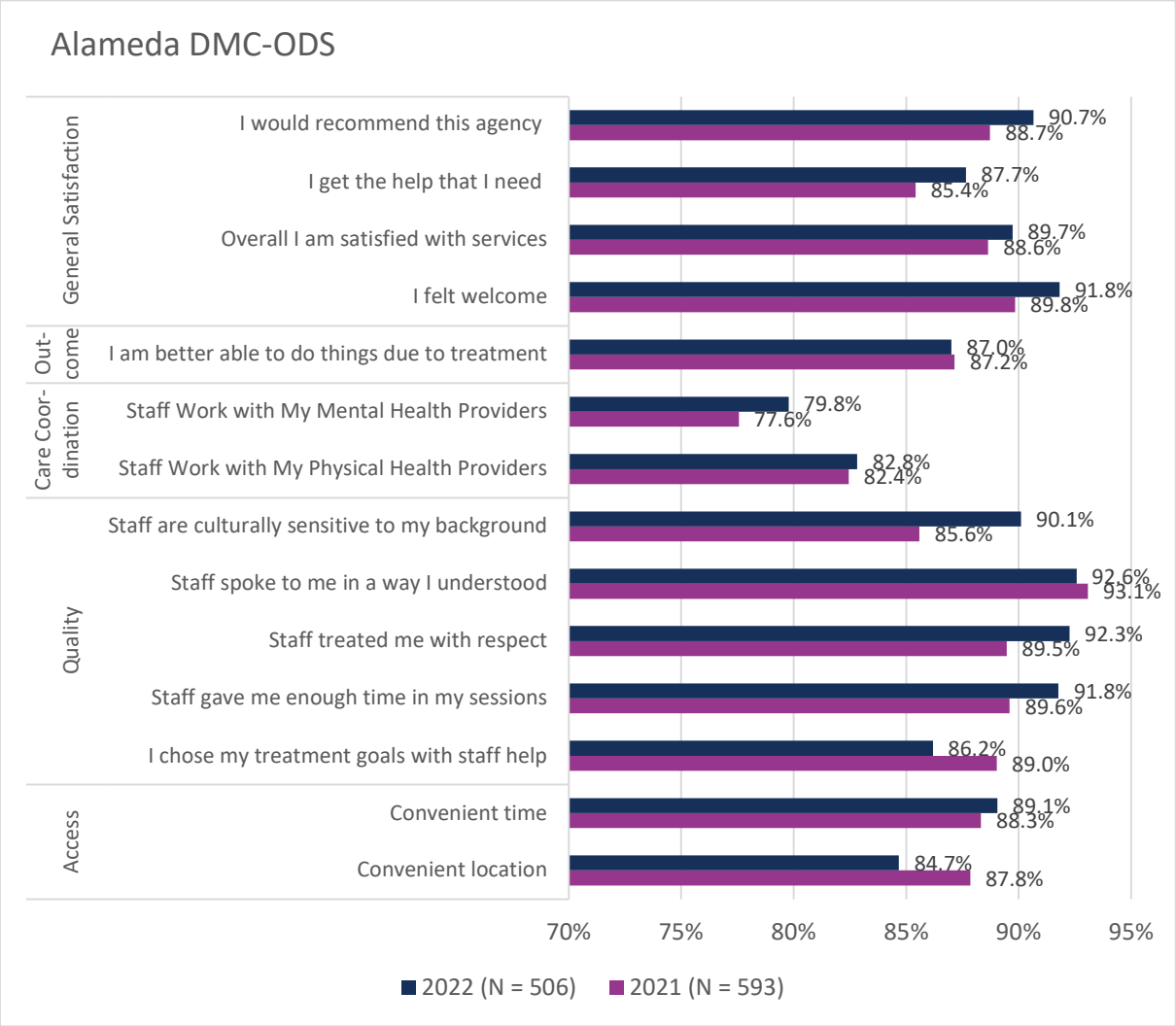
VALIDATION OF PLAN MEMBER PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

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

The DMC-ODS continues to conduct the annual survey through the contracted providers, although participation decreased by 15 percent from the previous year. The results are reviewed, compared to previous year's results, and shared with providers.

Figure 9: Percentage of Adult Participants with Positive Perceptions of Care, TPS Results from UCLA



** Note that the horizontal axis begins at 70% in order to display small differences in responses from year to year.*

- Members rated the DMC-ODS highest in General Satisfaction and Quality Care Coordination. Care Coordination continues to be rated the lowest with "Staff Work with My Mental Health Providers" rated the lowest at 79.8 percent though this is consistent with ratings from other DMC-ODS counties.
- Of all the questions, the largest satisfaction increase was for the item "Staff are culturally sensitive to my background." The response in the previous survey was 85.6 percent positive. The response in the recent survey was 90.1 percent.
- Only two items did not show improvement. The items "Convenient location" and "I chose my treatment goals with staff help" recorded decreases in satisfaction.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested 90-minute focus groups with Plan members (DMC-ODS members) containing 10 to 12 participants each.

Plan Member/Family Focus Group One

CalEQRO requested a diverse group of adult Plan member consumers who initiated services in the preceding 12 months. The focus group was held virtually and included eight members participating in treatment from six days to six months. A language interpreter was not needed for this focus group. All Plan members participating receive clinical services in a residential program from the DMC-ODS.

Individuals participating in this focus group were referred to residential treatment by a variety of sources, including other SUD programs and family members. Intake assessments were conducted promptly with admission, in some cases the same day as the assessment. No members were on MAT and most stated they had not heard of it before this focus group. Counselors and staff assist members in linking to primary care providers, psychiatrists, parole officers, and other significant individuals and entities, and sometimes will attend with the members. Transportation is available through Medi-Cal covered ride-share services if scheduled three days in advance, a mental health program van, and in specific instances, counselors have transported members to important appointments when no other transportation was available. All appeared to be happy with the program with one member starting school and another stating, “I’m finally trying to keep up with my health, because when I was on the streets, I didn’t.”

Recommendations from focus group participants included:

- All would like family education and counseling to be added to the program as they believe it would greatly enhance their recovery.

Plan Member/Family Focus Group Two

CalEQRO requested a diverse group of adult Plan member consumers who initiated services in the preceding 12 months. The focus group was held virtually and included eight members participating in treatment from three weeks to two months. A language interpreter was not provided for this focus group, but there was one monolingual Spanish member in the group being assisted by another Spanish speaking member. All Plan members participating receive clinical services in a residential program through the DMC-ODS.

Intake assessments and admission were reported as generally prompt with some identifying several issues contributing to longer wait times. One member was on MAT, and most were familiar with those services. The program provides transportation to outside appointments and has two case managers to assist members. All members were encouraged by the program to establish care with a primary care physician and assisted with access to psychiatrist. Twelve-step meetings are conducted on site and the program has an active alumni group. Members were generally happy with the program overall, expressing improved confidence and coping skills since they began treatment.

There are language issues with monolingual Spanish speaking members. No one in the group had heard of a language line for interpretation and reported that other members assist with translation when they can. One member was recently diagnosed with diabetes and is having difficulty getting a disability-approved meal plan. Other members reported there is some availability of culturally appropriate food items.

Recommendations from focus group participants included:

- Increased access to physical fitness gear.
- Community outings which were a part of the program prior to the pandemic.
- More family visits outside the monthly commencement ceremony.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, the members expressed satisfaction with the programs and were positive about recovery. Both programs provided support for access to physical and mental health care and counselors appear to be invested in successful recovery for the members. Transportation does not seem to be a problem within these two programs. All members would like more family involvement.

CONCLUSIONS

During the FY 2023-24 annual review, CalEQRO found strengths in the DMC-ODS' programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SUD managed care system.

STRENGTHS

1. Alameda has secured the services of David Mee Lee M.D., one of the authors of the ASAM, to meet with SUD treatment staff on a monthly basis. All staff are welcome to attend and discuss clinical challenges, LOC placement questions, and other concerns they may have regarding member treatment needs. Providing this resource will likely significantly contribute to the shift from program to person guided treatment, resulting in expanded use of best practices and higher quality SUD services in Alameda County.

2. Alameda has a robust partnership with the justice system. In partnership with the superior court, the DMC-ODS plays a major role in a variety of specialty courts and meets monthly or as needed with court representatives to discuss policy, ethnic disparities, successes, and challenges. Similarly, there are three specialty family dependency courts, and Alameda is involved with the Santa Rita Jail behavioral health housing units, providing mental health and SUD services. Safe Landing, a resource program located outside the jail on the same property provides links to SUD/mental health treatment, housing, vocational rehabilitation, and other needed resources.

3. Stakeholder communications are greatly improved with monthly meetings and evaluations of the Quality Work Plan are designed to secure stakeholder feedback and interests. Stakeholder involvement has also prompted networking and collaboration between the providers of different levels of care. The QIC now has members and their families incorporated in the committee, with some committee activity specifically designed for members and family members. Additionally, leadership from SUD services invites discussions with providers and the QI team from which communication has improved between the data team, QI team, and system providers. (Access, Quality, Information Systems)

4. The Office of the Medical Director/Integrated Care Services continues to partner with BACH to further support behavioral health and primary health care integration. As part of improving outreach to and engagement of the Asian/Pacific Islander population an Asian Wellness Project has been established that now includes Chinese medicine such as acupuncture and other culturally appropriate services in the community health centers, as well as replacing the term "behavioral health" with "the healing process." The project also works with BACH

to increase behavioral health capacity to service the API population by building an in-person and remote work force. BACH is located in the south part of the County where the Asian/Pacific Islander population is over 50 percent. This population has the lowest PR of all populations in the DMC-ODS at 0.10 percent lower than statewide and other counties of similar size. (Access, Quality)

5. The DMC-ODS is a data driven organization that is well supported by its data team known internally as the QIDAD. The data presented to DMC-ODS users is based on a data warehouse that combines multiple data sources and employs good techniques for data cleaning and mapping to ensure that data is validated and reliable. Since the last review, the DMC-ODS completed a successful initiative to deliver data to their community providers, making not only standard data available, but providers can also make specific data requests. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Alameda's no-show rate for first scheduled appointments after screening for residential treatment continues to increase year over year. The rate for FY 2020-21 was 55 percent and has steadily increased to the current 66 percent. (Access, Timeliness, Quality)

2. Youth SUD treatment services provided by the DMC-ODS appear minimal. While there are behavioral health providers serving youth on many school sites (149), it was reported that SUD specific services were limited to 25 school sites partially due to resistance from the schools. Alameda states the mental health providers also provide SUD services; however, it is unclear if those services are sufficient to address SUD needs of youth. (Access, Quality)

3. MAT expansion in Alameda County is not easily identified or recognizable. While there are examples of MAT prescribing and utilization in the county through physicians, FQHCs, and the Bridge Program, there were several considerations gleaned from this review indicating MAT education and expansion activities have not been effectively delivered throughout the county and the DMC-ODS. (Access, Quality)

4. Alameda continues to have a very low percentage of members completing treatment. During the last EQR, 20.2 percent of members completed treatment prior to discharge; however, this year that number dropped to 17.97 percent, leaving over 80 percent of members discharging prior to completion. While the DMC-ODS has developed a PIP to address residential member elopement, due to unforeseen circumstances, the PIP could not be formally implemented nor was data available to indicate the reported 80 percent elopement rate had been decreased. (Quality)

5. The Access Call Center system does not adequately address the needs of members seeking SUD services. Evening and weekend calls are received by

Alameda County CSS and messages are taken from those requesting SUD information or services. CSS' focus is on mental health and suicide and the program is staffed with volunteers. Any member (MH and SUD) calling in crisis will be linked to help at that time, however, having Access Center staff place follow-up calls up to 48 hours after the initial call for those needing services but not in an acute mental health crisis, creates a barrier to access for those members unfortunate enough to call after business hours. Additionally, when a follow-up call does not result in contact, that call is not recorded as a first request for service and does not become a part of data collection for tracking. (Access, Timeliness, Quality)

RECOMMENDATIONS

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

1. Conduct a thorough analysis to determine the root causes of the high no-show rate for residential treatment. Take meaningful steps to increase the number of potential clients who attend their first scheduled residential provider appointment and engage in treatment. (Timeliness)

   (This recommendation is a carry-over from FY 2022-23.)

2. Increase the population of youth participating in SUD treatment. Determine what level of SUD treatment is provided to youth on the school sites by behavioral health providers to verify if the youth are getting the SUD specific treatment they need and determine if some might be better served by an SUD treatment program off of the school site through the DMC-ODS. (Access)

3. Take meaningful steps to gain a clear picture of what MAT expansion and utilization in Alameda County, and what education efforts may be warranted to ensure that MAT is offered to those who would benefit. (Access, Quality)

4. Analyze root causes to reduce the high rates of discharges prior to completion of treatment.

   (This recommendation is a carry-over from FY 2022-23.)

5. Take active steps to develop a 24/7 access line with SUD trained staff available to provide a brief assessment and referral after business hours as is performed during business hours. In the interim, implement a system for tracking the calls received by CSS by the reason for the call so that all calls for services can be included in the data collection process, regardless of outcome of follow-up calls. (Access, Timeliness)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from DMC-ODS Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Alameda DMC-ODS
Opening session – Significant changes in the past year, current initiatives, and status of previous year's recommendations, baseline data trends and comparisons, and dialogue on results of PMs
Quality and Cultural Competence
Performance Measure Validation and Analysis
Validation and Analysis of the DMC-ODS Network Adequacy
ISCA / Validation and Analysis of the DMC-ODS Health Information System
Use of Data / Fiscal/Billing
ASAM Continuum of Care and Fidelity
PIP Validation and Analysis
Access Call Center Managers and Staff (2 group interviews)
Medication Assisted Treatments / Non-methadone MAT and NTP
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Interagency Coordination with Mental Health, Physical Health, and SUD
Criminal justice coordination with DMC-ODS
Contract Provider Group Interview
Youth Services and Prevention
Coordination With Criminal Justice
Clinical line staff group interview – Contracted providers
Member Focus Group – Residential (2 group interviews)
Closing session: Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Cynthia Hudgins, Lead Quality Reviewer
Eric McMullen, Quality Reviewer
Lorrie Sheets, Information Systems Reviewer
Katie Faires, Consumer/Family Member Reviewer

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

Last Name	First Name	Position	County or Contracted Agency
Benjamin	Danielle	Information Systems Analyst	Alameda County Behavioral Health
Bernhisel	Penny	Clinical Program Supervisor, Behavioral Health Forensic Court Programs	Alameda County Behavioral Health
Biblin	Janet	Info Systems Manager, Quality Improvement and Data Analytics	Alameda County Behavioral Health
Cabrera	Jose	Management Analyst, Decision Support Team	Alameda County Behavioral Health
Cannady	Angel	Program Manager, Oakland	Magnolia Women's Recovery Programs
Capece	Karen	Quality Management Director	Alameda County Behavioral Health
Ceja	Nancy	Associate Program Specialist	Alameda County Behavioral Health
Chapman, MD	Aaron	Behavioral Health Medical Director and Chief Medical Officer	Alameda County Behavioral Health
Chau	Mandy	Audit and Cost Reporting Director, Finance	Alameda County Behavioral Health
Chiang	Katy	Analyst, Information Systems	Alameda County Behavioral Health
Coombs, MD	Angela	Office of the Medical Director Associate Medical Director	Alameda County Behavioral Health
Cooper Kahn	Mia	Senior Manager of Behavioral Health	Community Health Center Network
Currie	Peter	Senior Director of Behavioral Health, Integrating Behavioral and Physical Health	Alameda Alliance
Diedrick	Sheryl	Analyst, Information Systems	Alameda County Behavioral Health
Dillon	Narges	Executive Director	Crisis Support Services of Alameda County
Douglas	James	Program Manager, SUD Helpline	Center Point, Inc.
Eady	Rashad	Program Specialist, Quality Improvement and Data Analytics	Alameda County Behavioral Health
Edwards	Charles	ACCESS Division Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Elliot	Anne	Critical Care Manager, Crisis System of Care	Alameda County Behavioral Health
Forsythe	Robert	Information Systems Analyst, Information Systems	Alameda County Behavioral Health
Gerchow	Christine	Juvenile Justice Health Services Director	Alameda County Behavioral Health
Gibbs	Laphonsa	Child & Young Adult Outpatient Services Interim Director	Alameda County Behavioral Health
Golub	Adm	Business Intelligence Analyst	Alameda County Behavioral Health
Goodman	Necole	Quality Improvement and Data Analytics	Alameda County Behavioral Health
Grilley	Stephen	Division Director, Criminal Justice Programs	Center Point, Inc.
Hall	Lorenza	Senior Management Analyst, Decision Support Team	Alameda County Behavioral Health
Herring, MD	Andrew	Substance Use Disorder Treatment Medical Director	Alameda Health Systems
Houston	Fonda	Substance Use Operational Specialist	Alameda County Behavioral Health
Lee	Sun Hyung	Transition Age Youth Services Division Director	Alameda County Behavioral Health
Jimenez	Richard	Vice President	Center Point, Inc.
Jones	Kate	Adult & Older Adult Services Director	Alameda County Behavioral Health
Judkins	Andrea	Supervising Financial Services Specialist, Fiscal Services	Alameda County Behavioral Health
Kayman, MD	Joshua	Consulting Psychiatrist for Substance Use Disorder Programs	Alameda County Behavioral Health
Lesova	Svetlana	Assistant Director of In-Custody Services, Forensic, Diversion, and Re-Entry Services System of Care	Alameda County Behavioral Health
Lewis	Stephanie	Acting Crisis System of Care Director	Alameda County Behavioral Health
Lewis	Clyde	Substance Use Disorder Services Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Lopez	Rickie	Assistant Finance Director	Alameda County Behavioral Health
Louie	Jill	Budget and Fiscal Services Director	Alameda County Behavioral Health
Lozano	Ed	Applications Development Manager, Information Systems	Alameda County Behavioral Health
Manor	Michelle	QI Project & Planning Manager/Supervising Program Specialist	Alameda County Behavioral Health
McKenzie	Anna	Management Analyst, Contracts Unit	Alameda County Behavioral Health
Meinzer Valentino	Chet	Quality Improvement and Data Analytics, Division Director	Alameda County Behavioral Health
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	Alameda County Behavioral Health
Moore	Lisa	Billing & Benefits Support Director	Alameda County Behavioral Health
Narvaez	Cheryl	EPSDT Coordinator, Children and Young Adult System of Care	Alameda County Behavioral Health
Orozco	Gabriel	Management Analyst, Decision Support Team	Alameda County Behavioral Health
Peterson	Camille	Analyst, Information Systems	Alameda County Behavioral Health
Phan	Jade	Information Systems Manager	Alameda County Behavioral Health
Phipps	Brion	Clinical Review Specialist Supervisor, Quality Assurance	Alameda County Behavioral Health
Provost	John	Services Manager, Information Systems	Alameda County Behavioral Health
Purciel-Hill	Marnie	Performance Improvement Manager, Quality Improvement and Data Analytics	Alameda County Behavioral Health
Rankin	Lauren	Program Contract Manager, Contracts	Alameda County Behavioral Health
Raynor	Charles	Pharmacy Services Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Rejali	Torfeh	Quality Assurance, Division Director	Alameda County Behavioral Health
Richholt	Kinzi	Chief Nursing Officer, Office of the Medical Director	Alameda County Behavioral Health
Sabar	Jennifer	Data Specialist, FSCM Case Manager RADT	Center Point, Inc.
Schrick	Juliene	Utilization Management Division Director	Alameda County Behavioral Health
Schulz	Henning	Adult Outpatient Services Division Director	Alameda County Behavioral Health
Serrano	Cecilia	Finance Director	Alameda County Behavioral Health
Shallcross	Lori	Clinical Review Specialist Supervisor, Utilization Management	Alameda County Behavioral Health
Smith	Freddie	Integrated Care Services Division Director	Alameda County Behavioral Health
Steven	Stefanie	Program Manager, Hayward	Magnolia Women's Recovery Programs
Taizan	Juan	Forensic, Diversion, & Re-Entry Services Director	Alameda County Behavioral Health
Tribble	Karyn	Director	Alameda County Behavioral Health
Vargas	Wendi	Contracts Director	Alameda County Behavioral Health
Wagner	James	Clinical Operations Deputy Director	Alameda County Behavioral Health
Williams	Ulrika	Treatment Center Director	BAART Programs
Wong	Jenny	Management Analyst, Quality Management	Alameda County Behavioral Health
Woodland	David	Clinical Review Specialist, Quality Assurance	Alameda County Behavioral Health
Yamamoto	Melissa	Administrative Support Manager, Substance Use Disorder System of Care	Alameda County Behavioral Health
Yuan	Eric	Manager, Integrated Care Services	Alameda County Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP was rated with Low confidence because: (1) Alameda has experienced a prolonged inability to collect data due to delays created by SmartCare implementation which is ongoing, transition to CPT codes for CalAIM, and glitches in receiving, ingesting, and cleaning the ADT data from the hospitals, (2) the interventions are the responsibility of contracted providers the County must rely on to provide added services and with current reported staffing shortages, (validated through focus groups), the extra care coordination may be difficult to achieve.
General PIP Information	
MHP/DMC-ODS Name: Alameda	
PIP Title: Care Coordination for Residential Substance Use Disorder (SUD) Services	
PIP Aim Statement: The aim of this PIP is to address the low rates of client progress within Alameda County residential treatment programs and to increase successful transfers for discharging clients to the next level of care.	
Date Started: 08/2022	
Date Completed: N/A	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): All adult members receiving residential treatment through the DMC-ODS with an SUD diagnosis.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): No changes
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): No changes
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): No changes

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1: Number and percent of clients receiving case management services in residential treatment	11/1/2021 – 10/31/2022	438/882 49.7%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2: Number and percent of clients who received case management within seven (7) days of enrollment	11/1/2021 – 10/25/2022	29/89 32.6%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3: Number and percent of clients who received at least three (3) case management services per month while enrolled in	Oct 2022	29/89 32.6%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 4: Number and percent of clients who remained in Residential Treatment at least 30 days of care	11/1/2021 – 10/31/2022	364/632 57.6%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 5: Number and percent of clients discharged from Residential Treatment with treatment progress	11/2021-10/2022	323/632 51.1%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 6: Number and percent of clients transitioning successfully to the next level of care (3+ visits in 34 days)	11/2021-10/2022	150/632 23.7%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Discussed extending the PIP for another year to provide enough time to collect appropriate data given the data collection delays should be resolved by the third week of January 2024. The DMC-ODS was already planning to do this. • CalEQRO recommends the DMC-ODS expand the Aim Statement to include clear descriptions regarding strategies, timelines, and performance measures. • CalEQRO recommends further analysis on the viability of this PIP given the concern regarding whether the data will reflect an increase in claiming the service vs. an increase in services rendered. • CalEQRO recommends a TA discussion regarding progress once three months of data has been collected to review whether the data collection process is operating as planned, allowing for an appropriate amount of data to be collected by December 2024. • CalEQRO is available to provide TA at any time.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP was rated with Low confidence because: (1) Alameda has experienced a prolonged inability to collect data due to delays created by SmartCare implementation which is ongoing, transition to CPT codes for CalAIM, and glitches in receiving, ingesting, and cleaning the ADT data from the hospitals, (2) the interventions are the responsibility of contracted providers the County must rely on to participate as planned and with current reported staffing shortages, (validated through focus groups), the extra work of timely follow-up calls may be difficult to achieve.
General PIP Information	
MHP/DMC-ODS Name: Alameda	
PIP Title: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	
PIP Aim Statement: Increase timely information sharing from primary care emergency departments (ED) to improve Outpatient and Opioid Treatment Program (OTP) substance use disorder (SUD) provider's 1) awareness of their Medi-Cal beneficiary clients' ED discharges; 2) capacity to provide follow-up services, and 3) rate of timely client follow-up. Implemented interventions aim to increase the percentage of follow-up activities within 30 days of ED visits for SUD conditions by 5% by March 31, 2024.	
Date Started: 08/2022	
Date Completed: N/A	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adult Medi-Cal members with a principal SUD diagnosis visiting an ED.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): No changes
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Specified that outpatient SUD programs and Opioid Treatment programs will pilot the interventions.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The DMC-ODS will obtain timely ED discharge data directly from hospitals. Previously, data was to come from MCPs.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1: Percent of SUD Outpatient and OTP programs reporting they are receiving the ED Discharge alerts	Aug-Sept 2023	50%	☒ Not applicable—PIP is in planning or implementation phase, results not available	N/A	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2: Number and percent of SUD Outpatient and OTP program clients who received a follow-up substance use treatment service within 7 days of ED discharge	Apr-Jun 2023	50%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3: Number and percent of SUD Outpatient and OTP program clients who received a follow-up substance use treatment service within 30 days of ED discharge	Apr-Jun 2023	68.8%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

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

PIP Validation Information
EQRO recommendations for improvement of PIP: • Discussed extending the PIP for another year to provide enough time to collect appropriate data. The DMC-ODS was already planning to do this. • CalEQRO recommends a TA discussion regarding progress once 3 months of data has been collected to review whether the data collection process is operating as planned, allowing for an appropriate amount of data to be collected by Dember 2024. • CalEQRO recommends consistent communication with providers to ensure timely follow-up to provide problem solving support should any provider have difficulty with this task. • CalEQRO is available to TA at any time.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the CalEQRO website: www.caleqro.com

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

A letter from the DMC-ODS Director was not required for this report.