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

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

FY 2018-19
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM EXTERNAL QUALITY REVIEW

CONTRA COSTA DMC-ODS FINAL REPORT

Prepared for:
California Department of Health Care Services

Review Dates:
August 28th-30th, 2018

TABLE OF CONTENTS

LIST OF TABLES

CONTRA COSTA DMC-ODS EXECUTIVE SUMMARY

Clients Served in Calendar Year 2017 —1,432 individuals out of 244,457 beneficiaries
Contra Costa Threshold Language(s) — Spanish
Contra Costa Size — Large
Contra Costa Region — Bay Area
Contra Costa Location — east of San Pablo Bay, south of Solano, west of Sacramento and San Joaquin, and north of Alameda
Contra Costa County Seat — Martinez
Site Review Process Barriers— No barriers

Introduction

Contra Costa County officially launched its Drug Medi-Cal Organized Delivery System (DMC-ODS) in June 2017 for Medi-Cal recipients as part of California's 1115 Drug Medi-Cal Waiver. Contra Costa County was the fourth to launch in California's Bay Area Region and fifth statewide. In this report, "Contra Costa" shall be used to identify the Contra Costa County DMC-ODS program unless otherwise indicated. They completed a six-month comprehensive strategic planning process in early 2017 outlining their implementation plan for 2017-2022. The plan includes integrating alcohol and other drug (AOD) services in mental health (MH) clinics and providing MH support services at the county-operated AOD residential treatment program. Contra Costa also works closely with the county's Health Department and coordinates Medication Assisted Treatment (MAT) for substance use disorders (SUD), as well as participation on an opioid task force.

Contra Costa is a large county located in the Eastern Bay Area region with a large land mass of 429,000 square miles and a water mass of 723 square miles. It is located on the eastern San Francisco Bay between Solano, Sacramento, San Joaquin and Alameda Counties. The population estimated for 2017 by Contra Costa is 1,149,363 (source: 2010 Decennial Census). The County is primarily suburban with the Medi-Cal Beneficiaries residing primarily in the eastern, northern and western area as shown in the Contra Costa geo-mapping. Healthcare is the largest industry employer in Contra Costa followed by retail and professional (including scientific and technical services) according to Data USA (https://datausa.io/). Because Contra Costa is primarily a suburban county, AOD Management reports difficulty in establishing new substance use treatment programs in several areas due to the negative response of the neighbors.

The population in Contra Costa is 46 percent Caucasian and 24 percent Hispanic. Other significant populations include Asians (15 percent) and African Americans (9 percent). Females comprise 51 percent of the population. County Health Rankings and Road Maps (http://www.countyhealthrankings.org/app/california/2018/overview)

ranks Contra Costa in the top 20 percent of healthiest counties in California. This includes indicators for mortality, health behaviors, and social and economic factors. The most significant environmental area of concern for Contra Costa is the long commute for almost 50 percent of their population.

General Medi-Cal insures 17 percent of the overall population including 56 percent who are female and 31 percent who are Hispanic. Spanish is the only threshold language in Contra Costa County. Contra Costa, like many other California counties has experienced a significant increase in opioid overdose deaths. To their credit they have several coalitions working together to address this issue and have made some headway in reducing the number of deaths in their county.

During the fiscal year (FY) 2018-2019 Contra Costa review, the California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, initiatives, and opportunities related to Drug Medi-Cal (DMC) access, timeliness, quality, and outcomes related to the first- year implementation of Contra Costa's DMC-ODS services. More details from the EQRO-mandated review are provided in the full report.

Access

Contra Costa's integrated Access Line began to respond to requests for services, with dedicated SUD staff, on July 1, 2017. Access Line counselors utilize a screening tool to determine level of care based on American Society of Addiction Medicine (ASAM) Criteria and principles. Contra Costa requires that the Access Line provide the initial screening and referral for all outpatient, intensive outpatient (IOT) and residential services, Contract providers do the initial screening for Narcotic Treatment Programs (NTP), MAT and withdrawal management (WM). Contra Costa uses Tapestry, a module of the Epic software to track the activities of the Access Line. This module is effective and was modified to include the ASAM screening form.

The DMC-ODS Waiver startup had to address many initial challenges. Among them were long wait times for residential treatment, which no longer exist due to expanded bed capacity and better matching of new clients to appropriate levels of care through ASAM Criteria-based screening. The Access Line services are only required for all DMC-ODS beneficiaries; some others seeking SUD treatment such as those covered by the criminal justice reform bill AB 109, those seeking NTP services, and those seeking WM services still have a separate process.

At the beginning of Contra Costa's implementation, the call volume went from 50 calls a week to 450 calls a week. This increase overwhelmed the existing SUD staff and additional staff were hired. As part of the integrated patient centered model, Contra Costa trained two full time employees (FTE) who are MH clinical specialists to support callers with dual diagnosis needs. The Access Line call volume continues to be substantial, but staffing is now sufficient, and the line is accessible with a low wait time and modest call abandonment rate.

The claims data show a higher penetration rate in Contra Costa of .59 percent than the average of .25 percent for all other counties statewide that are actively implementing DMC-ODS. The penetration rate is higher among all age groups, gender and ethnicity. This is a testament to the extensive outreach and engagement efforts of the Contra Costa team as part of their startup implementation strategies.

Access Line staff assist those clients who are appropriate to make an appointment for either residential or outpatient treatment. This is accomplished with a 3-way call to connect the client to the provider whenever possible. If the Access Line is unable to contact a provider, a message is left by the prospective client while the Access Line Counselor remains on the line. A list of client numbers referred to individual programs is generated daily and sent to providers to cross reference with their phone messages. The treatment program to which the person is referred will provide a full assessment and make a more definitive determination of the appropriate level of care. If the determination is for a different level of care, then the program will initiate a call to the Access Line and make a transfer. The Access Line is the county-required referral center for all levels of outpatient treatment, not just residential treatment.

Providers are responsible to complete a full ASAM Criteria-based assessment that includes use of the Addiction Severity Index, and then produce a treatment plan within specific timelines for outpatient (25 days) or residential (seven days). Once the assessment and treatment plan are completed they are sent to the Utilization Review/Utilization Management (UR/UM) team for authorization for services. Although not required in the DMC-ODS STCs, Contra Costa requires and provides authorizations for all levels of outpatient treatment in addition to residential treatment services. Initially there were many delays in this process due to documentation errors on the part of the providers and inconsistencies by the UR/UM team. This team is an integrated behavioral health unit and there was a learning curve for them in authorizing services for the DMC-ODS. A point person with AOD expertise was eventually identified on the UR/UM team as the contact for all providers (specifically responding to questions) resulting in an improved process.

Clients reported that their interactions with the Access Line staff and processes were user-friendly. Providers fax the results of the referrals they received on a weekly basis, including any rescheduling and the initial date of actual service. This information is then input into Tapestry by county staff. CalEQRO observed that there is a need for further development of these processes to improve the efficiency of how the data are input into the information system.

When Access Line staff cannot respond to a call due to excessive call volume, callers are transferred to clerical staff. The caller is briefly screened for crisis and, unless a crisis exists, is informed a person will call them back. The Access Line management reports that they usually get through a back log of calls within the day but at most they try to reach callers for call backs within 24 hours. The after-hour calls are contracted with Optum who first screen callers for possible crises and follow preset crisis response

protocols if there is one. If not, they screen for what the caller needs, provide information if appropriate, and take the caller's number for a callback in the morning.

MAT services will soon be available at the two NTP provider clinics as contracts for this service are in place. In addition, Contra Costa has a robust MAT program, Choosing Change, that utilizes suboxone, and is located in county-operated Federally Qualified Health Clinics (FQHCs). Although the MAT program is operated separately from the DMC-ODS, the two programs are well coordinated. Client data is reported to Contra Costa and if additional services are needed they are coordinated between the Choosing Change program and the Access Line.

The Waiver provided opportunities for expanded service capacity and an expanded range of services for Drug Medi-Cal beneficiaries. Contra Costa used geo-mapping to be confident that there would be services within a reasonable distance and drive time to all beneficiaries. Contra Costa reviewed these details separately for adults and youth. Adult beneficiaries live mostly in the west, north and east regions of the county, while youth live mostly in the northeast and east regions.

All providers were encouraged to become DMC certified for the services they were providing, including residential treatment and WM. This was challenging for some of the providers and about ten percent are still in the process of becoming DMC certified. Successful providers also became eligible to bill DMC for new services including case management and soon, recovery support. Contra Costa has phased in the new services with case management now in place and recovery services rolling out in this second year. Contra Costa is also sending out Request for Proposals (RFP) to add additional needed providers into their continuum of care. These new providers are expected to begin providing services in year two of the implementation.

Contra Costa County served a steadily increasing number of Drug Medi-Cal clients over the last four years: 1,024 in FY 2013-14, 1,511 in FY 2014-15, 1,716 in FY 2015-16, and 1,742 in FY 2016-17. In Calendar Year (CY) 2017 there was a substantial increase in clients served during the first six months of the waiver implementation, a testament to the outreach by Contra Costa.

Contra Costa's overall penetration rate for treating Medi-Cal beneficiaries with substance use disorders was .59 percent, more than double the statewide average of .25 percent. The same positive comparisons were demonstrated in more detailed analyses by all ages except youth (which was the same as statewide penetration), gender, and race/ethnicity.

Although the Waiver expanded funding through DMC for residential treatment, the expansion was conditional on shorter length of stay limits. This has been a significant cultural change in Contra Costa for both providers and referring partners such as the criminal justice system. On-going discussions have moved this new model forward, but the lack of sufficient capacity in sober living environments (SLEs, referred to in this report as Recovery Residences) has challenged those persons being discharged from

short-term residential treatment who were referred from jail and/or are homeless. Contra Costa is working to establish more Recovery Residences. Some of these residences may be through a modified Oxford Model described as self-run dwellings where residents obtain jobs, pay utility bills, and learn to be responsible citizens while participating in SUD treatment independent of the residence. Recovery Residences are not covered by DMC funding, but are an essential transitional component for DMC clients who need an alternative to or step-down from residential treatment that combines outpatient treatment with temporary drug-free housing. Clients in the adult client focus group during the onsite CalEQRO review echoed Contra Costa staff's assertions that Recovery Residences are a vital need.

Timeliness

Contra Costa has established timeliness standards for all the services in the Waiver implementation but has not added technological capacity for electronic tracking and has yet to add sufficient staff to assist with all the necessary data collection tasks and analyses. The current system can track requests for services by callers to the Access Line and walk-ins to providers who are then asked to call the Access Line from the provider site. There was initial confusion as to the procedure for walk-ins, and providers were turning clients away because they did not understand they could have them call the Access Line from the provider site. That has been resolved and clients are now calling Access directly or from the provider's site.

The Tapestry software program produces reports for timeliness from initial request to first scheduled appointment. The software can also run a manual report for timeliness to the first face to face appointment in outpatient and residential programs. Contra Costa has client counts for all services but limited timeliness data. New efforts will be necessary in the next year to utilize data to identify system problems, challenges, successes, and where needed to facilitate corrective action. Contra Costa agrees data tracking is an area that needs to and will receive more focus.

The average length of time from the first request for outpatient or residential service to the first offered appointment is 4.6 days for all services. For adult services the mean was 4.6 days and for youth the mean was 3.7 days with a standard of 10 days that was met 91.3 percent of the time for adults and 100 percent of the time for children. The average length of time from initial request to first face-to-face appointment for outpatient and residential services system wide was 5.5 days. For adults the mean was 5.6 days and for youth the mean was 4.1 days with a standard of 10 days that was met 87.4 percent of the time for adults and 100 percent of the time for children.

Contra Costa was not able to track timeliness for MAT, urgent appointments, or WM readmission rates within 30 days. This will be remedied with the development of tracking systems. Contra Costa can track no-shows prior to the first appointment as this is faxed from the provider and entered in Tapestry. The authorization approval process by the UR/UM group has a standard of three days, but it was reported by providers that it can take longer to get approval for extensions.

Contra Costa recently implemented ShareCare as a new billing system for behavioral health. There were initial implementation challenges for the SUD program providers but the majority of those are now resolved. Contra Costa is also evaluating the options for their Electronic Health Records (EHR). MH has moved forward with ShareCare for billing and will implement Epic for their clinical EHR, and Contra Costa is working with their County Counsel to determine if a similar solution is possible for DMC-ODS within the constraints of 42 CFR, Part 2 data privacy and security regulations. There is optimism that this might be workable, but they are not able to move forward at this time. It is critical that they develop a plan (and backup) in the next year so that they can use more and better data to improve their systems operations.

Quality

Contra Costa began training on ASAM principles in 2015 and has successfully implemented the use of ASAM Criteria across the system. They have educated partners to understand that treatment levels of care will be determined by the clinical needs identified through the assessment process. This has been a huge but successful cultural shift for county and provider staff. Line staff continue to struggle with the change, particularly how to engage clients in this new practice, but are working hard to adapt. The county has promised more training as an effort to improve quality and plans to utilize Dr. David Mee Lee for consultation and training. Dr. Mee Lee is a board-certified psychiatrist and is also certified by the American Board of Addiction Medicine . For over 30 years, Dr. Mee Lee has focused on developing and promoting innovative behavioral health treatment that values clinical integrity, high quality and cost-consciousness. He has been instrumental in the development of the ASAM Criteria and related assessment tools. Providers express enthusiasm and hope that these changes supported by increased training will make significant system improvements in the long term.

One effort at quality improvement is to clinically integrate mental health and substance use treatment services for those clients who have both disorders. The behavioral health system set this as a goal, and strategically located staff in both mental health and substance use programs to assure that both type of issues can be addressed for clients when needed concurrently.

This strategy design helps mental health clinics become DMC-ODS certified and assigns a SUD counselor to each certified clinic. Some clinics are also coordinating with physical health professionals in a multidisciplinary team that includes physical health, mental health and substance use treatment providers conducting the intake and treatment.

Throughout the county, similar cross-disciplinary efforts are growing. One such effort involves coordination of SUD services with a homeless clinic, and another with jail health services. Another initiative included placing a SUD counselor at the Psychiatric Emergency Services. The SUD counselor works with clients as they start to stabilize.

The counselor utilizes motivational interviewing to engage the client in withdrawal management or treatment, depending on their needs. The DMC-ODS Waiver has catalyzed many of these efforts.

Another part of this effort is the assignment of a Licensed Practitioner of the Healing Arts (LPHA) to the county-operated SUD residential treatment program for men to assist with issues related to mental health. This program assesses persons for depression using the nine-item Patient Health Questionnaire (PHQ-9) and for anxiety using the seven-item Generalized Anxiety Disorder questionnaire (GAD-7) upon entry and exit from the program. As the program reviewed their successful completions, they found that persons who have scored high for depression and anxiety are less likely to complete the program. Contra Costa determined this would be an excellent pilot site for their clinical Performance Improvement Project (PIP). The PIP intervention is the implementation of a group curriculum (adapted for use within the residential time frame) to determine if clients can be more successful at program completion if services specifically address and resolve depression and anxiety. Although there has only been one complete group intervention the initial results are encouraging.

Contra Costa had a robust set of SUD treatment programs for youth prior to the Waiver that includes programs in schools and in communities. One indicator of the high quality of these services was observed during the review at a youth/adult program that opens at noon and has hours into the evening. The adolescent program includes 2 levels of care for teenagers experiencing problematic substance use as well as inadequate impulse management, high risk behaviors, unhealthy practices, school failure and adverse childhood experiences. The level of care is based on ASAM assessment criteria. Services occur 2-3 times a week and include counseling for the youth and family, case management and monitoring. It is oriented to provide services to youth after school and adults in the evening with family services scheduled in between. The CalEQRO team was informed that the youth come early for their afternoon group and "hang out" at the program. The police chief came to the review to explain how valuable this program was for youth in his community and that the program is supported by the larger community. Clearly this is a community program engaging youth, parents and others.

In Contra Costa the Contra Costa Health Plan (CCHP) serves approximately 85 percent of the Medi-Cal population while Anthem Blue Cross (ABC) serves the remaining. CCHP was actively involved in the development of the DMC-ODS and their staff attended ASAM and SUD 101 trainings. CCHP remains actively involved in the Waiver implementation and works closely with Contra Costa to develop improved quality of care for Medi-Cal beneficiaries. For its responsibilities to cover its enrollees' mild to moderate behavioral health conditions, CCHP expects all FQHCs, both county-operated and contracted, to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) and short-term MH services through its behaviorists. The behaviorist staff are county behavioral health employees co-located in the clinics who bill fee for service (FFS) Managed Care. This provides access to those persons receiving SUD services who have mild/moderate MH conditions. When primary care clients appear to need

more treatment for behavioral health conditions than the clinic can provide, they are referred to county's Behavioral Health Access line for screening and services.

Another effort at improving quality is through the County Opioid Task Force that involves multiple divisions within the Health Department including Contra Costa AOD leaders. This Task Force achieved many accomplishments over the last several years including: adopting a set of best practices on prescribing for both primary care and specialty mental health prescribers; establishing an overdose death review that identified a group of persons at the highest risk (those withdrawing from treatment); providing robust alternatives to persons receiving opioids including alternative drugs and alternative therapies; establishing an interactive and engaging web page with education, resources and local data for Contra Costa; currently working to establish over 70 kiosks for disposal of needles; and tracking the reduction of opioid prescriptions and opioid deaths over the last two years.

This effort in addressing opiate addiction as a disease and identifying treatment options for the community is normalizing MAT services both in the community and within the treatment community. Contra Costa has been promoting MAT services for some time and it is evident that providers are clear that MAT services must be a regular part of treatment. Follow up is done if there is a complaint from a client restricted in receiving MAT services in conjunction with other treatment modalities.

Contra Costa's work with the five county-operated FQHCs to produce a program called Choosing Change should be highlighted as a MAT best practice model. Eleven clinics (operating in five FQHCs), use a team of a physician, nurse and mental health specialist to serve approximately 500 persons per year. It produces positive results for those persons who can benefit from suboxone. The services include induction, service coordination and health care. This collaborative effort results in services that are well-coordinated with those in Contra Costa's DMC-ODS continuum. Client information from diverse treatment services are included in each client's health record to further support care coordination. As this program is centered in primary care clinics, clients can request to see their Choosing Change provider for their primary care needs. Many clients make this choice.

Contra Costa has established clear direction for treatment providers that there is an expectation for a plan if someone relapses. This includes persons who have relapsed and as a result need to be moved to a different level of care. It has been made clear that it is not acceptable to simply discharge a client because of relapse.

Contra Costa can improve its system by enhancing its working relationship with the providers in the county. The relationship with providers was extremely strained during this first year of implementation and although it has improved there is still much to be done. To address issues Contra Costa held meetings and made changes in the system that were validated by providers. However, providers need to be involved for continued

planning and quality improvement efforts. There needs to be regular monthly meetings to listen to concerns and work together to come up with solutions for the entire system. Future rollouts need to include pilots with providers in addition to county operated programs to assure that the implementation plan works for providers.

Outcomes

Contra Costa utilizes a consultant who produces high-level and detailed reports, including ones from the California Outcome Measurement System (CalOMS) with pre- and post- treatment outcome data. These rich reports are produced annually and provide detail regarding what is working and where there are concerns. An example of an outcomes report is included in Attachment D. However, an annual report is not adequate for discovering issues and making timely changes to a system. Contra Costa is planning to review the existing reports more frequently as they move forward.

The Non-Clinical PIP is focused on engagement of persons being referred to residential treatment by engaging them with motivational interviewing as they move through the process. They are piloting this effort at all residential programs. Their goal is to engage clients at initiation to treatment to reduce no shows, and have more people engage in treatment and complete it successfully.

Client Feedback

There were two client groups conducted on the review: a women's perinatal group and a male adult group. There was a visit to a youth program with a stakeholder meeting, but youth were not part of the group. One person in the adult group had the assistance of a Spanish language translator. The client feedback provided that Contra Costa had significantly reduced wait lists and the new Access Line staff were helpful, patient, and able to explain how to navigate the system. Clients stated that it sometimes took a couple of days to get a call back from the Access Line but that was still a significant improvement. Most reported being comfortable with their counselors, and able to talk with them about urgent problems and practical ones. They also reported their counselors to be sensitive to their cultural background, and if they did not connect with their assigned counselor they were easily assigned a new one who made connecting easier. Only one person reported a counselor discussing the advantages of MATs. Recommendations from clients included for providers to be more open to medications, for the system to get clients into treatment faster, and for programs to encourage clients to come back more often as alumni. There was a general sense that if counselors had more time available, they could accomplish more effective treatment. Lastly, they expressed a need among clients for more help to transition from residential to the next level of care in treatment.

EXTERNAL QUALITY REVIEW COMPONENTS

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

The State of California Department of Health Care Services (DHCS) has received and approved 20 plans for California counties to provide Medi-Cal covered specialty DMC-ODS services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. DHCS may contract with up to 40 counties if all requirements including readiness standards and a contract agreement are approved.

This report presents the findings of an EQR of Contra Costa by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC). The EQR was conducted during August, 2018 and the findings pertain to Contra Costa's implementation of its DMC-ODS during FY 2017-18.

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

Validation of Performance Measures[1]

Both a statewide annual report and this DMC-ODS-specific report present the results of CalEQRO's validation of twelve performance measures (PMs) for year one of the DMC-ODS Waiver as defined by DHCS. The twelve PMs include:

- Total client beneficiaries served by each county DMC-ODS;
- Number of days to first face-to-face DMC-ODS service after referral;
- Total costs per beneficiary served by each county DMC-ODS;

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

- Cultural competency of DMC-ODS services to client beneficiaries;
- Penetration rates for clients, including ethnic groups, age, language, and risk factors are validated for access;
- Coordination of Care with physical health and mental health;
- Timely access to medication for narcotic treatment program (NTP) services;
- Timely access and numbers of client beneficiaries accessing non-methadone MAT;
- Timely transitions in levels of care (LOC) after residential treatment in year one of the waiver;
- 24-hour access call center line availability to link clients to ASAM assessments and treatment;
- Identification and coordination of the special needs of high-cost beneficiaries (HCB);
- Percentage of clients with three or more withdrawal management episodes and no other treatment to improve engagement.

Performance Improvement Projects[2]

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

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

DMC-ODS Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which Contra Costa meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of Contra Costa's reporting systems and

---

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

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

methodologies for calculating PMs. It also includes use of data for improvements in quality, coordination of care, billing systems, and effective planning for data systems to support optimal outcomes of care and efficient use of resources.

Validation of State and County Client/Consumer Satisfaction Surveys

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

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

Examples of the CalEQRO Consumer/Client Focus Group Forms are included in Attachments to this report.

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

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

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

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

OVERVIEW OF KEY CHANGES TO ENVIRONMENT AND NEW INITIATIVES

Past Year Accomplishments and Initiatives

- Internal planning groups and a provider working group were established in the year prior to implementation. The contract provider group was eventually discontinued.
- Contra Costa established an integrated call center with trained SUD counselors, using ASAM principles for screening.
- Contra Costa provided training on ASAM throughout the county through a consultant contract with Dr. Mee Lee.
- Establishment of the Access Line for entry into SUD treatment services was a substantial change in culture, as SUD clients were used to going directly to providers. Contra Costa worked with providers to make this change successful.
- Contra Costa encouraged existing providers to become DMC-ODS certified and offered them training and technical assistance. A Request for Proposal (RFP) increased the number of residential beds.
- Contra Costa conducted extensive presentations to market the new system as well as developing frequently asked questions, an updated web page and brochures and flyers.
- Contra Costa AOD staff worked with the county clinics to secure funds for addressing MAT using Homeless Funds through a federal Health Resources and Services Administration (HRSA) grant. This enabled the county operated FQHCs to establish 11 robust MAT suboxone clinics in five FQHC locations.
- Contra Costa established timeliness standards for all the services in the Waiver implementation.
- Contra Costa utilized its strong working relationship with the Contra Costa Health Plan who partnered in the design and implementation of the waiver.
- Contra Costa worked with other county health organizations in the implementation of the Whole Person Care Initiative.
- A direct line, with automated dialing, was established from jail to the Access Line allowing persons in jail to get information about treatment and work with Access Line counselors to schedule services when they are released from jail.
- Contra Costa utilizes the Treatment Perception Survey (TPS) data to evaluate client satisfaction and therapeutic alliance. Their high scores are consistent across the system and within their entire provider continuum. Their average score was 4.4 with a range of 4.3 to 4.6. The results of the TPS were shared with the Drug and Alcohol Advisory Board and with the Quality Improvement Committee.
- Links to the data and evaluation requirements for DMC-ODS are below:

1. CalOMS Treatment Data Collection Guide:

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

2. TPS: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information_Notice_17-026_TPS_Instructions.pdf
3. ASAM Level of Care Data Collection System: http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

Year Two Initiatives and Goals: July 1, 2018 to June 30, 2019

- The necessary expansion of withdrawal management is planned for the second year with a RFP.
- Expansion of residential treatment levels 3.2, 3.5, 3.7 is planned for the second year with a RFP currently underway.
- The implementation of Recovery Residences is planned for the second year with a RFP.
- Although case management services were implemented in year one, continued training in the implementation of these services will occur in the second year.
- The implementation of Recovery Services is planned for year two. This would benefit from close collaboration with providers in both the planning and implementation phases.
- EHR and data collections planning has been prioritized for the second year. Contra Costa acknowledges that data collection and analysis needs to be improved and expects increased staffing for this purpose.
- Continued work with the contract providers is needed to improve communication and to enhance system development with provider input.

PERFORMANCE MEASUREMENT

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

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

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

- Total beneficiaries served by each county DMC-ODS to identify if new and expanded services are being delivered to beneficiaries;
- Number of days to first DMC-ODS service after client assessment and referral;
- Total costs per beneficiary served by each county DMC-ODS by ethnic group;
- Cultural competency of DMC-ODS services to beneficiaries;
- Penetration rates for clients, including ethnic groups, age, language, and risk factors (such as disabled and foster care aid codes);
- Coordination of Care with physical health and mental health;
- Timely access to medication for NTP services;
- Access to non-methadone MAT focused upon client beneficiaries with 3 or more MAT services in the year being measured;
- Timely coordinated transitions of clients between LOCs, focused upon transitions to other services after residential treatment;
- Availability of the 24-hour access call center line to link clients to full ASAM-based assessments and treatment (with description of call center metrics);
- Identification and coordination of the special needs of high-cost beneficiaries (HCBs);
- Percentage of clients with three or more withdrawal management episodes and no other treatment to improve engagement.

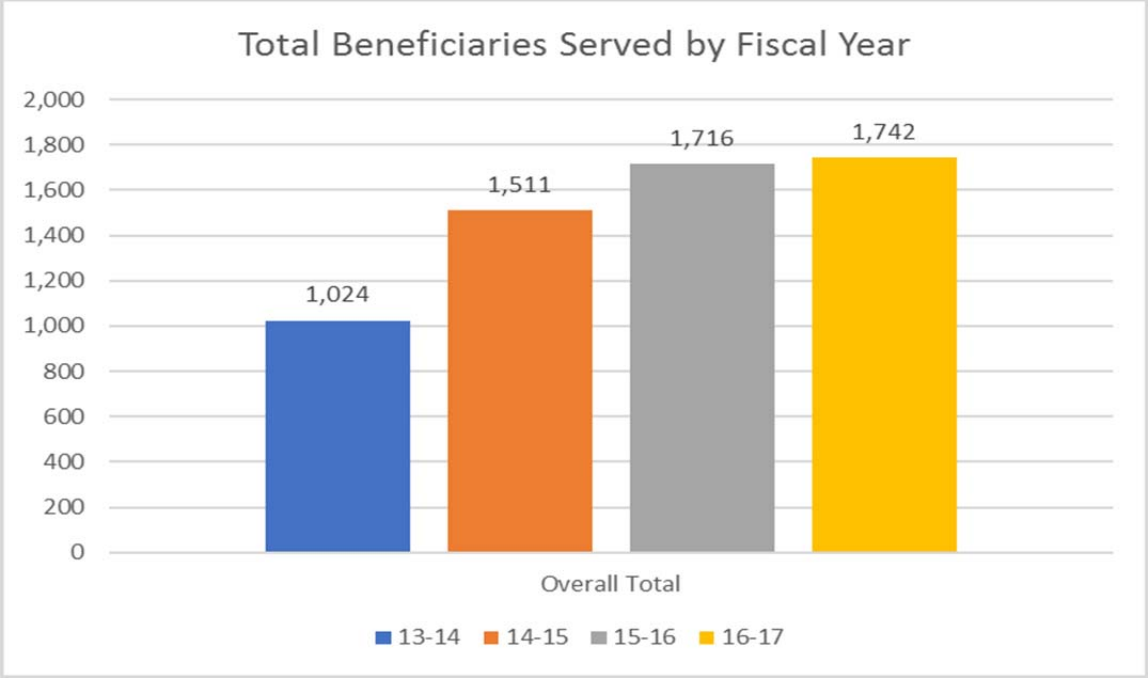
HIPAA Guidelines for Suppression Disclosure:

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

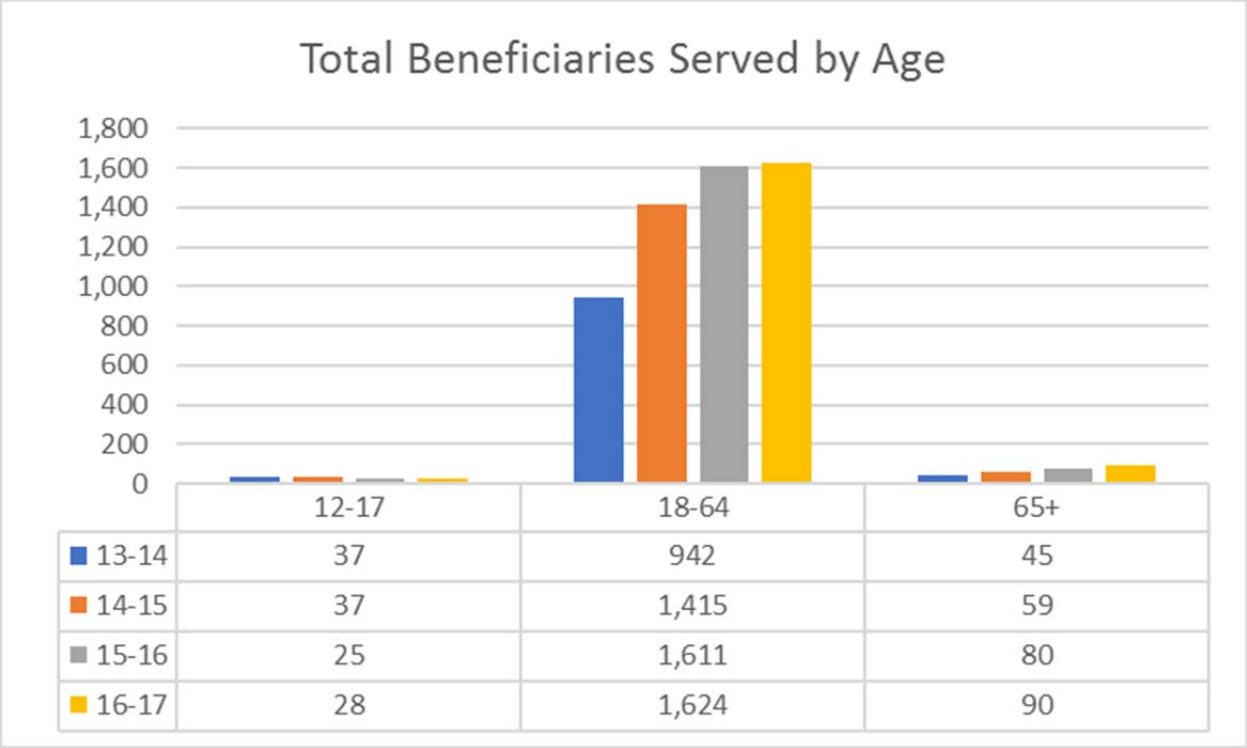
Baseline PM Data for Contra Costa Prior to the DMC-ODS Waiver

To evaluate the impact of the DMC-ODS Program and Waiver, baseline data for four prior FYs was analyzed both statewide and for each DMC-ODS County.

B Table 1-Total Beneficiaries Served



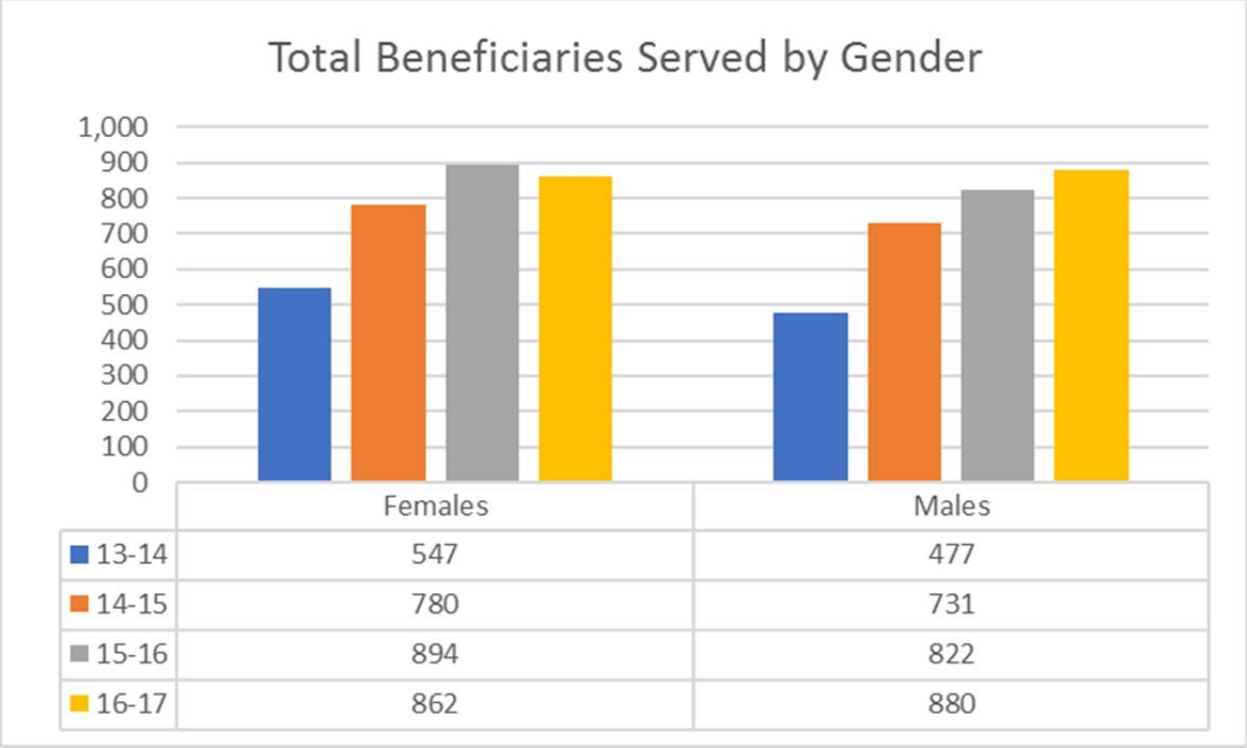
B Table 2 – Total Beneficiaries Served by Age



	12-17	18-64	65+
13-14	37	942	45
14-15	37	1,415	59
15-16	25	1,611	80
16-17	28	1,624	90

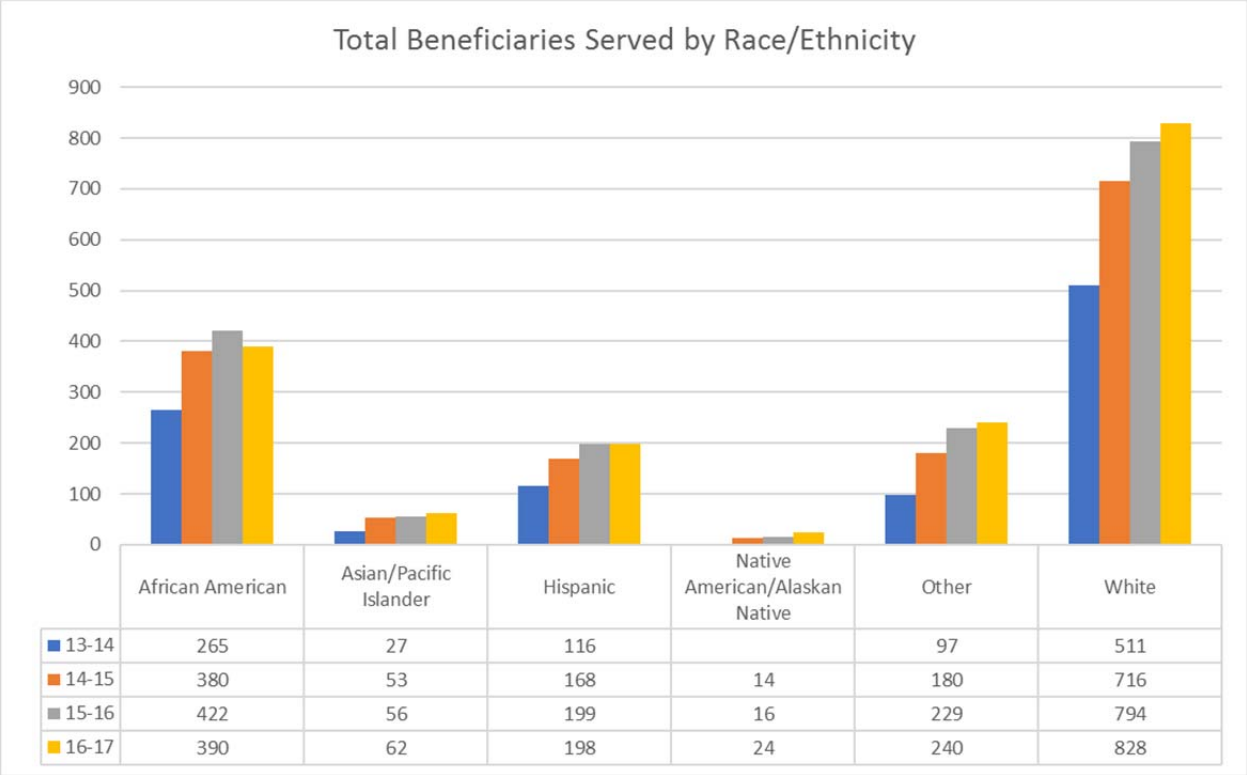
Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

B Table 3 – Total Beneficiaries Served by Gender



	Females	Males
13-14	547	477
14-15	780	731
15-16	894	822
16-17	862	880

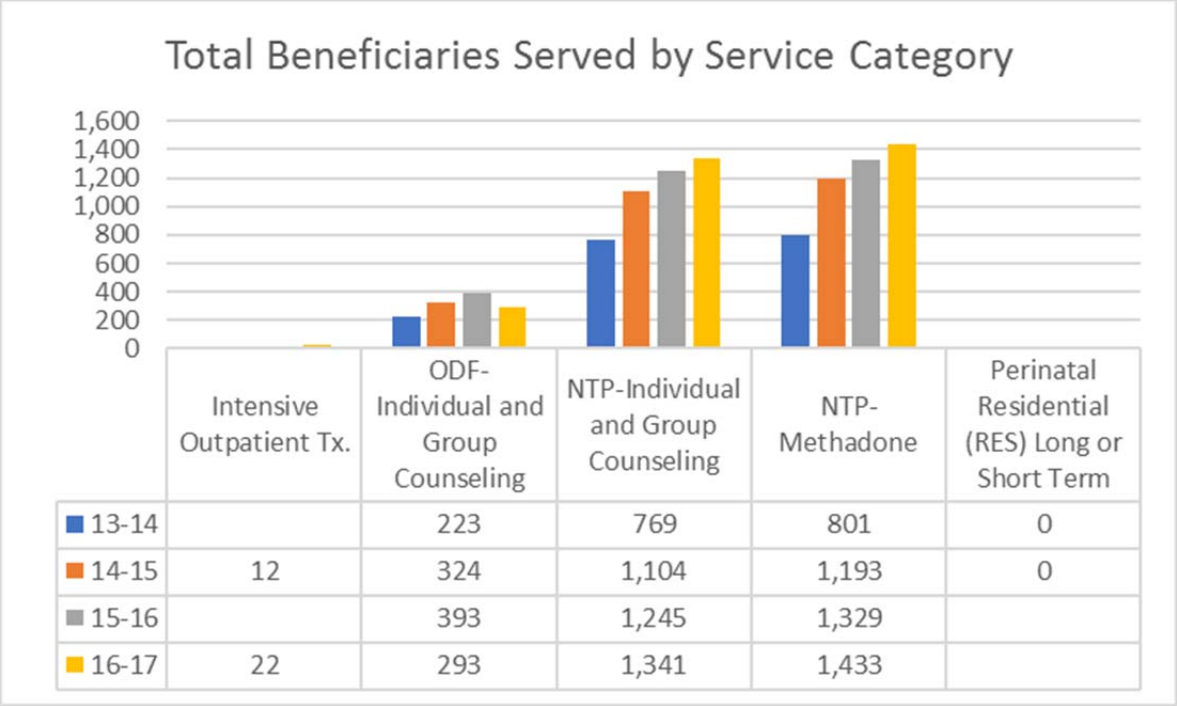
B Table 4 – Total Beneficiaries Served by Race/Ethnicity



	African American	Asian/Pacific Islander	Hispanic	Native American/Alaskan Native	Other	White
13-14	265	27	116		97	511
14-15	380	53	168	14	180	716
15-16	422	56	199	16	229	794
16-17	390	62	198	24	240	828

Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

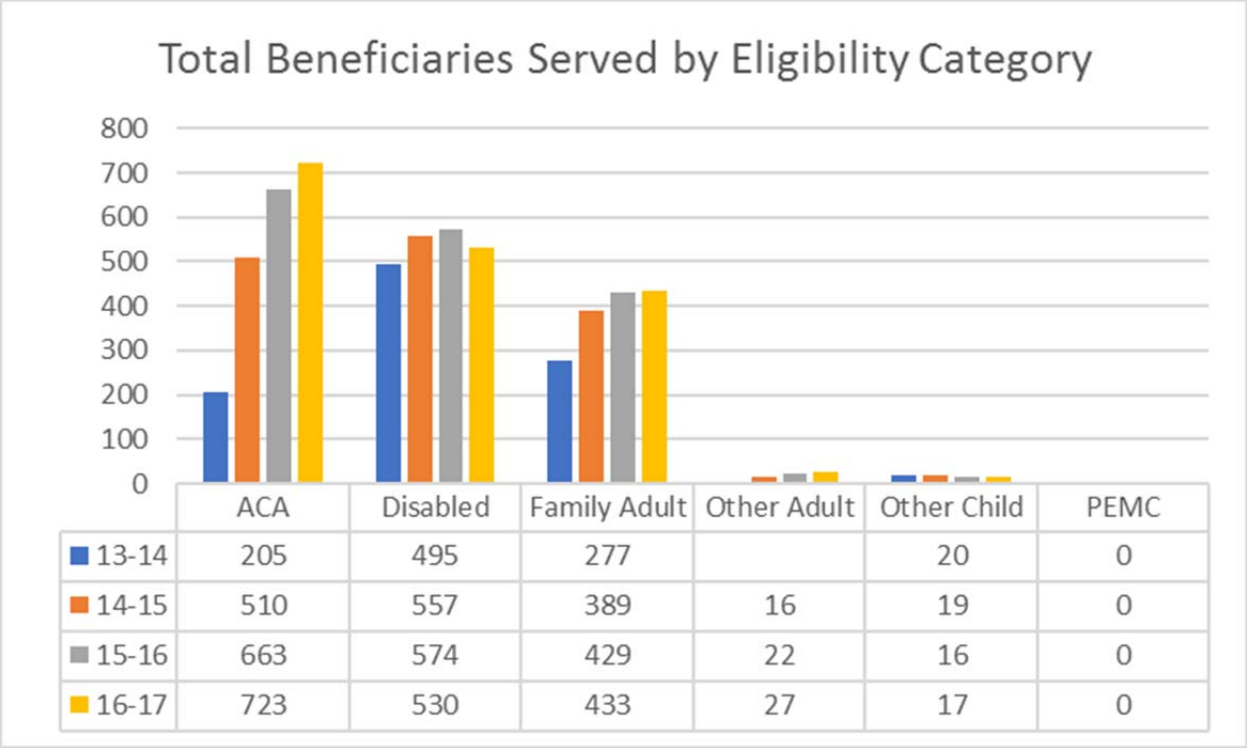
B Table 5 – Total Beneficiaries Served by Service Category



	Intensive Outpatient Tx.	ODF-Individual and Group Counseling	NTP-Individual and Group Counseling	NTP-Methadone	Perinatal Residential (RES) Long or Short Term
13-14		223	769	801	0
14-15	12	324	1,104	1,193	0
15-16		393	1,245	1,329	
16-17	22	293	1,341	1,433	

Blank cells indicate suppression of the data in accordance with HIPAA guidelines (see introduction to Performance Measurement - HIPAA Guidelines for Suppression Disclosure for detailed explanation).

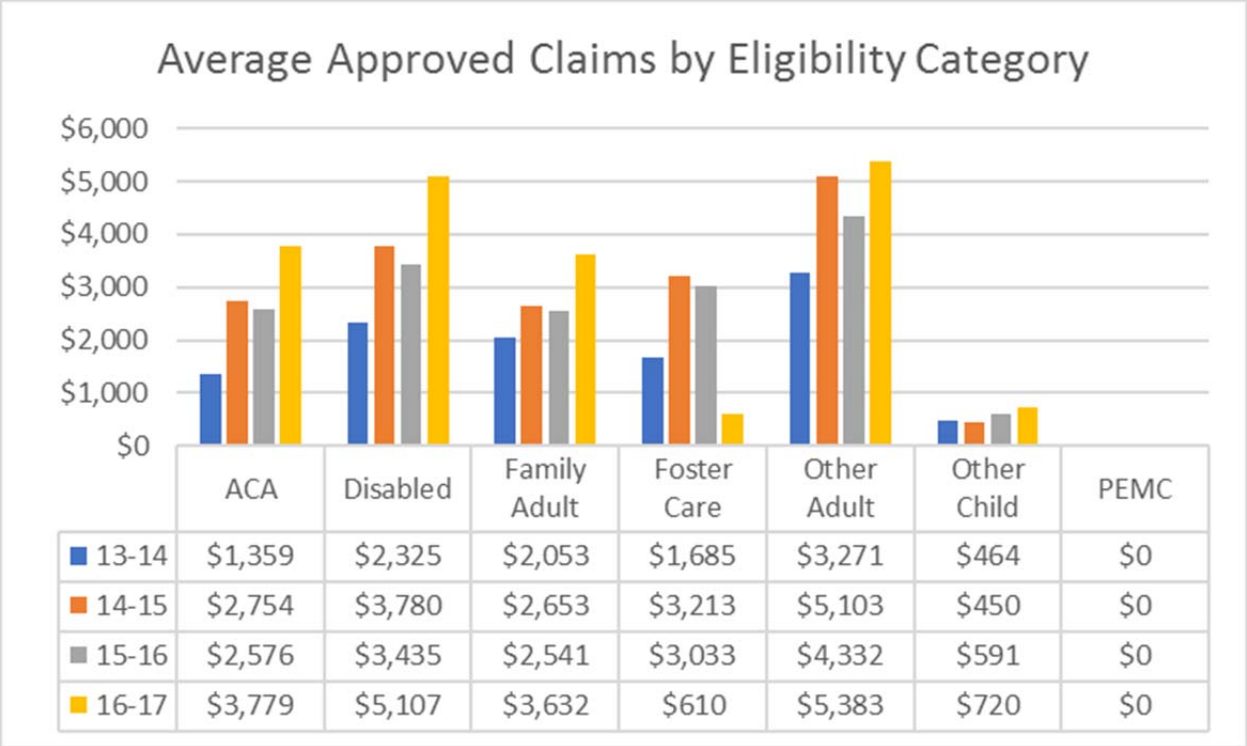
B Table 6 – Total Beneficiaries Served by Eligibility Category



	ACA	Disabled	Family Adult	Other Adult	Other Child	PEMC
13-14	205	495	277		20	0
14-15	510	557	389	16	19	0
15-16	663	574	429	22	16	0
16-17	723	530	433	27	17	0

In the above table, ACA is Affordable Care Act; PEMC is pregnancy/emergency/minor consent.

B Table 7 – Average Approved Claims by Eligibility Category



	ACA	Disabled	Family Adult	Foster Care	Other Adult	Other Child	PEMC
13-14	$1,359	$2,325	$2,053	$1,685	$3,271	$464	$0
14-15	$2,754	$3,780	$2,653	$3,213	$5,103	$450	$0
15-16	$2,576	$3,435	$2,541	$3,033	$4,332	$591	$0
16-17	$3,779	$5,107	$3,632	$610	$5,383	$720	$0

Discussion of Baseline Data Trends and Implications

Overall access increased steadily during the four prior fiscal years due to several key factors. Primary among them was changes in Medi-Cal eligibility through the Affordable Care Act (ACA) that began in January 2014. Prior to the ACA, Medi-Cal eligibility was based upon both poverty-level with children and disability criteria. Disabilities based upon either physical health or mental health conditions would qualify, but not disabilities based upon SUDs. Counties had to find other sources of funding for most of their clients with SUDs.

Prior to the Waiver, SUD treatment services covered by DMC were limited to a narrow range of services including narcotic replacement therapy with counseling, outpatient group counseling, IOT, and perinatal residential treatment. Case management, recovery support, residential treatment, and WM were not covered under the state Medicaid plan.

The Waiver expanded coverage to include several levels of WM, several levels of residential treatment, case management, recovery support services, partial hospitalization, MAT for all addiction medications, and physician consultation.

The age group with the least utilization of care depicted in Baseline Table 7 was youth, which will be a focus for expansion through the Waiver in many counties.

Costs per beneficiary were highest for the elderly population, even though there were low numbers served. The elderly population have many complicated SUD needs as well as health and mental health issues. The average cost per beneficiary across all age groups in FY 2016-17 was $4,119.

Calendar Year 2017 – Year 1 of the Waiver

Contra Costa services began in June 2017 and PM data was obtained by CalEQRO from DHCS for claims, eligibility, the provider file, and from UCLA for TPS for the six-month period from July through December 2017. The results of each PM will be discussed for that time period, followed by highlights of the overall results for that same time period. DMC-ODS Counties have six months to bill for services after they are provided and after providers have obtained all appropriate licenses and certifications. In addition, many DMC-ODS Counties phased in new and expanded services for billing, and thus there is not a stable set of services for the complete duration of the CY after launch.

DMC–ODS Beneficiaries Served in Calendar Year **2017**

CY 2017 Table 1 – Beneficiaries Served, by Race/Ethnicity

Table 1: Contra Costa DMC-ODS Enrollees and Beneficiaries Served in 2017, by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated DMC-ODS Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	48,709	20%	651	45.5%
Latino/Hispanic	85,656	35%	191	13%
African-American	35,793	15%	309	22%
Asian/Pacific Islander	30,078	12%	23	2%
Native American	732	0.3%	17	1%
Other	43,492	18%	241	17%
Total	244,460	**100%**	1,432	**100%**

The totals in the bottom row indicate a substantial increase in beneficiaries served as compared to FY2016-17. This is even more striking when considering that the data for CY2017 shown above is for a partial year.

The race/ethnicity results in this table can be interpreted to determine how readily the listed race/ethnicity subgroups access treatment through the DMC-ODS. If they all had similar patterns, one would expect the proportions they constitute of the total population of DMC-ODS enrollees to match the proportions they constitute of the total clients served. However, as the table shows, there are distinct differences. Those persons who are Caucasian accessed DMC-ODS services more readily than others, at a rate of twice the proportions of African-American enrollees. Persons who are Latino/Hispanic, Asian/Pacific Islander, and Other were even less inclined to access treatment. One cannot with confidence interpret the data for Native Americans since the subpopulation is so low. Contra Costa is exploring the reasons for low utilization by some subgroups and what can be done to increase it, especially within the Hispanic/Latino community.

Penetration Rates and Approved Claim Dollars per Beneficiary

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

Regarding calculation of penetration rates, Contra Costa uses the same method used by CalEQRO.

CY2017 Table 2 below shows Contra Costa's penetration rates overall and by age groups. The rates are compared to the statewide averages for all actively implemented DMC-ODS counties.

CY 2017 Table 2 – Penetration Rates by Age Groups

	Contra Costa			Statewide
Age Groups	**Average Number of Beneficiaries per Month**	**Number of Beneficiaries Served CY 2017**	**Penetration Rate**	**Penetration Rate**
Total	244,458	1,431	0.59%	0.25%
Age Group 12-17	65,957	17	0.03%	0.04%
Age Group 18-64	140,676	1,206	0.86%	0.36%
Age Group +65	37,825	208	0.55%	0.19%

CY2017 Table 3A below shows Contra Costa's average approved claims per beneficiary served overall and by age groups. The amounts are compared with the statewide averages for all actively implemented DMC-ODS counties.

CY 2017 Table 3A – Average Approved Claims by Age Groups

	Contra Costa		Statewide
Age Groups	**Total Approved Claims**	**Approved Claims per Beneficiary Served per Year**	**Approved Claims per Beneficiary Served per Year**
Total	$2,882,805	$2,013	$2,662
Age Group 12-17	$19,251	$1,132	$1,483
Age Group 18-64	$2,386,341	$1,979	$2,721
Age Group +65	$476,755	$2,292	$2,640

CY2017 Table 3B below shows Contra Costa's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties.

CY 2017 Table 3B –Beneficiaries Served and Penetration Rates by Eligibility Category

	Contra Costa			Statewide
Eligibility Categories	**Average Number of Beneficiaries per Month**	**Number of Beneficiaries Served CY 2017**	**Penetration Rate**	**Penetration Rate**
Disabled	27,569	433	1.57%	0.60%
Foster Care	1,059	*	0.38%	0.49%
Other Child	41,172	*	0.02%	0.03%
Family Adult	43,836	344	0.78%	0.25%
Other Adult	31,795	31	0.10%	0.03%
MCHIP	23,529	*	0.04%	0.03%
ACA	75,412	634	0.84%	0.43%

CY2017 Table 4 below shows Contra Costa's approved claims per beneficiary by DMC eligibility categories. The amounts are compared to the statewide averages for all actively implemented DMC-ODS counties.

CY 2017 Table 4 – Approved Claims by Eligibility Category

	Contra Costa			Statewide
Eligibility Categories	**Average Number of Beneficiaries per Month**	**Number of Beneficiaries Served CY 2017**	**Approved Claims per Beneficiary Served per Year**	**Approved Claims per Beneficiary Served per Year**
Disabled	27,569	433	$2,033	$2,495
Foster Care	1,059	*	$528	$1,110
Other Child	41,172	*	$700	$1,472
Family Adult	43,836	344	$2,075	$2,459
Other Adult	31,795	31	$2,335	$2,561
MCHIP	23,529	*	$1,290	$1,551
ACA	75,412	634	$1,886	$2,768

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

Children 12 and under rarely need treatment for SUD. Foster Care, Other Child and Maternal and Child Health Integrated Program (MCHIP) comprise the other categories of youth who even in combination comprise a low penetration rate. Expansion of

services to youth is an important focus of Contra Costa with their expanded residential and outpatient services.

ACA constituted the major group using SUD services by numbers of beneficiaries, although the Disabled had a much higher penetration rate. The group with the highest average costs per beneficiary was “Other Adult” which includes low income seniors, followed closely by “Family Adult”, “Disabled” and “ACA”.

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

Average Days from First Contact to First Dose at NTP is a measure in the Access to Care Domain.

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

Persons seeking methadone medication are likely to have been unable to stop using through non-MAT approaches and are also likely to be conflicted about giving up their use of addictive opiates. Consequently, if they do not begin methadone medication soon after requesting it, they are likely to go back to opiate use that can be life threatening. For these reasons, NTPs regard the request to begin treatment with methadone as urgent and requiring a timely response. Tables 5 and 6 show the average number of days from triage/assessment contact to the first dose of NTP services for opioid use disorder (OUD) diagnoses, first by age groups and then by race/ethnicity.

Average times indicated below for Contra Costa clients indicate they are able to access care in a timely manner, on average within one (1) day of diagnosis/assessment.

CY 2017 Table 5 – Number of Days to First Dose of NTP Services by Age

Age Groups	Contra Costa			Statewide		
	Clients	%	Avg. Days	Clients	%	Avg. Days
Total Count	1,109	100%	<1	13,867	100%	<1
Age Group 12-17	*	n/a	n/a	*	n/a	n/a
Age Group 18-64	915	83%	<1	10,831	78%	<1
Age Group 65+	*	17%	<1	*	n/a	<1

CY 2017 Table 6 – Number of Days to First Dose of NTP Services by Race/Ethnicity

Race/Ethnicity	Contra Costa			Statewide		
	Clients	%	Avg. Days	Clients	%	Avg. Days
Total Count	1,109	100%	<1	13,867	100.0%	<1
White	513	46.3%	<1	5992	43.2%	<1
Hispanic/Latino	139	12.5%	<1	3753	27.1%	<1
African-American	245	22.1%	<1	1815	13.1%	<1
Asian Pacific Islander	16	1.4%	<1	173	1.2%	<1
Native American	14	1.3%	<1	93	0.7%	<1
Other	182	16.4%	<1	2041	14.7%	<1

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

Contra Costa Services for Non-Methadone Medication-Assisted Treatment

Some people with opiate addictions have become interested in newer-generation addiction medicines that have increasing evidence of effectiveness. These include longer-acting medications such as buprenorphine and naltrexone that do not need to be taken in as rigorous a daily regimen as methadone. While these medications can be administered through NTPs, they can also be prescribed and administered by physicians through other settings such as primary care clinics, hospital-based clinics, and private physician practices. For those who may not find methadone as helpful, these other MATs have the advantages of being available in more types of settings, involving less stigma, and requiring far fewer appointments for regular dosing. The DMC-ODS Waiver encourages MATs for these reasons, in addition to the evidence supporting their effectiveness. However, physicians are required to receive specialized training before they prescribe some of these medications, and many feel the need for further consultation backup once they begin prescribing. Consequently, physician uptake throughout most of the country tends to be slow.

Contra Costa has yet to provide and claim for non-methadone MATs through its NTPs or other DMC-ODS certified sites. Contra Costa provided a data summary from its five county-operated FQHCs who provided non-methadone MATs in FY 2017/18. This data does not include non-methadone MATs provided by CCHP's contracted FQHCs, so it understates what the total number of ongoing and new clients. The data are as follows:

- Served approximately 500 ongoing clients: Suboxone (n=500), Naltrexone (n=0), Disulfiram (n=0) and other (n=0)
- Of the 500 ongoing clients, 341 were newly admitted; Suboxone (n=341), Naltrexone (n=0), Disulfiram (n=0) and other (n=0)
- Discharged clients: Data is unavailable

Expanded Access to Medication-Assisted Treatment

This measure is linked to the Access and Quality Outcomes Domain.

Tables 7 and 8 display the number and percentage of clients receiving three or more MAT visits per year provided through Contra Costa providers, at the county level for Contra Costa and statewide. Three or more visits were selected to identify clients who received regular MAT treatment versus a single dose. The numbers for this set of performance measures are based upon DMC-ODS claims data analyzed by EQRO. Because Contra Costa delivered its MAT services solely through its FQHCs and not through its DMC-ODS providers, there were no claims data to analyze. The tables are still displayed below as an indication of the potential of these measures for providing useful information in the future years of the DMC-ODS implementation.

CY 2017 Table 7 – Three or more DMC-ODS MAT Billed Visits, by Age

	Contra Costa				Statewide			
	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits
Total	0	0%	0	0%	154	0.53 %	80	0.27 %
Age Group 12-17	0	0%	0	0%	0	0	0	0
Age Group 18-64	0	0%	0	0%	141	0.58 %	75	0.31 %
Age Group 65+	0	0%	0	0%	12	0.36 %	*	n/a

CY 2017 Table 8 - Three or more DMC-ODS MAT Billed Visits, by Race/Ethnicity

	Contra Costa				Statewide			
	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits	At Least 1 Visit	% At Least 1 Visit	3 or More Visits	% 3 or More Visits
Total	0	0%	0	0%	154	0.5%	80	0.3%
White	0	0%	0	0%	91	0.9%	52	0.5%
Hispanic/Latino	0	0%	0	0%	31	0.3%	13	0.1%
African-American	0	0%	0	0%	*	n/a	*	n/a
Asian Pacific Islander	0	0%	0	0%	*	n/a	*	n/a
Native American	0	0%	0	0%	*	n/a	*	n/a
Other	0	0%	0	0%	20	0.6%	*	n/a

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

Transitions in Care Post Residential Treatment – CY 2017

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

Table 9 and Table 10 show two aspects of this expectation— (1) whether and to what extent clients discharged from residential treatment receive their next treatment session in a non-residential treatment program, and (2) the timeliness with which that is accomplished. Table 9 shows the percent of clients who began a new level of care within 7 days, 14 days and 30 days after discharge from residential treatment. Table 10 shows similar information from the perspective of statewide data for DMC-ODS counties. Also shown in each table are the percent of clients who had follow-up treatment from 31-365 days, and clients who had no follow-up within the DMC-ODS system.

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

CY 2017 Table 9 Timely Transitions in Care Post Residential Treatment DMC-ODS, Contra Costa

	Contra Costa								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	Cum. %	Total Clients	Transfer Admits	Cum. %	Total Clients	Transfer Admits	Cum. %
Within 7 days	0	n/a	n/a	0	*	n/a	0	n/a	n/a
Within 14 days	0	n/a	n/a	0	*	n/a	0	n/a	n/a
Within 30 days	0	n/a	n/a	0	*	n/a	0	n/a	n/a
Any days	0	n/a	n/a	71	*	n/a	0	n/a	n/a
Total Follow Up, Post Residential	0	n/a	n/a	71	17	24%	0	n/a	n/a

Of 71 clients discharged from residential treatment, 17 clients (24 percent) received follow-up treatment in a non-residential program that resulted in an approved claim. The percentage is slightly higher than the statewide average, but much lower than desired. In part this may be due to case management-supported discharge planning, and in part to aftercare services not yet billed as recovery support services. (Note: the asterisked data were suppressed according to HIPAA guidelines).

This measure, while constituting valuable information, is relatively new and without much in the research literature enabling comparison. To help provide for comparisons, the table below indicates the same type of performance data statewide across all counties already implementing a DMC-ODS. As with Contra Costa, the approved statewide claims data upon which the table is based were only partially complete at the time of this report.

CY 2017 Table 10 Timely Transitions in Care Post Residential Treatment DMC-ODS, Statewide

	Statewide								
	Age 12-17			Age 18-64			Age 65+		
	Total Clients	Transfer Admits	Cum. %	Total Clients	Transfer Admits	Cum. %	Total Clients	Transfer Admits	Cum. %
Within 7 days	105	*	n/a	5,133	388	7.6%	106	*	n/a
Within 14 days	105	*	n/a	5,133	516	10.1%	106	*	n/a
Within 30 days	105	*	n/a	5,133	641	12.5%	106	*	n/a
Any days	105	*	n/a	5,133	817	16%	106	*	n/a
Total Transfer Admits, Post Residential	105	*	n/a	5,133	817	16%	106	*	n/a

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

Statewide numbers of youth clients in residential treatment are low relative to their statewide numbers of Medi-Cal enrollees. DHCS and DMC-ODS counties, including Contra Costa, are making efforts to increase the number of youth treated in residential and other levels of care.

Regarding post-residential follow-up, the statewide statistics indicate similarly low percentages of clients across all age groups receiving timely follow-up care after discharge from residential treatment.

Access Line Quality and Timeliness

Most prospective clients seeking treatment for SUDs are understandably ambivalent about engaging in treatment and making fundamental changes in their lives. The moment of a person's reaching out for help to address a SUD represents a critical crossroad in that person's life, and the opportunity may pass quickly if barriers to access treatment are high. A DMC-ODS county is responsible to make initial access easy for prospective clients to the most appropriate treatment for their particular needs. For some people, an Access Line may be helpful to help the person find the best treatment

match in a system that can otherwise be confusing to navigate. For others, an Access Line may be perceived as impersonal or otherwise off-putting because of long telephone wait times. For these reasons, it is critical that all DMC-ODS counties monitor their Access Lines for performance using critical indicators.

Table 11 shows Access Line critical indicators from July 1, 2017 through June 30, 2018. Contra Costa provided this data in the Access Line Key Indicator form. For the complete set of Contra Costa responses to the form, please refer to Attachment F.

CY 2017 Table 11 – Access Line Critical Indicators

Contra Costa Access Line Critical Indicators 7-1-17 through 6-30-18	
Average Volume	1,751 calls per month
% Dropped Calls	7% a month
Time to answer calls	9 seconds
Monthly authorizations for residential treatment	68.5
% of calls referred to a treatment program for care, including residential authorizations	18% of callers are linked to treatment through the Access Line
Non-English capacity	Spanish-speaking clinical and clerical staff available.

Timeliness for residential authorizations exceeded the state standard for DMC-ODS, with 98% of Contra Costa responses within 24 hours of receipt of request.

High-Cost Beneficiaries

Table 12 provides several types of information on the group of clients who use a substantial amount of DMC-ODS services. These persons, labeled in this table as high cost beneficiaries (HCBs), are defined as those who incur SUD treatment costs at the 90th percentile or higher statewide, which equates to at least $5,668 in approved claims per year. The table lists the average approved claims costs for the year for Contra Costa HCBs compared with the statewide average. The table also lists the demographics of this group by race/ethnicity and by age group. Some of these clients use high-cost high-intensity SUD services such as residential WM without appropriate follow-up services and recycle back through these high-intensity services again and again without long-term positive outcomes. The intent of reporting this information is to help DMC-ODS counties identify clients with complex needs and evaluate whether they are receiving individualized treatment including care coordination through case management to optimize positive outcomes.

CY 2017 Table 12 – HCBs at 90th percentile or higher

	Contra Costa		Statewide	
HCBs by Age Group	HCB % of total clients	Average Cost	HCB % of total clients	Average Cost
Total	1.8%	$9,100	7.5%	$11,215
Age Group 12-17	5.6%	$5,797	4.0%	$10,489
Age Group 18-64	2.1%	$9,223	8.3%	$11,280
Age Group +65	0.0%	$0	0.02%	$9,823

CY 2017 Table 13 – HCB Claims per Beneficiary, DMC-ODS and Statewide by Race/Ethnicity

	Contra Costa		Statewide	
HCBs by Ethnicity	HCB % of total clients	Average Cost	HCB % of total clients	Average Cost
Total	1.8%	$9,100	7.5%	$11,215
White	2.1%	$9,590	7.8%	$11,220
Hispanic/Latino	1.9%	$10,758	7.9%	$11,247
African-American	1.5%	$7,385	7.1%	$10,971
Asian Pacific Islander	4.3%	$5,906	6.7%	$10,942
Native American	0.0%	$0	6.0%	$11,611
Other	1.2%	$7,434	5.9%	$11,404

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

Contra Costa HCB data shows they are consistently lower in cost than the statewide average in both age categories and ethnicities. This could be as a result of their having lower costs for treatment, shorter lengths of stay or a combination of both.

Withdrawal Management with No Other Treatment

This PM intends to measure engagement after WM for client beneficiaries with no other DMC-ODS treatment services for their SUDs. The goal is to track levels of engagement for a high-risk group of clients using only WM.

CY 2017 Table 14 – Withdrawal Management by Age

	Contra Costa		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	*	0%	970	0.62%
Age Group 12-17	*	0%	*	n/a
Age Group 18-64	*	0%	933	0.64%
Age Group 65+	*	0%	*	n/a

CY 2017 Table 15 – Withdrawal Management by Ethnicity

	Contra Costa		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
Total	*	0%	966	0.62%
White	*	0%	515	0.39%
Hispanic/Latino	*	0%	298	0.67%
African-American	*	0%	62	1.61%
Asian Pacific Islander	*	0%	*	0%
Native American	*	0%	*	0%
Other	*	0%	85	1.18%

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

Contra Costa did not fully implement and begin claiming their residential WM services until later in their first implementation year. Thus, the above tables are not an accurate reflection of the total numbers of clients served in residential WM. A data refresh in the annual report will include more data on treatment engagement after a withdrawal management episode.

Diagnostic Categories

Table 16 summarizes the diagnostic billing codes used statewide by DMC-ODS counties to identify diagnostic groups with SUDs.

Table 17 compares the breakdown by diagnostic category of the percent of client beneficiaries served and average approved claims per client beneficiary for Contra Costa. A comparison is also shown to the data for all counties actively implementing their DMC-ODS statewide. . Opioids, alcohol, and stimulants were the most prominent types of SUDs addressed by Contra Costa's DMC-ODS treatment providers.

CY 2017 Table 16 – Diagnosis Codes

Diagnosis Category – ICD 10	Diagnosis Codes (for dates of service on or after October 1, 2015)
Alcohol Use Disorder	F1010, F10120, F10129, F1020, F1021, F10220, F10229, F10230, F10239, F10920, F10929
Cannabis Use	F1210, F12120, F12129, F1220, F1221, F12220, F12229, F1290, F12920, F12929
Cocaine Abuse or Dependence	F1410, F14120, F14129, F1420, F1421, F14220, F14229, F1423, F1490, F14920, F14929
Hallucinogen Dependence or Unspecified	F1610, F16120, F16129, F1620, F1621, F16220, F16229, F1690, F16920, F16929
Inhalant Abuse/Dependence/Unspecified	F1821, F1810, F18120, F18129, F1820, F18220, F18229, F1890, F18920, F18929
Opioid	F1110, F11120, F11129, F1120, F1121, F11220, F11229, F1123, F1190, F11920, F11929, F1193
Other Stimulant Abuse/Dependence	F1510, F15120, F15129, F1520, F1521, F15220, F15229, F1523, F1590, F15920, F15929, F1593
Other Psychoactive Substance	F1910, F19120, F19129, F1920, F1921, F19220, F19229, F19230, F19239, F1990, F19920, F19929
Sedative, Hypnotic Abuse/Dependence	F1310, F13120, F13129, F1320, F1321, F13220, F13229, F13230, F13239, F1390, F13920, F13921, F13929, F13930, F13939

CY 2017 Table 17 – Percentage Served and Average Cost by Diagnosis Code

Diagnosis Codes	Contra Costa		Statewide	
	% Served	Average Cost	% Served	Average Cost
Total	100%	$3,402.51	100%	$2,888
Alcohol Use Disorder	4.5%	$2,523.28	11.2%	$2,648
Cannabis Use	2.3%	$1,222.78	6.4%	$1,543
Cocaine Abuse or Dependence	0.9%	$1,721.13	1.7%	$2,705
Hallucinogen Dependence	0.0%	$0	n/a	$2,388
Inhalant Abuse	0.0%	$0	n/a	$739
Opioid	84.8%	$3,652.19	58.6%	$3,221
Other Stimulant Abuse	7.3%	$1,968.87	20.3%	$2,521
Other Psychoactive Substance	0.1%	$3,885.00	1.1%	$2,684
Sedative, Hypnotic Abuse	0.1%	$463.00	0.3%	$2,831

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

Contra Costa has a much higher percentage of persons diagnosed with opioid addiction in comparison to the statewide data. This may be due to challenges in their start up causing delays in services for outpatient and residential treatment programs while NTP providers continued to serve their clients without delays. These issues were resolved in the second half of the implementation year however this data only represents the first six months of implementation.

Performance Measures Findings—Impact and Implications

Overview

Data in many sectors showed robust launch of SUD programs, but claims lag resulted in partial year data at the time of the review. Contra Costa has higher than statewide penetration rates but shorter lengths of stay. Contra Costa provided their MAT services through a partnership with county operated FQHCs. Although some data was reported it is expected the data will be more complete the next review.

Access to Care PM Issues

Claims data from baseline to CY 2017 reflect a steady expansion of services for DMC-ODS. The number of client beneficiaries served during the first six months of the Waiver was 1432, which will likely result in service numbers that will surpass the numbers of client beneficiaries served in FY2016-17. These reflect Contra Costa's responsiveness to the changing opportunities brought about by ACA when they actively encouraged substantial new enrollments in Medi-Cal. They also reflect Contra Costa's rapid action in implementing an ODS for Medi-Cal beneficiaries that broadened access to a range of DMC-covered services.

Contra Costa County achieved a higher penetration rate than the statewide average, and this is also reflected in most of the race/ethnicity, age group and gender analyses. Comparing subgroups within Contra Costa County, the Caucasian, African-American and Native American enrollees had a relatively higher rate of access to services than did the Latino/Hispanic and Asian/Pacific Islander enrollees.

Across age groups, the 18-64 age group had the highest penetration rate for age groups (0.86 percent). The average approved claims for the 65+ age group was slightly higher at $2,292 than the18-64 group at $1,979, suggesting that the older age group because of their more complex medical conditions may have needed and received somewhat more intensive and lengthier substance use treatment in addition to more physical health care.

FQHCs served a substantial number of client beneficiaries with non-methadone MAT, indicating that with assistance from the county DMC-ODS they made great progress in launching their prescribing of addiction medicines.

Timeliness of Services PM Issues

Contra Costa's clients who receive methadone from an NTP received timely dosing following their first request for NTP treatment. The average time to first dose at NTP is <1 day for all age and race groups.

The Access Line is tracking key indicators with appropriate call center software that provides dashboards on a daily and monthly basis for staff to monitor performance and identify performance improvement areas. Contra Costa provided monthly report data for the CalEQRO Review that indicated performance within Contra Costa's and comparable system of care standards, including a low call abandonment rate.

Quality of Care PM Issues

Contra Costa discharge data from residential treatment is limited at this early stage in their implementation, as is the case with other DMC-ODS counties statewide. Of the clients discharged from residential treatment during the startup of the DMC-ODS Waiver, 24 percent were successfully transferred to a less intensive level of care. While this number is lower than desired, it is higher than the statewide average for other DMC-ODS counties. The low number may be due in part to providing recovery support services without having yet set up billing procedures for them. It may also be due in part to insufficient case management nearing the time of discharge planning.

An important performance measure focused on the number and percent of clients with three or more WM episodes and no follow-up treatment. Because Contra Costa has yet to set up and bill for DMC-certified WM services, there was no data available to use for this performance measure.

Client/Consumer Outcomes PM Issues

CalEQRO will be establishing a set of PM measures for client outcomes to apply to DMC-ODS counties for year two of their implementations. In this first year of Contra Costa's implementation, although not required, they implemented use of CalOMS data for measure client outcomes with regards to progress at discharge, improvement in living arrangement, improvement in employment status, increase in use of drug-free social supports, and decrease in drug or alcohol use.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the DMC-ODS

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

ISCA Table 1 shows the percentage of services provided by type of service provider.

Table 1: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	13%
Contract providers	87%
Total	**100%**

Percentage of total annual budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 5 percent

The budget determination process for information system operations is:

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

DMC-ODS currently provides services to client/consumers using a telehealth application:

☐ Yes ☒ No ☐ In pilot phase

Summary of Technology and Data Analytical Staffing

DMC-ODS self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in ISCA Table 2.

ISCA Table 2 – Summary of Technology Staff Changes

Table 2: Summary of Technology Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
8	2	2	0

DMC-ODS self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in ISCA Table 3.

ISCA Table 3 – Summary of Data and Analytical Staff Changes

Table 3: Summary of Data and Analytical Staff Changes			
IS FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
31	10	10	6

The following should be noted regarding the above information:

- DMC-ODS IT support is provided by Contra Costa Health Services.
- The staff listed in Table 3 are largely Health Services resources and this allocation does not reflect the resources available to DMC-ODS. There is no one specifically assigned to DMC-ODS. Of the 31 data and analytical staff available, it is reported that one FTE is allocated to DMC-ODS.
- The six unfilled Health Services data and analytic positions have been vacant for over one year.

Current Operations

- ShareCare, from The Echo Group, is used for practice management. The Behavioral Health Access Line uses Epic, there is no EHR functionality.
- The lack of IT and analytic resources not permanently assigned to DMC-ODS leave them without technical and analytic resources directly knowledgeable about DMC-ODS business operations and service delivery.

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

ISCA Table 4 – Primary EHR Systems/Applications

Table 4: Primary EHR Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Operated By
InSyst	Performance Management	The Echo Group	16	Health Services IT
ShareCare	Performance Management	The Echo Group	2 months	Health Services IT
Epic	Screening only	Epic	<1 year	Health Services IT

Priorities for the Coming Year

- Create an interface between ShareCare and Epic's Tapestry module. The Tapestry database currently contains data regarding initial contact, findings from the initial screening call, resulting referral decision, and first offered appointment. The ShareCare database contains the data regarding the first actual appointment for an intake and assessment. The interface will enable tracking the results of referrals and increasing rates of client initiation into treatment. This project is expected to begin in Fall 2018.
- To move forward with an Epic EHR implementation, Health Services established a 42 CFR Part 2 Steering committee to address SUD client privacy issues and regulatory compliance. Meetings are ongoing and Contra Costa Health Services IT participates with Behavioral Health Services. There is currently no target date set to establish the viability for SUD use of Epic or the selection of an alternative EHR.

Major Changes since Prior Year

- In July 2017, CCHS' SUD department went live as a participant in and began billing under the 1115 DMC-ODS Waiver.
- CCHS participated in DHCS's beta test pilot program to test the new CalOMS migration from ITWS to the new BHIS system platform.
- ShareCare was implemented July 1, 2018.

Other Significant Issues

- Epic direct entry capacity is limited to the Behavioral Health Access Line. While initial request for service information and first offered appointment are entered directly into Epic's Tapestry module, first face-to-face appointment data is manually entered into Tapestry after being received via faxed documentation from providers.
- Data analytic capacity is insufficient to meet current reporting and analytic needs. While 31 FTE are listed as Data Analytic staff, there is only one FTE allocated to the DMC-ODS. Data analytic staff embedded in the DMC-ODS will be essential to acquiring the knowledge of DMC-ODS operations necessary to make the best use of data for informing management decision making and system of care improvements.
- With its current limited suite of applications and lack of IT staff dedicated to the DMC-ODS, Contra Costa is not able to systematically track key timeliness indicators. Without this tracking capability, Contra Costa cannot identify emerging system problems related to timeliness and make informed decisions on system improvements.
- EQRO onsite review sessions indicated many time-intensive and error-prone manual data entry processes, and many needs for enhanced data reports and for a functional EHR. Contra Costa's list of IS priorities for the coming year do not seem to sufficiently address these needs. In particular, they do not seem to address the information system needs of their contract providers, who comprise 87 percent of the DMC-ODS delivery system.

Plans for Information Systems Change

- Contra Costa currently does not have an EHR; however, the intent is to use Epic if outstanding privacy issues can be addressed. A 42 CFR Part 2 Steering committee has been established to address SUD client privacy issues and 42 CFR Part 2 compliance.
- The Epic system was designed to support physical health care operations and will have to be modified to accommodate the clinical workflow automation and data needs of the DMC-ODS. There is no target date by

which AODS will either establish the viability of Epic for SUD use or commit to selecting an alternate EHR.

Current Electronic Health Record Status

ISCA Table 5 summarizes the ratings given to the DMC-ODS for EHR functionality.

Table 5: EHR Functionality

		Rating			
Function	**System/ Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts				x	
Assessments				x	
Care Coordination				x	
Document imaging/storage				x	
Electronic signature—client/consumer				x	
Laboratory results (eLab)				x	
Level of Care/Level of Service				x	
Outcomes				x	
Prescriptions (eRx)				x	
Progress notes				x	
Referral Management				x	
Treatment plans				x	
Summary Totals for EHR Functionality:				**12**	

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- The Contra Costa Behavioral Health Access line uses Tapestry, an Epic product, for direct entry of data related to initial access to care. While initial request for service information and firsts offered appointment are entered directly into Epic, first face-to-face appointment data are manually entered into Epic after being received via faxed documentation from providers. DMC-ODS county-operated clinics and contracted programs have no EHR functionality.

Client/consumer's Chart of Record for county-operated programs (self-reported by DMC-ODS):

☒ Paper ☐ Electronic ☐ Combination

Findings Related to use of ASAM Level of Care (LOC) Referral Data, CalOMS, and Treatment Perception Survey

Summary of Findings	Yes	No	%
ASAM criteria is used for assessment of clients in all Medi-Cal Programs.	x		
ASAM criteria is used for treatment planning to improve care.	x		
CalOMS being administered on admission, discharge and annual updates.	x		
CalOMS being used to improve care. Track discharge status. Outcomes.	x		
Percent of treatment discharges that are administrative discharges.	x		19.2%
TPS being administered in all Medi-Cal Programs.	x		

Highlights of use of outcome tools above or challenges:

- Contra Costa reports that ASAM Criteria are used in client screenings and assessments. The related data used for metrics in the ASAM LOC Referral Data, such as concordance of assessed LOC to referred LOC, are entered via Tapestry software for initial screenings by access center staff, and via paper forms for assessments by contracted providers.
- Timely ASAM LOC Referral Data reporting to DHCS is one of the requirements in the DMC-ODS Waiver. It is unclear what processes are deployed to convert the paper-based ASAM LOC Referral Data values from contract providers to Excel worksheet format and upload them through the county to DHCS.
- Contra Costa has begun using CalOMS data as part of their Quality Management evaluation plan, including tracking outcomes such as housing and vocational status.

For examples of the kinds of data tracking related to ASAM, CalOMS, and TPS, please see County Highlights Attachment.

Drug Medi-Cal Claims Processing

- Contra Costa has successfully submitted a limited number of claims for NTP services, residential treatment, residential withdrawal management, intensive outpatient and outpatient treatment service categories during CY 2017.
- Excel, Access and a local SQL database are utilized for claims review, reconciliation, and reporting.
- ShareCare replaced Insyst July 1, 2018.

Special Issues Related to Contract Agencies

Upon ShareCare implementation, designed for direct entry by providers, Contra Costa discovered that contract provider setup issues existed, particularly regarding the new DHCS coding of reporting units. Affected providers were temporarily required to manually track and submit services. While the issue resolution was ongoing, it was reported that approximately 75 percent of contact provider setup issues have been resolved.

Overview and Key Findings

Access to Care

- Tapestry, an Epic product or module is utilized by the Behavioral Health Access Line to track initial screening and referrals of prospective clients and link that data to first offered and first actual appointment. However, data on first actual appointment is received via fax and manually entered into Tapestry. Contract providers have no direct access to Tapestry information.

Timeliness of Services

- The timeliness of initial screening to first offered appointment and first kept appointment can be tracked in Epic by a combination of direct data entry and manual entry of faxed information. Contra Costa also enters no show information manually from faxed information, which is an inefficient and unreliable process.
- Timeliness is not tracked for withdrawal management readmission, however, Contra Costa has not yet begun claiming for withdrawal management services. There is a similar situation with tracking timeliness of post-residential follow-up appointments. They will need to address timeliness tracking as part of their current year implementation.

Quality of Care

- A paper chart of record is used. There is no DMC-ODS EHR for clinical documentation. ShareCare is limited to claims/ processing and state-mandated data reporting based on claims data.
- Contra Costa DMC-ODS has chosen a difficult path by selecting Epic, an EHR designed for physical health care delivery, for SUD services primarily offered through contract providers. Without a clear commitment from Epic that they are invested in making this work, it may be an enormous resource commitment for Contra Costa that might meet regulatory requirements but not be an optimal fit for SUD providers and their clients. There should be a clear back up plan to this strategy.

Client/Consumer Outcomes

- Outcomes are tracked using CalOMS data. A data analytic consultant analyzes the admission and discharge data for changes.
- Contra Costa has only one dedicated FTE performing data analytic services. The need is clearly many times that in such a large county. The best value from an organization's data is obtained through analysts that are intimately familiar with the data, have enough experience with it to recognize an anomaly, and have effective working relationships with the users of their analytic work.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Contra Costa PIPs Identified for Validation

Each DMC-ODS is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated two PIPs submitted by Contra Costa, as shown below.

PIP Table 1 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

PIP Table 1

Table 1: PIPs Submitted by Contra Costa		
PIPs for Validation	**# of PIPs**	**PIP Titles**
Clinical PIP	1	PHQ9/GAD7 in a Substance Abuse Treatment Center
Non-clinical PIP	1	Improving Timeliness to SUD Treatment

PIP Table 2, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially M, Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

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

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

PIP Table 3 provides a summary of the PIP validation review.

PIP Table 3

Table 3: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	14	13
Number Partially Met	3	3
Number Not Met/Unable to Determine	8	9
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating Clinical: ((14*2)+(3))/(25*2) Non-clinical: ((13*2)+(3))/(25*2)	**62%**	**58%**

Clinical PIP—PHQ9/GAD7 in a Substance Abuse Treatment Center

This PIP involves concurrent MH and SUD treatment interventions for clients with both types of disorders co-occurring. In addition to individualized treatments, the PIP also includes as interventions the periodic administration of two widely-recognized short-term measures: the nine-item Patient Health Questionnaire (PHQ-9) for depression, and the seven-item Generalized Anxiety Disorder Questionnaire (GAD-7) for anxiety. The PIP specifies these measures for screening at the outset of residential treatment, for measuring progress periodically during residential treatment, and for measuring outcomes at discharge from residential treatment.

Contra Costa presented its study question for the clinical PIP as follows:

"*Does implementing a curriculum to specifically address mental health symptoms at a residential treatment facility increase program completion rates by 10 percent*?"

Date PIP began: 7/27/18

Status of PIP: Active and ongoing

Brief Description: To better serve clients at our Discovery House residential drug and alcohol dependence treatment program and further integrate services with mental health, all incoming clients are screened on depression and anxiety. Data are being used to identify and test interventions to treat clients with co-morbid issues.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

Technical Assistance Provided: Assistance with problem statement clarification and clarification of performance indicators.

Non-Clinical PIP—Improving Timeliness to SUD Treatment

Contra Costa presented its study question for the non-clinical PIP as follows: "*Will providing appointment reminders, using Motivational Interviewing, improve initial appointment adherence by 10%*?"

Date PIP began: 7/16/18

Status of PIP: Active and ongoing

Brief Description: To address the high percentage of individuals who no show to their intake appointment for substance use disorder services, providers identified and are piloting outreach and engagement strategies with potential consumers.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

Technical Assistance Provided: Recommended that both a SUD consumer and a contract provider be added to the PIP committee.

PIP Findings—Impact and Implications

Overview

The PIPs have only recently started but both are addressing relevant issues that will result in quality of care improvements for clients. The non-clinical PIP focuses on enhancing initial engagement into residential treatment for referrals across all DMC-ODS residential treatment sites. The clinical PIP focuses on concurrent treatment of co-occurring mental health issues to increase successful completions by clients of substance use residential treatment. It was begun as a pilot at a county-operated residential treatment site and has the potential to be expanded to other residential treatment programs.

The PIP committees would benefit from expanding their membership to include contract providers, SUD consumers and line staff.

Access to Care Issues related to PIPs

Engaging clients with motivational interviewing prior to their first appointment for

residential treatment can improve the access to care. Clients are often apprehensive about beginning treatment and this intervention is designed to address the barriers to treatment that keep clients from attending their first appointment.

Persons with depression and anxiety were found to be dropping out of residential treatment prematurely due to their mental health symptoms. Addressing mental health symptoms will increase access to residential treatment to persons with mental health issues who need this level of care.

Timeliness of Services related to PIPs

Reducing no shows impacts the whole system. Increasing the number of persons who attend their intake appointment can reduce rescheduling and make more appointments available for others.

Quality of Care related to PIPs

The engagement of clients, using motivational interviewing, an evidenced based practice, improves the quality of early interactions and so enhances the initial treatment experience.

A curriculum designed to address depression and/or anxiety for persons who have been assessed to have either of these disorders co-occurring with a SUD improves the quality and effectiveness of treatment. This approach of treating both MH and SU disorders concurrently provides individualized care meeting an individual's unmet need while allowing a group process to provide additional support to all the individuals participating.

Client/Consumer Outcomes related to PIPs

Increased engagement to assist clients to address their barriers and fears about treatment will benefit clients by assisting them to begin treatment at the recommended level of care.

Addressing specific client issues as part of a residential treatment program will assist those clients to successfully complete the program.

CLIENT/CONSUMER FOCUS GROUPS

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

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

Focus Group One: Adult Perinatal Consumers

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

The group met on August 28, 2018 at the La Casa Ujima at 904 Mellus Street Martinez, CA, a perinatal residential program for women and their children. Eight women showed for the focus group. The mood in the room was light-hearted and friendly, although some of the stories about the suffering they and their children endured through their addiction were understandably grim. Many of the participants had been in various levels of treatment multiple times throughout several years, so they were able to compare access to county substance use treatment services prior to and after the launch of the DMC-ODS. All group participants were female, seven were adults 25 years of age or over and 1 a young adult 18-24. All were SUD clients. All spoke English, so no interpreter was needed. The group was about half and half persons Hispanic and Caucasian but there were also persons who were African American.

Number of participants: 8

Participants are first facilitated through a group process to rate each of eight (8) items on a survey, and discussion is encouraged. The facilitator asks each participant to rate each item on a five (5)-point scale (using feeling facial expressions, not numbers) using five (5) for best and one (1) for worst experiences. Clients are told there are no wrong answers, and that feelings are important. The group facilitators explain that the information sharing is regarded as confidential and reflects the participating group members' own experiences and feelings about the program. The facilitators further explain that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvement. See Attachment E for tools.

Participants described their experience as the following:

Question	Mean	Range
1. I easily found the treatment services I needed.	4.75	4-5
2. I got my assessment appointment at a time and date I wanted.	4.25	2-5
3. It did not take long to begin treatment soon after my first appointment.	4.5	3-5
4. I feel comfortable calling my program for help with an urgent problem.	4.88	4-5
5. Has anyone discussed with you the benefits of the new medication for addictions and cravings?	4.0	2-5
6. My counselor(s) were sensitive to my cultural background (race, religion, language, etc.)	4.63	3-5
7. I found it helpful to work with my counselor(s) on solving problems in my life.	4.88	4-5
8. Because of the services I am receiving, I am better able to do things that I want.	4.75	4-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help	4.88	4-5

The 8 participants who entered services within the past year described their experiences as the following:

- Overall positive
- One participant remarked “La Casa has saved my life.”

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

- If counselors had more one on one time available with fewer cases, more could be accomplished, especially in helping client with transitions from residential treatment.
- Clients feel supported to get medication to assist them in recovery and receive assistance to assure they can get to medication-related appointments.

Recommendations for improving care included the following:

- Counselor could provide specific assistance to clients when they had specific requirements in addressing their CPS cases
- Some participants wanted programs to allow them to come back more often as alumni to assist others and receive their own support.
- More outings were requested
- Children need to be assessed and receive their own treatment.

Interpreter used for focus group 1: No

Focus Group Two: Adult SUD Family Focus Group

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

The group met on April 29, 2017 at A Chance for Freedom Central, 2290 Diamond Blvd., Suite 202, Concord CA, a program that provides services to persons who are homeless. The group was animated, mostly friendly and good-humored but sometimes fidgety and somewhat agitated. Several were talkative and went off on tangents. All reported previous heavy use of methamphetamines. Six participants attended plus a person who was a volunteer translator. All were male with a mix of Caucasian and Hispanic ethnicities. All spoke English except for one who had a volunteer translator. Group members primarily identified as clients but also identified as family members of others who have SUDs.

Number of participants: six

Participants are first facilitated through a group process to rate each of eight items on a survey, and discussion is encouraged. The facilitator asks each participant to rate each item on a five-point scale (using feeling facial expressions, not numbers) using five for best and one for worst experiences. Clients are told there are no wrong answers, and that feelings are important. The group facilitators explain that the information sharing is regarded as confidential and reflects the participating group members' own experiences and feelings about the program. The facilitators further explain that the goal of the survey is to understand the clients' experiences and generate recommendations for system of care improvements. See Attachment E for tools.

Participants described their experience as the following:

Question	Mean	Range
1. I easily found the treatment services that my child/person I am caring for needed.	4.5	4-5
2. My child/ person I am caring for got an assessment appointment at a time and date we wanted.	4.5	4-5
3. It did not take long for my child/person I am caring for begin treatment after their assessment appointment.	4.5	4-5
4. I feel comfortable calling the program for help with an urgent problem concerning my child/person I am caring for.	4.33	4-5
5. Has anyone discussed with you the benefits of new medications for addiction and cravings?	3.33	2-5
6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.) of my child/person I am caring for.	4.5.	4-5
7. My child/person I am caring for responds in the following way to learning it is time to go to see their counselor again:	4.17	4-5
8. Because of the services my child/ person I am caring for is receiving, he/she is better able to do things he/she wants.	5.0	5-5
9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.	4.67	4-5

The three participants who entered services within the past year described their experiences as the following:

- Very positive overall experiences with outpatient services through Contra Costa providers.
- One participant remarked “I like the openness and honesty of staff”

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

- I have had enjoyable classes and sessions
- Long waits for treatment have been eliminated with DMC-ODS
- Counselors are found to be sensitive to their cultural background, and one of them can obtain Spanish translation help when needed
- Request to change a counselor happens easily

Recommendations for improving care included the following:

- Satisfaction was high and there were no specific recommendations

Interpreter used for focus group 2: Yes

Client Focus Group Findings and Experience of Care

Overview

Two focus group were conducted with adult clients with experiences from a variety of programs and experiences.

Access Feedback from Client Focus Groups

- The participants remarked that a common cause of relapse for clients in recovery is due to not having a place to stay other than the streets or a temporary shelter. They suggested more housing options are needed for clients graduating from residential programs.

Timeliness of Services Feedback from Client Focus Groups

- The participants in the adult client focus groups discussed the improvement in access since the implementation of the DMC-ODS. Waiting for services was significantly reduced.
- The participants found the Access Line staff to be helpful and appreciated the staff assistance in finding appropriate treatment.
- They agreed that for most substance use treatment services access to treatment is relatively easy, usually taking less than a week to see someone and often less than 24 hours.

Quality of Care Issues from Client Focus Groups

- The adult client participants were very satisfied with the quality of their services. Case management services were identified as an extra support.
- Clients appreciate the range of skills taught by the program including life skills, parenting groups, gardening, budgeting and sober living skills.

Client/Consumer Outcomes Feedback from Client Focus Groups

- Clients appreciate the help the program offers with aftercare to support their recovery post-discharge from residential treatment. They believe this is a key to their being successful.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

KC Table 1

Table 1: Access to Care Components

	Component	Quality Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	M
Contra Costa assures that Spanish language capabilities exist in their continuum of services. Their ACCESS line includes a response to any language by utilizing a language line service. Their provider services include bilingual staff as well as Spanish language programs in both residential and outpatient.		
1B	Manages and Adapts its Capacity to Meet SUD Client Service Needs	M
Contra Costa tracks requests, referrals and intakes to respond to system challenges. They are expanding withdrawal management services through a RFP to increase capacity. They need to continue to review their capacity in this area to assure it is adequate.		
1C	Integration and/or Collaboration with Community-Based Services to Improve Access & Care	M

Contra Costa has excellent collaboration with many organizations. Their work with county and private FQHCs has extensively expanded MAT services. Their work with their contracted DMC-certified providers has improved but is still challenged and needs further improvement.

Timeliness of Services

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

KC Table 2

Table 2: Timeliness of Services Components		
	Component	**Quality Rating**
2A	Tracks and Trends Access Data from Initial Contact to First Face to Face Appointment	M
Timely access is tracked from the screening to the first accepted appointment. A three-way call with ACCESS efficiently connects clients to their provider to schedule the first appointment. The time from screening to first appointment requires a manual process to track. Clients report easy access to services in both focus groups.		
2B	Tracks and Trends Access Data from Initial Contact to First MAT/NTP Appointment	NM
Contra Costa does not track MAT/NTP through their ACCESS system.		
2C	Tracks and Trends Access Data for Timely Appointments for Urgent Conditions	NM
Contra Costa does not track this data.		
2D	Tracks and Trends Timely Access to Follow-Up Appointments after Residential	NM
Contra Costa produces an annual report to review timely access to follow up. They have established a standard of 7 days from discharge to follow up. In the annual report this is met a small percentage of time.		
2E	Tracks and Trends Data on Re-Admissions to Residential Treatment and WM	NM
Contra Costa does not track re-admission to residential treatment and WM		
2F	Tracks and Trends No Shows	PM
Contra Costa does track the no shows prior to the first appointment for residential or outpatient but does not have the ability to track no shows after the first appointment.		

Quality of Care

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

KC Table 3

Table 3: Quality of Care Components		
	Component	**Quality Rating**
3A	Quality Management and Performance Improvement are Organizational Priorities	PM
The Quality Improvement (QI) Plan is combined with the Mental Health Plan (MHP) but does have some specific measurable QI goals and objectives related to DMC-ODS quality improvements. Goals are monitored at the combined QI committee when there is time. However, there is usually insufficient time or dedicated staff for focus on DMC-ODS issues. The data is primarily available on an annual basis and is not able to be extracted in a timely manner for quality improvement purposes. The QI committee is missing SUD provider and SUD consumer representation.		
3B	Data is Used to Inform Management and Guide Decisions	PM
There has been a lot of training and follow up to assure that the ASAM LOC Referral Data are entered consistently across the system. Similarly, other data such as CalOMS are used inconsistently. Expectations have been established but the ability to use data for tracking adherence to access and timeliness standards are limited across the system. Regular timely reports are not available to management for decision making or actions for system improvement. Contra Costa has put in place two PIPs: one to measure increased engagement with specific interventions and the second to measure completion of services with interventions to address co-occurring issues. These PIPs have begun as pilots but are planned to be expanded across the system as more information is gathered. Authorizations are used between levels of care to assure appropriate placement.		
3C	Evidence of Effective Communication from DMC-ODS Administration and SUD Stakeholder Input and Involvement on System Planning and Implementation	PM
Consumers were engaged initially to solicit their input into the development of the		

Table 3: Quality of Care Components		
Component		**Quality Rating**
Contra Costa DMC-ODS. The Alcohol and Drug Advisory Board has consistently been engaged to provide feedback during the implementation of the first year. Line staff and supervisors receive regular communication from management. Other community groups are engaged such as criminal justice. However, there is a clear lack of productive two-way communication with providers across the county. On-going feedback from clients is limited and there does not appear to be any formal family member feedback. Line staff need support to effectively transition their treatment practices to meet the new requirements.		
3D	Evidence of an ASAM Continuum of Care	M
Contra Costa requires the ASAM Criteria to be used across the system for LOC referrals, and the data to be entered into the ASAM LOC Referral Data Spreadsheet. The reimbursement of services is contingent upon documentation that shows adherence to ASAM principles. The ASAM Criteria-based screening can only be used to track services currently available and not those yet to be established. The ASAM LOC Referral Data spreadsheet needs to be expanded so it will track the levels of care needed that are not currently available.		
3E	MAT Services both outpatient and NTP exist to Enhance Wellness and Recovery:	PM
MAT services are an area of strength in Contra Costa. Clients have access and support for using medications within all levels of DMC treatment. NTP providers have contracted to provide buprenorphine and naltrexone medications but have yet begun this service. The MAT suboxone program is largely county operated at health clinics and integrated with health care services. This effective model coordinates with the CCHP who analyze data and actively promote best prescribing practices. There is good coordination with the DMC-ODS system.		
3F	ASAM Training and fidelity to core principles is evident in programs within the Continuum of Care	M
Contra Costa has utilized Dr. Mee-lee to train and implement the ASAM. There is a current plan to bring Dr. Mee-lee back to assist with fidelity training for both county and provider staff. Some of the timelines have made it difficult for line staff to adhere to the client-centered principles that are promoted. Staff report they cannot incorporate new information from clients and still meet required deadlines. Good work has been done to change the culture of the system and to ensure that clients continue to be engaged in treatment through relapse. The implementation of all levels is not yet complete. Contra Costa is adding higher levels of residential through an RFP that has been recently released. Case management has been established recently and providers are all utilizing this resource. The recovery support services and recovery residences will be implemented in year two and will be a critical addition.		

Table 3: Quality of Care Components		
Component		**Quality Rating**
The Tapestry program currently used does include the ASAM dimensions as part of the screening tool. However, one of the biggest challenges for this system is the lack of an electronic health record (EHR). It is critical that Contra Costa develop a plan to move forward with an EHR implementation plan to better manage the developing DMC-ODS and work with providers on how this can be most effectively implemented.		
3G	Measures Clinical and/or Functional Outcomes of Clients Served	NM
Client level outcomes are collected, and the system uses the ASAM level of care data as well as the CalOMS data. In fact, the system has excellent annual data at multiple levels from CalOMS that is reviewed annually. Increased review of the data more frequently would assist Contra Costa in responding to program challenges and opportunities in a timelier manner. Due to the lack of staffing support this data is not currently available more than annually for review.		
3H	Utilizes Information from Client Perception of Care Surveys to improve care	M
Contra Costa administers the TPS to clients as required, and the results measure several important domains in clients' experience of care: Access, Quality, Outcomes Care Coordination, and Satisfaction. Clients report high satisfaction in all areas. A review of provider level responses did not find any outliers.		

DMC-ODS REVIEW CONCLUSIONS

Access to Care

Strengths:

- Contra Costa's overall penetration rate for treating Medi-Cal beneficiaries with substance use disorders was .59 percent, more than double the statewide average of 0.25 percent. The same positive comparisons were demonstrated in more detailed analyses by all ages except youth (which was the same as statewide penetration), gender, and race/ethnicity. Claims data were available for only the first six months of Contra Costa's first year of implementation, so the number of client beneficiaries served is understandably less than for previous full years. However, the numbers were trending to go well over the previous year once all claims data are processed and reportable.

- Contra Costa expanded the mental health access line to develop an integrated centralized call center called the Access Line. SUD Counselors were added to screen and refer callers using ASAM Criteria-based tools. Mental Health staff were trained to provide back-up for the system. They use Tapestry, an Epic product to keep standard call center statistics (e.g. call volume, call wait times, and call abandonment rates). Clerical staff provide back up by assessing clients for crisis, taking their number and letting them know someone will call them back. The statistics indicated good accessibility (9 seconds average call wait time, and 7 percent average monthly caller abandonment rate).

- Contra Costa used existing providers initially and assisted them to become DMC-ODS certified with training and technical assistance. They used geo-mapping to identify where the majority of eligible beneficiaries lived within their county. They are expanding the existing capacity through RFPs to increase withdrawal management and recovery residence capacity.

- Contra Costa is ahead of many counties in its expansion of MAT services. The NTPs deliver methadone services to a substantial number of beneficiaries and are contracted to begin delivering non-methadone MAT. Meanwhile, the county's Choosing Change Program delivers non-methadone MAT through the five county-operated FQHCs to persons who can benefit from suboxone. The program collaborates closely with Contra Costa's SUD service continuum of care and is identified as a best practice model that is producing positive results. As this program is centered in primary care clinics, the clients can request to see their Choosing Change provider for their other primary care needs, and many are doing so.

- This effort in addressing opiate addiction as a disease and identifying treatment options for the community is normalizing MAT services both in the community and within the treatment community. Contra Costa has been promoting MAT services for some time and it is evident that providers are clear that MAT services must be a regular part of treatment. Follow up is done if there is ever a complaint from a client who has been restricted in receiving MAT services in conjunction with other treatment modalities.

Opportunities:

- Although the Hispanic/Latino penetration rate for Contra Costa was higher than the statewide average, it was relatively lower than for most other race/ethnicity groups in Contra Costa County. Contra Costa has several types of outreach to the Hispanic community, services in Spanish Language and bilingual staff at county and provider level services. Contra Costa does recognize it needs to do more to understand what barriers exist for this community.

- Program line staff expressed concern about meeting client needs while having to address the requirements of the DMC-ODS, especially the increased documentation requirements and timeliness requirements of assessments and treatment planning. They requested training to assist them on these issues. Leadership has indicated they plan to work with the county and provider staff to find ways to address these issues and develop solutions.

- Contra Costa and its contracted providers have worked through challenging issues during this first year of implementation. Progress has been made but additional regularly scheduled meetings need to take place to move forward effectively. Meetings that include feedback from providers and partnership in designing new elements and redesigns will benefit the system.

- Access to residential withdrawal management is severely compromised due to under-capacity from years of cutbacks to this level of service. Contra Costa is cognizant of this shortage and is working through RFPs to correct it.

- Contra Costa intends to build out its recovery residences in year two of its DMC-ODS implementation to address the needs of persons who are homeless and need temporary sober living while in intensive outpatient or outpatient treatment.

Timeliness of DMC-ODS Services

Strengths:

- Contra Costa established timeliness standards for all the services in the

Waiver implementation and has clear tracking for outpatient and residential treatment programs. The average length of time from the first request for outpatient or residential service to the first offered appointment is 4.6 days for all services. For adult services the mean was 4.6 days and for children the mean was 3.7 days with a standard of 10 days that was met 91.3 percent of the time for adults and 100 percent of the time for children. The length of time from initial request to first face to face appointment for outpatient and residential services system wide was an average of 5.5 days. For adults the mean was 5.6 days and for children the mean was 4.1 days with a standard of 10 days that was met 87.4 percent of the time for adults and 100 percent of the time for children.

Opportunities:

- Contra Costa has yet to begin systematic tracking of timeliness for NTP and other MAT services or no shows. NTP services are provided in a timely manner but regular reports are not generated and reviewed by Contra Costa at this time. Performance measures such as urgent appointments, post residential follow-up, and withdrawal management readmission are not tracked. Contra Costa needs to decide as soon as possible about the use of Epic as the EHR for DMC-ODS. Only with the full implementation of an effective EHR set up to optimize the efficiency of DMC-ODS business processes and care delivery will they be able to meaningfully track timeliness to services. IT resources dedicated to DMC-ODS will be essential to this effort.

Quality of Care in DMC-ODS

Strengths:

- Contra Costa has successfully implemented the use of ASAM Criteria across the system and educated partners to understand that treatment levels of care will be determined by the clinical needs identified through the assessment process. Line staff continue to struggle with the change, particularly how to engage clients in this new practice, but are working hard to adapt. The Access Line staff utilize a screening tool, built within the Tapestry program, to determine level of care based on ASAM principles. The county continues to provide training as the system evolves.

- Contra Costa is providing integrated MH and SUD treatment to persons with co-occurring issues to better address both issues and improve outcomes. MH clinics are becoming DMC-ODS certified and assigned a SUD counselor. Some clinics are also coordinating with physical health professionals, and integrating teams to include physical health, mental health and substance use treatment providers. Throughout Contra Costa, the County, similar cross-disciplinary efforts include placing a SUD counselor at the Psychiatric Emergency Services to

engage persons as they stabilize into appropriate SUD treatment; providing SUD services at a homeless clinic and integrating SUD services with jail health services. The DMC-ODS Waiver has catalyzed many of these efforts.

- The County Opioid Task Force, operational for several years, involves multiple divisions within the Health Department including Contra Costa AOD leaders. This Task Force has achieved many accomplishments over the last several years including: adopting a set of best practices on prescribing practices for both primary care and specialty mental health prescribers; establishing an overdose death review that identified a group of persons at the highest risk (those withdrawing from treatment); providing robust alternatives to persons receiving opioids including alternative drugs and alternative therapies; establishing an interactive and engaging web page with education, resources and local data for Contra Costa; working to establish over 70 kiosks for disposal of needles; and tracking the reduction of opioid prescriptions and opioid deaths over the last 2 years.

Opportunities:

- Contra Costa needs a system-wide electronic health record system that supports enhanced documentation, care coordination, data tracking, and ongoing system improvements. These needs underpin meeting the requirements of the DMC-ODS Waiver STCs.

- The proposed combination of Epic and ShareCare is a bold, yet untried and high-risk solution for refining and merging a practice management system and a separate EHR system. Epic is a proven EHR for physical health care, but not for SUD treatment. ShareCare is a proven billing system, but untried in combination with Epic. In addition, Contra Costa's County Counsel has raised concerns regarding how best to address 42CFR Part 2 privacy regulations in combining the two information systems. To address all these issues successfully, Contra Costa (and the respective software vendors) will need to dedicate more staff resources and may take a longer time to succeed than if it were to pursue an EHR solution that had already integrated both clinical and billing/claims processing functionality.

Client/Consumer Outcomes for DMC-ODS

Strengths:

- Contra Costa utilizes the TPS data to evaluate client satisfaction and therapeutic alliance. Their high scores are consistent across the system and within their entire provider continuum. Their average score was 4.4 with a range of 4.3 to

4.6. The results of the TPS were shared with the Drug and Alcohol Advisory Board and with the Quality Improvement Committee.

- Contra Costa produces high-level and detailed reports, including ones from the CalOMS with pre and post-treatment outcome data. These reports are produced annually and provide detail regarding what is working and where there are concerns.

Opportunities:

- Contra Costa has delayed the implementation of electronic data collection tools as well as an EHR accessible to county and provider staff. In addition, the staff dedicated to data collection and analysis is minimal. This has impacted their ability to analyze existing data or to develop regular reporting that would enable them to identify and quickly resolve areas not working well in their programs.

Recommendations for DMC-ODS for FY 2018-19

1. The DMC-ODS needs an electronic health record system to support enhanced documentation, care coordination, data tracking and service system improvements. The DMC-ODS EHR system needs to be available to their contracted providers who provide 87 percent of services.
   a. Finalize selection of an electronic health record with clinical functionality to support the delivery of SUD services
   b. Develop an implementation plan with time-bound goals.
   c. Assess staffing resources requirements for the implementation and continuing maintenance and enhancement of an EHR.
   d. Develop a hiring plan to assure timely and successful implementation. These new resources should be dedicated to DMC-ODS so that they have deep knowledge of the EHR system and DMC-ODS operations.
   e. Develop an automation solution for contract providers to share client data with Contra Costa and other providers based upon electronic data interchange (EDI) or health information exchange (HIE).

2. Increase data analytic capacity dedicated to DMC-ODS to support the analytic and reporting needs of the organization.

3. Increase its validation of data received from providers, the range of data reports it generates, and the use of data reports for improving the timeliness and quality of its services. As an example, Contra Costa should make more use of its CalOMS outcome reports by generating them at least quarterly, sharing them with providers, and using them for quality improvement purposes.

4. Develop an electronic process for contract providers to submit ASAM LOC referral data to the County. Providers currently send ASAM LOC referral data to the County by fax. Contra Costa is required by DHCS to verify the data and then send it in a timely manner to DHCS. To meet this requirement, it needs a more streamlined process to receive the data from providers.

5. Meet monthly with contract providers to address their concerns about the DMC-ODS implementation. Also invite their input on enhancements to the DMC-ODS and on improvements to provider/county collaboration.

6. Address serious shortages in bed capacity for residential withdrawal management, residential treatment, and recovery residences. Conduct an ongoing evaluation of access to and capacity for these services, including input from line staff and contract providers, and further adjust the capacity levels as needed to serve beneficiary needs.

7. Enhance the frequency, quality and documentation of case management and recovery support services. Accomplish these goals through ongoing communication with providers to clearly define the scope of these services, provide training in both delivery and documentation of the services, and obtain feedback on how delivery and documentation of these services can be improved.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

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

Attachment D: County Highlights

- D-1 Interactive web page addressing opioid use
- D-2 Outcomes for clients based upon CalOMS data

Attachment E: Client Family Focus Group Forms

Attachment F: Access Call Center Key Indicators

Attachment G: Continuum of Care Form

Attachment H: Acronym List Drug Medi-Cal EQRO

Attachment A—On-site Review Agenda

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

Table A1—CalEQRO Review Sessions - Contra Costa DMC-ODS
Opening session – Changes in the past year, current initiatives, baseline data trends and comparisons, and dialogue on results of performance measures
Quality Improvement Plan, implementation activities, and evaluation results
Information systems capability assessment (ISCA)/fiscal/billing
General data use: staffing, processes for requests and prioritization, dashboards and other reports
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
Performance improvement projects
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments (MATs)
Access Center Site visit and staff interviews
Criminal justice coordination with DMC-ODS
Contract provider Directors group interview
Clinical supervisors group interview – county and contracted
Clinical line staff group interview – county and contracted
Site visits such as residential treatment (youth, perinatal, or general adult), withdrawal management, access center, MAT induction center, and/or innovative program
Key stakeholders and community-based service agencies group interview
Contra Costa response to Opioid Crisis
Medication Assisted Treatments at FQHC's Choosing Change
Sobering Center Discussion
Exit interview: questions and next steps

Attachment B—Review Participants

CalEQRO Reviewers

Maureen Bauman, Lead Reviewer
Tom Trabin, Second Reviewer
Lisa Farrell, Information Systems Reviewer
Robyn Walton, Child/Client and Family Member Reviewer

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

Sites for Contra Costa's DMC-ODS Review

DMC-ODS Sites

AODS Administration
1220 Morello, Ave, Martinez, CA

Access Call Center
30 Douglas St., Suite 238, Martinez, CA

Discovery House
4645 Pacheco Ave, Martinez, CA

Contract Provider Sites

La Casa
904 Mellus St., Martinez

A Chance for Freedom
2290 Diamond Blvd., Suite 202, Concord, CA

Pueblos Del Sol
2090 Commerce Ave., Concord, CA

REACH Antioch
1915 D St., Antioch, CA

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Aguirre	Priscilla	Quality Management Program Coordinator	Behavioral Health
Artola	Elizabeth	REACH Youth Treatment Counselor	REACH Project
Battis	Claire	Planner/Evaluator	Behavioral Health
Beath	Lori	Client Advocate	Public Defender's Office
Bernstein	Marsha	Substance Abuse Counselor	Behavioral Health
Birch	Rachael	Health Services Administrator	Public Health
Bowman	Rob	Mental Health Clinical Specialist	Behavioral Health
Brooks	Dr. Nathan	Medical Staff Physician	Hospital and Health Services
Brown	Mitch	Substance Use Disorder Counselor- Access	Behavioral Health
Boulden	Shanna	Certified AOD Counselor	Anka Behavioral Health
Butler	Susan	Substance Abuse Counselor	BI-BETT Frederic Ozanam Center
Calloway	Vernon	Health Services Info Tech Manager	Behavioral Health Information Technology
Cheney	Shirley	Behaviorist	Choosing Change
Cinelli	Susan	Executive Director	BI-BETT
Cobbaleda-Keggler	Jan	Adult Mental Health Chief	Behavioral Health
Collins	Michelle	Patient Accounting Billing Supervisor	Finance
Crandle	Ed	Program Coordinator	Cole House
Crosby	Sue	Director of Public Health Clinical Services	Public Health
Down	Adam	Ethnic Services and Training Manager	Behavioral Health
Elliot	Marissa	PHN Program Manager	Choosing Change
Gallagher	Ken	Research/Evaluation Manager	Behavioral Health
Gaulden	Heather	Behaviorist	Choosing Change
Granados	Alex	REACH Project Counselor	REACH Project
Grant	Patti	Director/ Inmate Services	Office of the Sheriff
Hall	Keith	AB109 Counselor	Behavioral Health

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Hayden	Andrew	Health Plan Pharmacy Manager	Contra Costa Health Plan
Hayes	Warren	Mental Health Program Manager	Behavioral Health
Hermerding	Melissa	Intern	Public Health
Huovinen	Daniel	Probation Supervisor	Contra Costa County Probation
Jacob	Jean	Planner/ Evaluator	Behavioral Health
Jamison	Lance	Substance Abuse Counselor	Discovery House
Janssen	Chris	Intern- AODS	Behavioral Health
Jarrar	Aous	Substance Abuse Counselor	Behavioral Health
Jenssen	Erika	Assistant to Health Services Director	Behavioral Health
Jupiter	Addie	Alcohol and Drug Counselor	Ujima Central (Outpatient)
Juranovich	Paul	Substance Abuse Counselor- ACCESS Line	Behavioral Health
King	Ginger	Customer Care Liaison	Behavioral Health
Kogler	Victor	AODS Consultant	Behavioral Health
LeDee	David	Probation Officer	Contra Costa Probation Department
Luu	Matthew	Deputy Director of Behavioral Health	Behavioral Health
Loenicker	Gerold	Child/Adolescent Mental Health Chief	Behavioral Health
Marchetti	Mickie	Executive Director	REACH
Marchetti	Shirley	Assistant Director	REACH
Matal Sol	Fatima	AODS Program Chief	Behavioral Health
McDonnell	Ellen	Contra Costa Public Defender's	Contra Costa Public Defender's Office
McNutt	Steve	AODS Program Manager	Behavioral Health
Mendoza	Laura	Clerk- Specialist Level- AODS	Behavioral Health
Messerer	Mark	AODS Program Manager	Behavioral Health
Monroe	Michelle	Alcohol and Drug Counselor	Ujima Residential
Moore	Greg	Program Manager	REACH

Table B1 - Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Murray	Chris	Lead Counselor	BI-BETT Diablo Valley Ranch
Naghshineh	Morvarid	Planner/ Evaluator	Behavioral Health
Nasrul	Kimberly	Quality Improvement Coordinator and Compliance Coordinator	Behavioral Health
Neilson	Jersey	Planner/ Evaluator	Behavioral Health
Nuval	Pepe	Accountant- AODS	Finance
Oliveira	Phoebe	Registered Nurse	Public Health
Pedraza	Chris	AODS Program Manager	Behavioral Health
Pena	Jorge	PSP/Insyst Support	Behavioral Health Information Technology
Pormento	Alicia	AODS Finance Manager	Health Services Finance
Richardson	Michelle	AODS Program Manager	Behavioral Health
Santiago-Nederveld	Catania	Substance Abuse Counselor- ACCESS Line	Behavioral Health
Schank	Rita	Executive Director	Ujima
Seastrom	Trisha	AODS Program Manager	Behavioral Health
Sooter	Stephen	Treatment Center Director	BAART Antioch
Stewart	Harrison	Discovery House Program Supervisor	Behavioral Health
Stribling	Alison	Planner/ Evaluator	Behavioral Health
Sunderberg	Bruce	Substance Abuse Counselor	Cole House
Tanquery	Patricia	Chief Executive Officer	Contra Costa Health Plan
Todd	Zachariah	Lead Substance Abuse Counselor -Access	Behavioral Health
Webb	Darren	Substance Abuse Counselor- ACCESS Line	Behavioral Health
White	Katy	ACCESS Line and Care Management Unit Program Manager	Behavioral Health
White	Dr. Matthew	Interim Director	Behavioral Health
Williams	Ulrika	Treatment Center Director	BAART Richmond

Attachment C – PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2017-19 CLINICAL PIP	
GENERAL INFORMATION	
DMC-ODS: Contra Costa	
PIP Title: PHQ9/GAD7 in a Substance Abuse Treatment Center	
Start Date :7/27/18 **Completion Date:** TBD **Projected Study Period** :24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 08/28/18 **Name of Reviewer**: Maureen F. Bauman, LCSW, MPA	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established, and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): In an effort to better serve clients at our Discovery House residential drug and alcohol dependence treatment program and further integrate services with mental health, all incoming clients are screened on depression and anxiety. Data are being used to identify and test interventions to treat clients with co-morbid issues.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1 Was the PIP topic selected using stakeholder input? Did Contra Costa develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP committee consists of integrated Behavioral Health Staff including managers of QA/UM, contracts/compliance, QI, Integration, Research/Evaluation, Program Supervisor, and Mental Health Clinician. Staff are now working to identify a representative with SUD lived experience and a contract provider
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	After the implementation of the PHQ-0/GAD-7 in January of 2018 it was discovered that clients who successfully completed treatment had significantly lower PHQ-9/GAD-7 scores at intake than those who did not successfully complete.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Plan identified that persons with anxiety and depression were not successful in completing the SUD residential program. The goal of the developed intervention was to assist clients to be more successful completing this program resulting in increased health for the client.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The selection of clients was based on their scores on the PHQ-9/GAD-7. Everyone with high scores was asked to participate in the program. Participation was voluntary but everyone with specific scores was invited to participate
	Totals = 4	**3** Met **1** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
(1) Does implementing a curriculum to specifically address mental health symptoms at a residential treatment facility increase program completion rates by 10 percent?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The population targeted was identified based on data collected in the residential program. The goal of the PIP is to improve the health of these persons who have co-morbid disease. The intervention specifically addresses mental health issues.
	Totals = 1	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☒ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, the population was clearly defined as those persons who scored high for anxiety and depression.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☒ Referral ☐ Self-identification ☒ Other: Scores of PHQ-9 and GAD-7	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study included the entire population, but its data approach selected only those who met specific criteria.
	Totals = 2	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* (1) Percentage of clients who successfully complete treatment (2) Percentage of clients with moderately/severe depression who complete treatment (3) Percentage of clients with severe depression who successfully complete treatment (4) Average LOS for clients who do not compete treatment (5) Average LOS for clients who have severe depression at intake (6) Percentage of clients with severe depression at intake whose PHQ-9 severity improves by 1 category (7) Percentage of clients with severe anxiety at intake whose GAD-7 scores improves by at least one category.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The objectives were clearly defined and measurable. The timing of the re-taking of the PHQ-9/GAD-7 tests was specifically increased in order to get data even from those who left treatment prematurely.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client/consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators specifically measure changes in health and functional status based on increase/decreased score on a validated tool for depression and anxiety. The goal of the intervention was to increase health status and functioning by score as well as successful completion of treatment. The completion of treatment would also increase health status with recovery from substance use disorders.
	Totals 2	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals 3	**0** Met **0** Partially Met **0 N**ot Met **3** NA **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study specifically collected discharges from treatment both completed and not completed as well as on-going scores on the two clinical tests.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☒ Provider ☒ Other: Results of PHQ-9/GAD7 clinical tests	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Client discharge data and clinical testing scores. The pilot group will be compared to the population as a whole.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, the clinical testing scores are collected at intake, discharge and after 30 days in the program. The senior clerk at the program is responsible for collecting this data as well as the intake and discharge dates whether or the client completed the program. The data is kept in a data sheet.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: intake, discharge dates and clinical test results	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data collection, although not part of the systems data, is collected on a schedule for the duration of the project.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The datasheet was planned to be sent to the Research and Evaluation team for analysis. There were no specific contingencies identified. Of most concern is that one of the 2-person team who completed the first intervention is not available and so the PIP needs to assure the intervention is completed the same way for the second time. This was addressed during the review.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Mark Messerer Title: AOD Quality Assurance/UM Manager Role: Oversee the DMC-ODS QA/UM and study *Other team members:* Names: Kimberly Nasrul, QI, Priscilla Aguirre QM, Christopher Pedraza, Harrison Stewart, Supervisor, Ken Gallagher, Research,	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Staff were expertise in quality improvement and evaluation were involved as well as staff operating the program.
	Totals 6	**5** Met 1 Partially Met **0** Not Met 0 UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions:* An evidence-based practice of cognitive behavioral therapy curriculum was modified to fit into the residential treatment schedule (most limiting factor was many people complete the program in 30 days. The sessions identified: How thoughts affect mood How activities affect mood How interactions with others affect mood	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The intervention was specifically designed to augment the residential treatment program. The curriculum was designed to fit into the regular program but to address specific needs of a population with depression and anxiety. There were 6 sessions scheduled twice a week for three weeks utilizing Cognitive Behavioral Therapy and providing skills that were immediately applicable and useful for group participants.
	Totals 1	**1** Met **0** Partially Met 0 Not Met 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Yes, after 1 complete intervention of the cognitive behavior curriculum clients who participate had remained in treatment.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The results are very preliminary, so no formal finding was appropriate at this time.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? *Indicate the time periods of measurements*: *Indicate the statistical analysis used*: *Indicate the statistical significance level or confidence level if available/known:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	With only 1 complete intervention (1 it is not possible to determine the impact of the intervention.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:* **Continue study**.	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	No analysis as the PIP had only 1 complete intervention.
	Totals 4	**0** Met **1** Partially Met 0 Not Met 0 NA **3** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The data has not yet been measured a second time.

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

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: The study is addressing a population for which data indicates are less successful in completing critical health enhancing treatment. The evidenced based intervention preliminarily seemed to impact the LOS for the persons in this first group.		
Recommendations: Continue with the PIP through completion.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☒ Confidence in PIP results cannot be determined at this time	

((14*2) +3)/(25*2) .62

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2017-19
NON-CLINICAL PIP

GENERAL INFORMATION

DMC-ODS:

PIP Title: Improving Timeliness to SUD Treatment

Start Date :07/16/18

Completion Date: TBD

Projected Study Period 24

Completed: Yes ☐ No ☒

Date(s) of On-Site Review: 8/29/18

Name of Reviewer: Maureen Bauman, LCSW, MPA

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

☒ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

☐ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

To address the high percentage of individuals who no show to their intake appointment for substance use disorder services, providers identified and are piloting outreach and engagement strategies with potential consumers.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did Contra Costa develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Contra Costa, concerned about no shows, reviewed data to validate the concern. A group of involved staff were established as the PIP team. It was recommended that at minimum a consumer be added to this team. Potential to also add family members and line staff.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The rate for 1st appointments ranged from 22 percent to 37 percent. No shows are associated with decreased length of treatment and abstinence. This measures engagement with care and ultimately outcomes. The study population was selected due to the high needs of the population and availability of data.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	In addition to studying no show rates the Plan will also study change in timeliness of service, contacting consumers with reminders, engagement of consumers and impact of the intervention.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP focus is all persons scheduled for the pilot program of a all residential treatment programs. However, the goal is to expand to other programs after the pilot and then a larger population would be tested over time.
	Totals 4	**3** Met **1** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative: Will providing appointment reminders using Motivational Interviewing improve initial appointment adherence by 10 percent?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The pilot established a clear and measurable goal for the study.
	Totals 1	**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☒ Race/Ethnicity ☒ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The focus is on Access line callers scheduled for an appointment for residential. There were 281 appointments of which 56 percent were for men/44 percent women. These were adults ranged from 18-66 with an average age of 36.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: ASAM Level of Care Results	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study focused on the population of persons scheduled for residential based on ASAM Level of care results. The pilot is limited to residential referrals but can be expanded to other programs to expand the population.
	Totals 2	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* *1. Initial appointment adherence* *2. Consumer enrollment in residential treatment* *3. Rate of consumers contacted for initial appointment* *4. Rate of completed appointments among successful contacts*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The measures were clear and measurable. The PIP tracks the results of the intervention for completing the initial assessment. It also tracks the success of the intervention in reaching the client with motivation interviewing intervention.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be client/consumer focused. ☒ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP assumes that engagement in treatment will improve the health status of the person with a SUD disorder severed enough to indicate residential on the ASAM screener. It is recommended that in addition they track the completed outcomes of residential treatment in this study. That would validate that attending the first appointment with an engagement process results in improved outcomes over time.
	Totals 2	**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals 3	**0 Met** **0Partially** Met **0 Not** Met **3** Not Applicable **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data to be collected will be specified persons referred to residential, scheduled appointment confirmation or not of kept appointment. In addition, it will track the motivational interview calls to the client.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ASAM ☐ Claims ☐ Provider ☒ Other: Tapestry report	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The pilot data will come from Tapestry that includes data from the Access Line, as well as county operated program and provider data. In addition, a new spread sheet will be developed for persons doing outreach calls to fill in for the duration of the study with specified information including narrative data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The collection of data applies to the entire population to be studied. As this project expands the data collection for the outreach staff needs to be reviewed and standardized.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☒ Level of Care tools ASAM ☒ Other: Spreadsheet filled out by outreach staff	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Tapestry data is systematic and reliable with reports that are generated from the system. The plan for the outreach worker to fill out a spread sheet is less systematic and will need to be monitored to assure consistency and reliability.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study design is set up to review the specific data for residential treatment program. As the project expands this data analysis system will need to become more developed
6.6 Were qualified staff and personnel used to collect the data? *Project co-leaders:* Name: Mark Messerer Title: SUD QI Program Manager Role: Project Lead *Other team members: SUD Leadership staff* Names: Priscilla Aguirre, Kimberly Nasrul, Christopher Pedraza, Harrison Stewart	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Qualified staff were used to collect the data
	Totals 6	**5** Met **1** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe Interventions: Adjusting the MI intervention to meet the timelines of the intervention*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This study is very early in intervention but thus far is was reported that an adjustment needed to be made in the intervention. Initially the engagement was so lengthy that it was causing more connection than anticipated. The outreach worker modified the approach so that engagements could still utilized MI but were more limited to accomplish the complete intervention which was 3 contacts prior to the scheduled appointment.
	Totals 1	**1** Met **0** Partially Met **0** Not Met **0** NA **0** UTD

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

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

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

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: The PIP addresses and important issue of engagement immediately following an appointment. The target population are persons of high risk and the intervention will address health concerns. The data collection from Tapestry is systematic. The data collection from the outreach workers needs to be developed so that collections are consistent between workers. Knowledge of motivational interviewing techniques was clearly demonstrated during the presentation.		
Recommendations: Review the results quarterly and review the data collection success in order to make adjustments as necessary. Identify other providers who can participate in the PIP by initially being on the PIP committee.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☒ Confidence in PIP results cannot be determined at this time	

PIP item scoring	**PIP overall scoring**
((13*2) + 3)/ (25*2)	.58

Attachment D—County Highlights

The following attachments show highlights of Contra Costa in the area of their robust response to the opioid crisis and their use of CalOMS data.

D-1 Interactive web page addressing opioid use
D-2 Outcomes for clients using CalOMS data

D-1 Interactive web page addressing opioid use

In response to the Opioid crisis and the increasing deaths in their county Contra Costa established an interactive and engaging web page with education, resources and local data for Contra Costa.

The website is:

https://cocogis.maps.arcgis.com/apps/Cascade/index.html?appid=e7021dd08df149949cd480cd76a952ff

D-2 Outcomes for clients using CalOMS data

Contra Costa has developed and reviewed multiple reports using CalOMS data to review client profiles, trends and discharge data. One report shows outcomes for clients in their first year of the DMC ODS in all modalities of treatment. The following pages show the details of this report.

FY 17-18 Alcohol Use Outcomes

		Days Used Alchol, Past 30 Days - Admission	Days Used Alchol, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	1.85	.69
	Level 1 - Women's Outpatient Treatment	3.32	.95
	Level 1 - Youth Outpatient Treatment	.30	.16
	Level 2.1 - Women's Intensive Outpatient	3.74	1.54
	Level 3.1 - Adult Residential Treatment	2.40	.38
	Level 3.1 - Women's Residential Treatment	2.23	.01
	Level 3.2WM - Adult Residential Withdrawal Management	2.83	2.18
	Opioid Treatment Program	1.13	.47
	Total	1.95	.85

FY 17-18 Injection Drug Use Outcomes

		Times Injected Drugs, Past 30 Days - Admission	Times Injected Drugs, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	1.03	.18
	Level 1 - Women's Outpatient Treatment	.49	.00
	Level 1 - Youth Outpatient Treatment	.02	.01
	Level 2.1 - Women's Intensive Outpatient	.45	.24
	Level 3.1 - Adult Residential Treatment	3.08	.65
	Level 3.1 - Women's Residential Treatment	3.53	.79
	Level 3.2WM - Adult Residential Withdrawal Management	3.27	2.54
	Opioid Treatment Program	7.74	2.06
	Total	3.31	1.29

FY 17-18 Days Worked Outcomes

		Days Paid for Working, Past 30 Days - Admission	Days Paid for Working, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	3.29	2.23
	Level 1 - Women's Outpatient Treatment	2.96	3.84
	Level 1 - Youth Outpatient Treatment	2.07	1.55
	Level 2.1 - Women's Intensive Outpatient	1.13	1.92
	Level 3.1 - Adult Residential Treatment	.78	.61
	Level 3.1 - Women's Residential Treatment	.27	.00
	Level 3.2WM - Adult Residential Withdrawal Management	2.12	1.85
	Opioid Treatment Program	4.38	1.47
	Total	2.42	1.58

FY 17-18 Number of Arrests Outcomes

		Number of Arrests, Past 30 Days - Admission	Number of Arrests, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.22	.04
	Level 1 - Women's Outpatient Treatment	.04	.02
	Level 1 - Youth Outpatient Treatment	.72	.48
	Level 2.1 - Women's Intensive Outpatient	.08	.06
	Level 3.1 - Adult Residential Treatment	.32	.08
	Level 3.1 - Women's Residential Treatment	.25	.03
	Level 3.2WM - Adult Residential Withdrawal Management	.32	.24
	Opioid Treatment Program	.04	.08
	Total	.25	.13

FY 17-18 School Participation Outcomes

		Enrolled in School - Admission	Enrolled in School - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.04	.02
	Level 1 - Women's Outpatient Treatment	.05	.04
	Level 1 - Youth Outpatient Treatment	.75	.67
	Level 2.1 - Women's Intensive Outpatient	.02	.02
	Level 3.1 - Adult Residential Treatment	.01	.04
	Level 3.1 - Women's Residential Treatment	.02	.01
	Level 3.2WM - Adult Residential Withdrawal Management	.00	.00
	Opioid Treatment Program	.03	.01
	Total	.06	.05

FY 17-18 Job Training Participation Outcomes

		In Job Training Program - Admission	In Job Training Program - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.04	.01
	Level 1 - Women's Outpatient Treatment	.01	.04
	Level 1 - Youth Outpatient Treatment	.01	.01
	Level 2.1 - Women's Intensive Outpatient	.04	.07
	Level 3.1 - Adult Residential Treatment	.01	.06
	Level 3.1 - Women's Residential Treatment	.01	.02
	Level 3.2WM - Adult Residential Withdrawal Management	.00	.00
	Opioid Treatment Program	.01	.00
	Total	.01	.02

FY 17-18 Days in Jail Outcomes

		Days in Jail, Past 30 Days - Admission	Days in Jail, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	1.03	.12
	Level 1 - Women's Outpatient Treatment	.20	.00
	Level 1 - Youth Outpatient Treatment	10.97	10.23
	Level 2.1 - Women's Intensive Outpatient	.62	.44
	Level 3.1 - Adult Residential Treatment	3.76	.69
	Level 3.1 - Women's Residential Treatment	1.84	.47
	Level 3.2WM - Adult Residential Withdrawal Management	1.18	1.06
	Opioid Treatment Program	.28	.06
	Total	1.90	1.05

FY 17-18 Days in Prison Outcomes

		Days in Prison, Past 30 Days - Admission	Days in Prison, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.02	.00
	Level 1 - Women's Outpatient Treatment	.00	.12
	Level 1 - Youth Outpatient Treatment	.00	.00
	Level 2.1 - Women's Intensive Outpatient	.00	.00
	Level 3.1 - Adult Residential Treatment	.00	.08
	Level 3.1 - Women's Residential Treatment	.00	.00
	Level 3.2WM - Adult Residential Withdrawal Management	.04	.09
	Opioid Treatment Program	.04	.00
	Total	.02	.04

FY 17-18 Social Support Outcomes

		No. of Times Participated in Social Support Activities, Past 30 Days - Admission	No. of Times Participated in Social Support Activities, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	3.50	3.81
	Level 1 - Women's Outpatient Treatment	11.06	8.75
	Level 1 - Youth Outpatient Treatment	1.19	1.73
	Level 2.1 - Women's Intensive Outpatient	11.59	9.61
	Level 3.1 - Adult Residential Treatment	4.46	22.84
	Level 3.1 - Women's Residential Treatment	5.23	19.76
	Level 3.2WM - Adult Residential Withdrawal Management	2.84	6.42
	Opioid Treatment Program	1.66	.43
	Total	3.66	8.14

FY 17-18 Living With AOD User Outcomes

		Days Living with AOD User, Past 30 Days - Admission	Days Living with AOD User, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	4.74	2.21
	Level 1 - Women's Outpatient Treatment	3.38	2.22
	Level 1 - Youth Outpatient Treatment	1.78	1.31
	Level 2.1 - Women's Intensive Outpatient	5.11	3.22
	Level 3.1 - Adult Residential Treatment	5.17	.73
	Level 3.1 - Women's Residential Treatment	9.87	1.87
	Level 3.2WM - Adult Residential Withdrawal Management	5.71	5.17
	Opioid Treatment Program	2.54	.78
	Total	4.83	2.50

FY 17-18 Family Conflict Outcomes

		Days of Serious Family Conflict, Past 30 Days - Admission	Days of Serious Family Conflict, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	1.81	.90
	Level 1 - Women's Outpatient Treatment	2.10	.72
	Level 1 - Youth Outpatient Treatment	1.79	.81
	Level 2.1 - Women's Intensive Outpatient	4.71	3.17
	Level 3.1 - Adult Residential Treatment	3.52	.51
	Level 3.1 - Women's Residential Treatment	7.37	1.37
	Level 3.2WM - Adult Residential Withdrawal Management	7.00	5.55
	Opioid Treatment Program	.67	.33
	Total	3.80	2.12

FY 17-18 ER Visit Outcomes

		ER Visits, Past 30 Days - Admission	ER Visits, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.26	.09
	Level 1 - Women's Outpatient Treatment	.25	.10
	Level 1 - Youth Outpatient Treatment	.07	.03
	Level 2.1 - Women's Intensive Outpatient	.28	.16
	Level 3.1 - Adult Residential Treatment	.58	.25
	Level 3.1 - Women's Residential Treatment	.49	.13
	Level 3.2WM - Adult Residential Withdrawal Management	.51	.39
	Opioid Treatment Program	.20	.05
	Total	.37	.19

FY 17-18 Hospital Days Outcomes

		Nights in Hospital, Past 30 Days - Admission	Nights in Hospital, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.29	.09
	Level 1 - Women's Outpatient Treatment	.02	.01
	Level 1 - Youth Outpatient Treatment	.03	.00
	Level 2.1 - Women's Intensive Outpatient	.15	.05
	Level 3.1 - Adult Residential Treatment	.47	.16
	Level 3.1 - Women's Residential Treatment	.38	.07
	Level 3.2WM - Adult Residential Withdrawal Management	.28	.31
	Opioid Treatment Program	.33	.07
	Total	.30	.15

FY 17-18 Physical Health Problem Outcomes

		Days with Health Problems, Past 30 Days - Admission	Days with Health Problems, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	3.54	1.55
	Level 1 - Women's Outpatient Treatment	2.69	1.06
	Level 1 - Youth Outpatient Treatment	1.04	.36
	Level 2.1 - Women's Intensive Outpatient	3.69	2.59
	Level 3.1 - Adult Residential Treatment	5.38	3.64
	Level 3.1 - Women's Residential Treatment	2.11	.59
	Level 3.2WM - Adult Residential Withdrawal Management	5.70	4.83
	Opioid Treatment Program	3.84	.82
	Total	4.20	2.51

FY 17-18 Outpatient Psych Emergency Outcomes

		Times Received Emergency Outpt. MH Services, Past 30 Days - Admission	Times Received Emergency Outpt. MH Services, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.12	.04
	Level 1 - Women's Outpatient Treatment	.43	.02
	Level 1 - Youth Outpatient Treatment	.24	.00
	Level 2.1 - Women's Intensive Outpatient	.41	.00
	Level 3.1 - Adult Residential Treatment	.12	.15
	Level 3.1 - Women's Residential Treatment	.14	.20
	Level 3.2WM - Adult Residential Withdrawal Management	.75	.57
	Opioid Treatment Program	.09	.00
	Total	.32	.20

FY 17-18 Psych Facility Stay Outcomes

		Nights in Psychiatric Hospital, Past 30 Days - Admission	Nights in Psychiatric Hospital, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.06	.06
	Level 1 - Women's Outpatient Treatment	.14	.01
	Level 1 - Youth Outpatient Treatment	.01	.01
	Level 2.1 - Women's Intensive Outpatient	.56	.00
	Level 3.1 - Adult Residential Treatment	.13	.07
	Level 3.1 - Women's Residential Treatment	.40	.10
	Level 3.2WM - Adult Residential Withdrawal Management	.17	.20
	Opioid Treatment Program	.05	.00
	Total	.14	.08

FY 17-18 MH Medication Outcomes

		Taken RX Meds for MH Needs, Past 30 Days - Admission	Taken RX Meds for MH Needs, Past 30 Days - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.25	.18
	Level 1 - Women's Outpatient Treatment	.23	.23
	Level 1 - Youth Outpatient Treatment	.10	.07
	Level 2.1 - Women's Intensive Outpatient	.34	.22
	Level 3.1 - Adult Residential Treatment	.29	.40
	Level 3.1 - Women's Residential Treatment	.07	.08
	Level 3.2WM - Adult Residential Withdrawal Management	.25	.25
	Opioid Treatment Program	.10	.03
	Total	.21	.19

FY 17-18 Child Custody Outcomes

		No. of Children Living with Someone Else - Admission	No. of Children Living with Someone Else - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.23	.18
	Level 1 - Women's Outpatient Treatment	1.11	.72
	Level 1 - Youth Outpatient Treatment	.02	.01
	Level 2.1 - Women's Intensive Outpatient	.88	.61
	Level 3.1 - Adult Residential Treatment	.10	.09
	Level 3.1 - Women's Residential Treatment	.93	.86
	Level 3.2WM - Adult Residential Withdrawal Management	.16	.16
	Opioid Treatment Program	.07	.02
	Total	.25	.20

FY 17-18 Termination of Parental Rights Outcomes

		No. of Children with Parental Rights Terminated - Admission	No. of Children with Parental Rights Terminated - Discharge
		Mean	Mean
Level of Care	Level 1 - Adult Outpatient Treatment	.07	.04
	Level 1 - Women's Outpatient Treatment	.21	.11
	Level 1 - Youth Outpatient Treatment	.00	.00
	Level 2.1 - Women's Intensive Outpatient	.09	.12
	Level 3.1 - Adult Residential Treatment	.06	.06
	Level 3.1 - Women's Residential Treatment	.17	.21
	Level 3.2WM - Adult Residential Withdrawal Management	.10	.07
	Opioid Treatment Program	.05	.01
	Total	.08	.06

Attachment E—Client Focus Group Forms

Client focus group forms
Parents/ Guardians of Adolescent Clients Focus Group Feedback

Program/Clinic Name: _____ Date: _____

1. What is your age?
   - 0-17
   - 18-24
   - 25-59
   - 60 +

2. What is your gender?
   - Male
   - Female
   - Transgender
   - Other
   - Decline to state

3. What is your Race/Ethnicity?
   - African American/Black
   - Asian American/Pacific Islander
   - Caucasian/White
   - Hispanic/Latino
   - Native American
   - Other _____

4. What is your preferred Language?
   - English
   - Spanish
   - Other _____

My child/ person I am caring for started therapy in the last year with this counselor/program: Yes_____ No_____

My child/ person I am caring for have seen their counselor for more than a year: Yes____ No_____

Please read the sentences below about working with your counselor/program. After reading each sentence decide how much the sentence is correct based on what you feel. There are no right or wrong answers for this questionnaire, just how you feel.

---

1. I easily found the treatment services that my child/person I am caring for needed.

ongly Disagree Disagree Undecided Agree Strongly Agree

2. The child/ person I am caring for got an assessment appointment at a time and date we wanted.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3. It did not take long for my child/person for whom I am caring for to begin treatment after their assessment appointment.

Strongly Disagree Disagree Undecided Agree Strongly Agree

4. I feel comfortable calling the program for help with an urgent problem concerning my child/person I am caring for.

Strongly Disagree Disagree Undecided Agree Strongly Agree

5. Has anyone discussed with you and your family the benefits of new medications for addiction and cravings?

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.) of my child/person I am caring for.

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. The child/person I am caring for responds in the following way to learning it is time to go to see their counselor again:

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. Because of the services my child/ person I am caring for is receiving, he/she is better able to do things he/she wants.





Strongly Disagree Disagree Undecided Agree Strongly Agree

9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.





Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

10. What do you think would make the program or counselor more helpful to your recovery?

11. What would you change if you could to make the services better?

Client focus group forms
Transitioning Age Youth (TAY) Focus Group Feedback

Program/Clinic Name: _____ Date: _____

1. What is your age?
- 0-17
- 18-24
- 25-59
- 60 +

2. What is your gender?
- Male
- Female
- Transgender
- Other
- Decline to state

3. What is your Race/Ethnicity?
- African American/Black
- Asian American/Pacific Islander
- Caucasian/White
- Hispanic/Latino
- Native American
- Other _____

4. What is your preferred Language?
- English
- Spanish
- Other _____

I started therapy in the last year with this counselor/program: Yes_____ No_____

I have seen my counselor for more than a year: Yes____ No_____

Please read the sentences below about working with your counselor/program. After reading each sentence decide how much the sentence is correct based on what you feel. There are no right or wrong answers for this questionnaire, just how you feel.

---

1. I easily found the treatment services I needed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

2. I got an assessment appointment at a time and date I wanted.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3. It did not take long to begin treatment after my first appointment.

Strongly Disagree Disagree Undecided Agree Strongly Agree

4. I feel comfortable calling my program for help with an urgent problem.

Strongly Disagree Disagree Undecided Agree Strongly Agree

5. Has anyone discussed with you or your family the benefits of new medications for addiction and cravings?

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.).

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. I found it helpful to work with my counselor(s) on solving my problems in life.

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. Because of the services I am receiving, I am better able to do things I want.

Strongly Disagree Disagree Undecided Agree Strongly Agree

9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

10. What do you think would make the program or counselor more helpful to your recovery?

11. What would you change if you could to make the services better?

Client focus group forms
Adult Client Focus Group Feedback

Program/Clinic Name: _____ Date: _____

1. What is your age?
   - ☐ 0-17
   - ☐ 18-24
   - ☐ 25-59
   - ☐ 60 +

2. What is your gender?
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Other
   - ☐ Decline to state

3. What is your Race/Ethnicity?
   - ☐ African American/Black
   - ☐ Asian American/Pacific Islander
   - ☐ Caucasian/White
   - ☐ Hispanic/Latino
   - ☐ Native American
   - ☐ Other _____

4. What is your preferred Language?
   - ☐ English
   - ☐ Spanish
   - ☐ Other _

I started therapy in the last year with this counselor/program: Yes_____ No_____

I have seen my counselor for more than a year: Yes____ No_____

Please read the sentences below about working with your counselor/program. After reading each sentence decide how much the sentence is correct based on what you feel. There are no right or wrong answers for this questionnaire, just how you feel.

---

1. I easily found the treatment services I needed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

2. I got an assessment appointment at a time and date I wanted.

Strongly Disagree Disagree Undecided Agree Strongly Agree

3. It did not take long to begin treatment after my assessment was completed.

Strongly Disagree Disagree Undecided Agree Strongly Agree

4. I feel comfortable calling my program for help with an urgent problem.

Strongly Disagree Disagree Undecided Agree Strongly Agree

5. Has anyone discussed with you the benefits of new medications for addiction and cravings?

Strongly Disagree Disagree Undecided Agree Strongly Agree

6. The counselor(s) were sensitive to my cultural background (race, religion, language, etc.).

Strongly Disagree Disagree Undecided Agree Strongly Agree

7. I found it helpful to work with my counselor(s) on solving my problems in life.

Strongly Disagree Disagree Undecided Agree Strongly Agree

8. Because of the services I am receiving, I am better able to do things I want.

Strongly Disagree Disagree Undecided Agree Strongly Agree

9. I feel like I can recommend my counselor(s) to friends and family if they need support and help.

Strongly Disagree Disagree Undecided Agree Strongly Agree

Discussion questions:

10. What do you think would make the program or counselor more helpful to your recovery?

11. What would you change if you could to make the services better?

Attachment F—Summary of Access Call Center Key Indicators

Access Line Performance Measure

Overview/ Analysis

Average Monthly Call Volume in Last 12 months: 1751 from 7/1/2017 to 6/30/2018

Average Dropped Calls Per Month: 7 percent

Average Wait Time on the Phone until Answered: 9 Seconds

Dedicated Full Time Equivalent (FTE) Staff Assigned to Call Center: 8

Software/Vendor for Tracking Call Metrics:
Software Name: InContact /Tapestry
Software Version: Spring 2018
Or ☐ *DMC-ODS Data Not Available*

County Has No Wrong Door Policy	☒ Yes	☐ No
If yes, does the county track walk-ins and calls at other sites requesting service?	☒ Yes ☐ N/A	☐ Not currently
Call Center Linkage to EHR (Electronic Health Records) for county services	☐ Yes	☒ No
Call Center Does ASAM Based Screening	☒ Yes	☐ No
Call Center Does Full ASAM Based Assessments	☐ Yes	☒ No
Call Center Authorizes Admissions to Residential Treatment	☒ Yes	☐ No
Call Center Tracks Disposition of Calls	☒ Yes	☐ No
Call Center Allows Callers to Leave a Message	☐ Yes	☒ No

Attachment G—Continuum of Care Form

Continuum of Care–DMC-ODS/ASAM

DMC-ODS Levels of Care & Overall Capacity: Contra Costa Review Dates: August 27-29, 2017

Person Completing Form: Fatima Matal Sol, Mark Messerer, Chris Pedraza

County Role for Access and Coordination of care for persons with SUD requiring social work/linkage/peer supports to coordinate care and ancillary services.

Describe County Role and Functions linked to access and coordination of care:

The county operates an integrated Behavioral Health Access Line which includes Alcohol and Other Drugs certified counselors and Mental Health Clinicians. The unit operates 24/7 as a call center, 4FTE AOD counselors and 1FTE MH Clinician conduct ASAM screenings over the phone, facilitate warm hand offs via three-way calls between the prospective beneficiary and the SUD provider. AOD counselors provide intake appointments as needed and facilitate access to Medi-Cal enrollment with the BH Financial counselors. AOD counselors also provide brief support/encouragement to callers not ready for treatment along with information and referrals to significant others seeking information for their loved ones. When the counselors are on the phone serving another beneficiary, a clerical staff takes the call immediately and provides the caller with an approximate time in which the counselors will return the call.

AOD counselors also provide:

A) Referrals to recovery support-oriented activities for individuals who have completed treatment
B) Facilitate transitions of level of care as needed by callers
C) ASAM screenings for individuals who are incarcerated in all 3 county jails through a speed dial number

While the county has centralized entry into the system through the Behavioral Health Access Line, there are other portals of entry, which include:

1) 1FTE AOD Counselor who is part of the Access Line team conducts Face to Face ASAM screenings in all 3 Contra Costa courts, and coordinates transfers of levels of care as needed by clients who are referred by the Courts.

2) The AB109 counselor conducts face to face ASAM screenings in all 3 detention facilities including the Reentry Center, probation Offices and the community at large. The AB109 team includes 2FTE Case Managers who target AB109 clients with multiple relapses in the system and who need more intense support. The AB109 AOD team, provides linkages to ancillary services and coordination of the needs of the clients including after care and recovery support services mostly available through the AB109 Reentry Network and outside the DMC-ODS Plan.

3) Substance Abuse and Mental Health Services for CalWorks recipients (SAMHWorks) assessment team-conducts SAMHworks screenings and referrals to Access Line for SUD treatment as needed.

4) Beneficiaries may directly access withdrawal management and methadone treatment bypassing the Access Line.

5) Outpatient providers also facilitate the call to the Access Line with the beneficiaries if they present in any of their programs and use the opportunity to further engage the client.

At the present time, coordination of care originates from administration at the system wide level, particularly for special/priority populations such as women with children/parenting, perinatal, IV users, youth and homeless.

Case Management- Describe if it's centralized or integrated into programs or both:	
Monthly billable hours of Case Management: 135*	**Total Billable hours: 1624**

Comments:
In Contra Costa, Case Management (CM) Services is a decentralized service with coordination provided by the county AODS office. Case management services are integrated into the budget of each community-based service provider with assigned service codes for this purpose. During this first year of DMC-ODS implementation, case management services have been incremental. Due to the slow ramp up period, the number of hours that have been captured is relatively low compared to the needs of the clients. In an effort to avoid duplication of services with other local and existing case management initiatives, Contra Costa developed a manual for CM services prior to the Waiver.
*Monthly average billable hours

How are you structuring Recovery Services?

Recovery Services – Support services for clients in remission from SUD having completed treatment services, but requiring ongoing stabilization and supports to remain in recovery including assistance with education, jobs, housing peer			
Pick 1 or more as applicable and explain below: **1) Included with Outpatient sites as step-down** **2) Included with Residential levels of care as step down** **3) Included with NTPs as stepdown for clients in remission**			
Total Legal Entities:	**0**	Choice(s):	**1 and 2**

Explanation:
What is your estimated monthly estimated billable hours of recovery support services?

Explanation:
We envision that all programs in our system of care Outpatient and Residential will integrate recovery support services. To that end, Contra Costa expects that each program has a Recovery Support Specialist to provide recovery Support Services. Prior to implementation of the Waiver, Contra Costa convened 2 work sessions which included members of the AOD Advisory Board, clients and members of Support4Recovery (S4R) which is a grassroots organization comprised by former end users of the system. During those 2 sessions, we discussed what clients considered to be the most important recovery support activities after completion of treatment. From those sessions, a list was developed, and a form created and distributed to providers. An expectation from the input of the recovering community is that the county consolidates a list of all recovery support activities into a calendar that is available at each facility and in areas frequented by individuals with SUD.
Given factors pertaining to the delay of ramp up of services, Contra Costa is in the early stages of gradually adding recovery support specialists.

Withdrawal Management Outpatient – withdrawal from SUD related drugs which lead to opportunities to engage in treatment programs (use DMC definitions).			
Number of Sites:	2	Billable hours per month:	

How are you structuring it? - *Pick 1 or more as applicable and explain below* **1) NTP?** **2) Hospital** **3) Outpatient** **4) Primary Care Sites**	
Choice(s):	NTP and Primary Care Sties (None to DMC)

Explanation:

Withdrawal Management Residential Beds- withdrawal management in a residential setting which may include a variety of supports for the withdrawal.			
Number of Sites:	2	Billable Days:	1,576
Total Legal Entities:	1		
Pick 1 or more as applicable and explain below: **1) Hospitals** **2) Freestanding** **3) Within residential treatment center**			
Choice(s)	**Freestanding within residential facility**		

Explanation:
BiBett is our only and largest provider for this level of care. The only detoxification programs that they have certified consist of a few beds embedded in 2 of our women level 3.1 facilities. Though this provider became DMC certified in August 2017, they opted to start DMC billing effective December 2017, the number of billing hours correspond to those 2 facilities. BiBett also operates our freestanding detoxification facility and the second is located out of county, both of which are not the Non-DMC certified. We are expecting certification by December 2018 Additionally, we hope to begin operations for a new facility in West part of the county with the following capacity: 8 beds Level 3.2, Seven beds 3.1 and 9 Recovery Beds in late Fall.

How are they organized?

NTP Programs- Narcotic Treatment Programs for opioid addiction and stabilization including counseling, methadone, and coordination of care.				
Total Slots:	1500		Number of Sites:	2 SITES
Total Legal Entities:	1 Baymark Co			
Out of County NTP	**Slots:**	unknown	**Sites:**	
In County NTP	**Slots:**	**1500**	**Sites:**	2

Comments:

We are currently in discussions with BAART and Aegis regarding clients who received services out of county. The data corresponding to the number of clients has not been submitted. We understand that there were 30 out of county residents who receive services with BAART, but the details about the sites are unknown. Similarly, Aegis has documented information regarding clients seen in their clinics in FY16-17 and FY17-18, but with few details.

MAT Outpatient (providing other drugs besides methadone) - Outpatient services providing MAT medical management including a range of medications other than methadone, usually accompanied by counseling for optimal outcomes.			
Total Legal	Contra Costa Health Services	Number of Sites:	7 (none to DMC)

Comments:

Contra Costa Heath Services (CCHS) operates the Choosing Change clinics under Primary Health Care and FQHCs, this is an integrated program that includes AODS. The following sites provide Buprenorphine, behavioral health support and referrals for higher ASAM levels of care as well as other recovery support services in the community. West County Health Centers, Miller Wellness Center (Martinez), Martinez Health Center, Concord Health Center, Antioch Health Center, and the Pittsburg Health Center. In addition, specialty pain management clinics in our County operated hospital have already started to provide services. As of June, there were 90 Waivered County physicians who are part of the Choosing Change network.

In 2016 there were 3 groups, in 2017 there were 6 groups and at the present time a total of 7 groups plus as indicated above a Pain Management Clinic group has started. We have plans to begin Choosing Change services at the Martinez and Richmond jails.

2016

Year	No shows	Complete Appointments
2016	189	297
2017	1,687	3,429

Effective August 1, 2018 Baymark (BAART) will begin Buprenorphine, Disulfiram, and Naloxone services at 2 county sites and for our out of county residents. Likewise, we are working with Aegis for the provision of similar services in the Modesto area.

Level 1: Outpatient – Less than 9 hours of outpatient services per week (6 hrs/week for adolescents) providing evidence-based treatment.			
Average estimated billable hours per month:		**1,650**	
Total Legal	5	***Total Sites for all Legal Entities:***	11

Comments:
We have at least 4 additional sites that are undergoing DMC certification process, which billable hours were not counted, this includes our tow Mental Health clinics in Central County.

Level 2.1: Outpatient/Intensive – 9 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient SUD treatment.			
Billable hours per month:	***Total 673 per month***		
Total Legal Entities:	6	***Total Sites for all Legal Entities:***	11

Comments:
We have several sites including the Mental Health clinics that have been certified as Level 2.1; however, have not started operations.

Level 2.5: Partial Hospitalization – 20 hours or more of outpatient services per week to treat multidimensional instability requiring high-intensity, outpatient treatment but not 24-hour care.			
Total Number of Programs:	(1)	***Total Sites for all Legal***	
Average Client Capacity per			

Comments:

Not Available

Level 3.1: Residential – Planned, and structured SUD treatment / recovery that are provided in a 24-hour residential care setting with patients receiving at least 5 hours of clinical services per week.			
Number of Program Sites:	18	***Number of Legal Entities:***	**6**
Total Beds:			

Comments:
Of the 18 Level 3.1 facilities that are now DMC certified, two have not started to bill Medi-Cal. Altogether a total of 26,782 units of service have been provided. Additionally, there are 2 out of county providers: Thunder Road and Sunny Hills ReStart for young people. Sunny Hills is DMC certified but Sunny Hills is not.

Level 3.3: Clinically Managed, Population Specific, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals with significant cognitive impairments.			
Number of Program Sites:	0	***Number of Legal Entities:***	***0***
Total Bed Capacity:	**0**		

Not available in Contra Costa

Level 3.5: Clinically Managed, High-Intensity Residential Services – 24-hour structured living environments with high-intensity clinical services for individuals who have multiple challenges to recovery and require safe, stable recovery environment combined with a high level of treatment services.			
Number of Program Sites:	1	***Number of Legal Entities:***	**1**
Total Bed Capacity:			

(Can be flexed and combined with 3.1)

Comments:

Although not available in Contra Costa, Behavioral Health has a contract with Sunny Hills ReStart program certified for DMC but not yet able to accept this as funding.

Level 3.7: Medically Monitored, High-Intensity Inpatient Services – 24-hour, professionally directed medical monitoring and addiction treatment in an inpatient setting. (May be billing Health Plan/FFS not DMC-ODS but can you access service??)			
Total Program Sites:	0	***Number of Legal Entities-***	***0***
Total Bed Capacity:	***0***		

NOT AVAILABLE IN CONTRA COSTA

Level 4: Medically Managed Intensive Inpatient Services – 24-hour services delivered in an acute care, inpatient setting. (Billing Health Plan/FFS can you access services?)			
Total Program Sites:	0	***Number of Legal Entities-***	***0***
Total Bed Capacity:	***0***		

Comments:

NOT AVAILABLE IN CONTRA COSTA

Other comments on Continuum of Care:

Attachment H—Acronym List Drug Medi-Cal EQRO Reviews

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

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

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