Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 402
Emeryville, CA 94608

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

FY 2021-22 MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

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September 21-23, 2021

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EXECUTIVE SUMMARY

DMC-ODS INFORMATION

DMC-ODS Reviewed —Contra Costa

Review Type— Virtual

Date of Review— September 21-23, 2021

DMC-ODS Size — Large

DMC-ODS Region — Bay Area

DMC-ODS Location — East of San Pablo Bay, south of Solano, west of Sacramento and San Joaquin, and north of Alameda

DMC-ODS Beneficiaries Served in Calendar Year (CY) 2020 — 2,269

DMC-ODS Threshold Language(s) — Spanish

SUMMARY OF FINDINGS

Of the seven recommendations for improvement that resulted from the FY 2020-21 External Quality Review (EQR), the DMC-ODS addressed or partially addressed six recommendations and did not address one recommendation related to their EHR/IS system.

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

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 100 percent (six of six components)
- Quality of Care: 100 percent (eight of eight components)
- Information Systems (IS): 83 percent (five of six components)

The DMC-ODS submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Transition Team Case Management”, was found to be active with a high confidence rating. The non-clinical PIP, “Improving Access to MAT for Alcohol Use Disorder Patients”, was found to be in implementation active phase with a moderate confidence validation rating.

CalEQRO conducted two consumer family member focus groups, comprised of 14 participants – one outpatient adult mixed programs and one perinatal adult.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

Contra Costa was found to have significant strengths in expanding access through a series of strategies, improving cultural competence, and taking steps to address their computer infrastructure gaps which have hampered their quality efforts and created burdens for both county and contractor staff. These were achieved through new grants, identification of new providers for remote areas of the county and to serve youth, an upated cultural humility plan and strategies, and an RFI to establish a unified and functional EHR for the DMC-ODS programs and hopefully the network to work together as a whole and in collaboration with mental health and physical health partners.

Contra Costa has opportunities for improvement in continuing to develop its network of services in recovery support services, outpatient capacity, services to ethnic minorities and youth. In addition, as noted on prior reviews, the EHR gap for the DMC-ODS had left many inefficiencies and problems with communication and problems with timeliness of service and getting information to make decisions for clients and for change management in an efficient and effective manner. This will be very problematic in a CalAIM environment and needs to addressed which is why the RFI is critically important.

FY 2021-22 CalEQRO recommendations for improvement include:

1. Evaluate outpatient services and recovery services, consider capacity needs and goals for the future, and incorporate these into an updated QI plan and continuum of care for FY 2022-23.
2. Continue current efforts to expand Latino and youth services access, including the multi-pronged approach with the Latino Commission, support of current bilingual staff, work with La Familia, addition of supported bilingual groups, tracking language line bilingual requests, the New Beginnings (Nuevos Comienzos) program at the Family Justice Center, and expanded use of bilingual peers.
3. Implement expanded communication and planning activities with contract providers to work on shared problems areas, plan for expected computer system changes, clarify areas of confusion or misinformation such that they understand the many changes are state driven, not generated by Contra Costa, and prepared for CalAIM using new opportunities to improve the care system.

4. For measurement of outcomes and quality, Contra Costa should make every effort to expand Latino and youth participation in TPS at all LOCs and work to reduce the administrative discharge percent rate for CalOMS which compromises the validity of the data overall. These efforts will improve the usefulness of both these tools in evaluating quality and outcomes related to SUD systems.
5. Improve timeliness data collection to be as automated as possible so that feedback to providers and QI is timely, relevant, and actionable. If possible, eliminate manual data entry of the timeliness data coming in from contractors. Consider leveraging resources linked to Access Center nights and weekend services as a possible solution for contractor interface to improve data monitoring and reporting.
6. Make MAT documentation available at all service sites through the MAT expansion program in Spanish and English and require programs to share this information with new clients who have primary opioid or alcohol use disorders who may benefit. www.californiamat.org/toolkit_resource

INTRODUCTION

BACKGROUND

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

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

Additionally, DHCS requires the CalEQRO to evaluate counties on the following: delivery of substance use disorder (SUD) treatment services in a culturally competent manner, coordination of care with other healthcare providers, and beneficiary satisfaction. CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205.

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Contra Costa DMC-ODS by Behavioral Health Concepts, Inc., conducted as a virtual review on September 21-23, 2021.

METHODOLOGY

CalEQRO's review emphasizes the county's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public behavioral health system, including former directors, information services (IS) administrators, and individuals with lived experience as consumers or family members served by substance use disorder systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review county-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the

conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables, and graphs throughout this report are derived from multiple source files, unless otherwise specified. These statewide data sources include the Monthly Medi-Cal Eligibility Data System Eligibility File, DMC-ODS approved claims, the TPS, CalOMS, and the American Society of Addiction Medicine (ASAM) level of care data. CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020, unless otherwise indicated. As part of the pre-review process, each county is provided a description of the source of data, and a summary report of their PMs, including Medi-Cal approved claims data. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the county's approach to performance management – emphasizing the utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of two elements pertaining to NA: Alternative Access Standards (AAS) requests and use of out-of-network (OON) providers.
- Summary of county-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of continuous quality improvement and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, including sixteen PMs.
- Review and validation of submitted Performance Improvement Projects (PIPs).
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the county's quality and operational processes.
- Consumer perception of the county's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of county strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of county beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE DMC-ODS ENVIRONMENT AND WITHIN THE COUNTY

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

ENVIRONMENTAL IMPACT

This review occurred from September 21-23, 2021 in Contra Costa County. Currently, the county was still experiencing outbreaks of the Delta variant in facilities and needing to take extra precautions with both staff and client screenings. This continued to affect residential capacity and DMC-ODS access levels overall due to workforce issues and reduced census in the congregate care settings. CalEQRO worked with the county to design a full review agenda despite these factors. CalEQRO was able to complete the review without any insurmountable challenges. However, the client focus group needed to be relocated at the last minute to a new treatment setting due to an outbreak.

SIGNIFICANT CHANGES AND INITIATIVES

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

- There were numerous staff changes most significant was the addition of Dr. Stephen Field as the new Behavioral Health Division Medical Director. Kennisha Williams is the new Chief of Mental Health Housing and Intensive Services. However, many other vacancies are not filled due to impacts on County Personnel. Fortunately, all Access positions are filled, and one additional bilingual position is part of the staffing, and a new data position added is helping with CalOMS, which has improved the quality of that outcome data set. However, there are many other vacancies unfilled, and SUD counselors are particularly impacted in both the county services and contract agencies. Competition for this classification of clinicians has increased.
- COVID-19 has continued to have impacts on DMC-ODS facilities and services, staffing, and outbreaks with the new Delta variant, though the staff working with Public Health have organized support for vaccines for clients both onsite in their facilities and with special scheduling through Epic. Protective equipment, access to rapid testing, coordination of isolation housing at hotels for persons with potential positive exposure, and enhanced levels of emergency sick leave were approved for staffing at both the county and contract agencies. Rate adjustments

were also approved for contractors to maintain program stability with COVID-19 utilization impacts. County DMC-ODS and Public Health support for programs was provided when program sites had outbreaks to help them handle these events appropriately and safely without further spreading the disease. BinaxNOW rapid COVID-19 testing was given to residential providers to help with further containment starting in January, and the training to access the testing included the withdrawal management (WM) residential programs and other residential treatment settings where outbreaks were most at risk.

- This year, several important initiatives with SUD providers, including the SUD Data group and the Ad-hoc Documentation workgroup, streamlined paperwork workflows and reviewed data trends together to work on quality of care. They are currently reviewing changes to medical necessity, recovery support, and elimination of the two admissions in residential treatment. They also worked together to eliminate the need for authorization for outpatient services and worked on utilization review (UR) issues together. There was also a collaborative effort to develop specific procedures for discharges of persons with co-occurring needs. There was also a group studying the recovery services model in Napa county for potential application in Contra Costa.
- As part of CalAIM efforts, numerous efforts were linked to integration and coordination with primary health and mental health. Some of these efforts related to the Epic electronic health product and bringing data across to others in coordinated ways but in line with confidentiality requirements using the Provider Portal. Special sessions led by the Behavioral Health Director and executive team to discuss system barriers and reach across teams to better understand the system of care were held. More engagement and discussions are planned.
- The SUD counselor at the Psychiatric Emergency Service continues to be extraordinarily successful, and there is a desire for more capacity in this area, as seen by stakeholders. This is common for hospitals to know the value and want a 12-hour daily presence for SUD specialists, but that is not possible currently per staff with current resources. However, this personnel can quickly triage clients to other LOCs and assist with evaluations and improve efficiency.
- Proposition 64 Grant for Adolescent Treatment was awarded to Contra Costa for Middle School services in southeastern Antioch with an after-school program with mentors and role models to support youth and assist with avoiding SUD involvement. This will begin in the fall. Expansion of youth services is incredibly positive, especially in this more remote community.
- Treatment in Detention Medical Correction Grant - Residential Substance Abuse Treatment grant was awarded by the Board of Corrections. It included integrated medical staff, which was used with the local MAT Collaborative and Oxford

Houses. Contra Costa has requested the positions be filled so the program can begin.

- Outpatient Services for Spanish Speakers are an essential initiative. Nuevos Comienzos or Early Beginnings started in May 2021, right after the hiring of Bilingual counselors. Services for Spanish speakers started increasing, and more calls were coming to Access requesting services in Spanish. Contra Costa has a partnership with the Family Justice Center in Concord.
- Expansion of Adolescent and Perinatal Services: These two populations need outreach and engagement to enhance their options for entry into treatment. Both areas have special staff and initiatives planned to work on expanding admissions and engagement.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: To reduce paperwork burden, combine ASI and ASAM assessment elements into one document, and continue to look at other streamlining opportunities. CalEQRO will assist with ASI and ASAM if needed, as this has been a common need across counties.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Contra Costa formed an Ad-Hoc Provider Documentation/Policy Collaboration Workgroup, which reviewed assessment processes and paperwork. They looked for duplicative forms, fields, and documentation. They recommended streamlined admission forms and eliminating redundancies. They also eliminated ASI and added needed fields to ASAM as an addendum to address elements in ASI omitted from ASAM. They also developed a new Alcohol and Drug (AOD) Face Sheet and reviewed updated ICD-10 codes released in October 2020. All recommendations were supported by management.

Recommendation 2: Start tracking urgent requests for services as it is a DHCS required timeliness metric, and technical assistance is available from CalEQRO to assist.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Contra Costa did set up a system to track urgent requests. Narcotic treatment program/Opioid treatment programs (NTP/OTPs) track their requests and data and have a same-day service policy since they are open every day to meet client requests within 48 hours. Any requests for methadone can be directed by the Access Team to NTP/OTP closest to them on the same day. Contra Costa was also reviewing requests that come into Access that due to peak volumes, go to clerical staff, and then clients must be called back to track those requests if they are urgent and be sure they are identified and prioritized. Their definition for urgent is persons needing WM services. All service request calls, including those that roll to clerical staff, must be tracked for timeliness of the callback, offered appointment, and linkage to care.

Recommendation 3: Complete the development of a SUD Face Sheet that will highlight all clinical services a client has received in the DMC-ODS.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- With input from contract providers and support from the Business Intelligence team, AODS released Face Sheet reports in January 2021 that were distributed to providers' secure folders on a county server.
- The Face Sheet highlights treatment episodes a client has received in the DMC-ODS along with demographic and insurance information.
- A Tip Sheet was also developed as part of the effort for improved communication.

Recommendation 4: Follow through with plans to review electronic interface options with contract agencies to mitigate the latter's inefficiency of entering service transactions in their own systems and ShareCare.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Contra Costa has decided not to pursue the development of electronic interfaces to ShareCare with contract providers.

Recommendation 5: Continue efforts to add Oxford housing and recovery housing in general.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Contra Costa added three new Oxford house facilities and is planning on continuing to add more. The current operator of the program, however, has given notice, and the County has worked with a local housing provider to continue to support the housing with the special values and rules of Oxford house, which is an evidence-based practice (EBP).

Recommendation 6: Expand recovery services and CM and work with DHCS to optimize billing options, particularly for CM. Technical assistance from DHCS may be required.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Based on billing reviewed for the past fiscal year by LOC, case management has increased in both residential and outpatient LOCs though most of the transition team members are still not billing due to the categorical matching funding sources or qualification issues linked to current DMC-ODS restrictions; however, some of these rules and requirements may change in CalAIM with medical necessity and will allow the use of peers for more functions with the DMC-ODS system.
- Contra Costa did investigate recovery support services program in Napa county and met with providers related to expanding recovery support services but felt that the current restriction which is being eliminated to have all recovery clients "in remission" was a barrier to having them in recovery support services because their conditions change so quickly, and many are still using MAT and requiring periodic treatment supports. With the elimination of the "in remission" diagnosis and flexibility with more use of peer staff in supportive programming and linkage,

Contra Costa felt this could be expanded in the next year despite the current workforce challenges.

Recommendation 7: Develop a plan and timeline to develop an EHR for the DMC-ODS program inclusive of contract agencies.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Contra Costa has released an RFI to solicit qualified vendors to develop an electronic health record and billing system for the DMC-ODS.
- Currently, AODS and Contra Costa Health Services (CCHS) are reviewing needs, information gaps, and workflows related to data exchanges with contract providers and key requirements related to CalAIM.

None of the recommendations were carried over from the prior year except recommendation seven which had been requested several times be addressed.

NETWORK ADEQUACY

BACKGROUND

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

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

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

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

FINDINGS

For Contra Costa County, the time and distance requirements are 30 minutes and 15 miles for outpatient SUD services, and 30 minutes and 15 miles for NTP/OTP services.

These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Access

Contra Costa had submitted an AAS request for youth and adult outpatient and NTP services for three zip codes (94505, 94582, 94583) which was approved by DHCS in a March 2021 letter. Since that approval, Contra Costa has identified a new provider who is now providing services in two of the zip codes addressing the treatment needs to be required named Harmonic Solutions LLC. This will leave one zip code 94505 requiring an AAS in the future, assuming the provider continues to provide DMC-ODS services to youth and adults needing MAT and outpatient care.

Contra Costa has a contract with an Aegis site for 94505 services as an OON provider which is two miles over the distance requirement.

In addition, Contra Costa added capacity with Bright Heart Health to provide outpatient MAT and counseling to youth and adults who are able and willing to participate in non-methadone MAT and outpatient service via telehealth technology as well.

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[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN CONTRA COSTA COUNTY

SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Regardless of payment source, 2.53 percent of services were delivered by county-operated/staffed clinics and sites, and 97.47 percent were delivered by contractor-operated/staffed clinics and sites. Overall, 69.33 percent of services provided are claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is staffed by county-operated staff; beneficiaries may request services through the Access Line as well as directly through the following system entry points: NTP, MAT, and residential WM programs. The DMC-ODS operates a centralized access team with Transition Team case management supports that is responsible for linking beneficiaries to appropriate, medically necessary services.

In addition to site-based services, the DMC-ODS provides telehealth services to clients in support of COVID-19 social distancing requirements. Specifically, the DMC-ODS delivers group therapy, group education and support, individual therapy, case management, and new client intake and assessment services via telehealth to youth and adults. In FY 2020-21, the DMC-ODS reports having served 1,016 adult beneficiaries, 118 youth beneficiaries, and 59 older adult beneficiaries across seven county-operated sites and 30 contractor-operated sites. Among those served, 171 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Component – Access

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

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

- Contra Costa expanded unduplicated clients served again this year even with COVID-19 and fires and added a new youth provider in a remote area of the county, eliminating the need for an AAS for two zip codes with access challenges related to time and distance requirements for outpatient and medication services in the future.
- Contra Costa continues to have challenges engaging and serving Latino eligibles which constitute a significant percentage of the Medi-Cal population and has developed a multi-pronged plan to expand services in partnership with two non-profit agencies, beginning mono-lingual groups in specific areas, and support of bilingual staff and providing more cultural orientation training particularly for the help of newer immigrant populations.
- Access was also expanded in the continuum of care through new grant writing activities, which were successful for youth and those SUD clients in the criminal justice system.

- Also, Contra Costa has improved initiation and engagement using their Transition team, which provides intensive case management for those who cannot get an intake appointment within 3-days and those who are transitioning between LOC to support continuity of care.

PERFORMANCE MEASURES

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

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

Total Beneficiaries Served

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

Contra Costa served 2,269 unique clients in CY 2020, the majority of whom were between the ages of 18 and 64 (83 percent). The total penetration rate of 1.09 percent was on par with the statewide and large counties averages.

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

Contra Costa				Large Counties	Statewide
Age Groups	**Average # of Eligibles per Month**	**# of Beneficiaries Served**	**Penetration Rate**	**Penetration Rate**	**Penetration Rate**
Ages 12-17	31,290	99	0.32%	0.26%	0.25%
Ages 18-64	148,129	1,872	1.26%	1.44%	1.26%
Ages 65+	28,769	298	1.04%	0.90%	0.77%
TOTAL	**208,188**	**2,269**	**1.09%**	**1.18%**	**1.03%**

Table 3 shows the penetration rates by race/ethnicity compared to counties of like size and statewide rates. Latino/Hispanics are the largest beneficiary group in Contra Costa, but they were under-represented in the use of DMC-ODS services in CY 2020.

The Latino/Hispanic group's penetration rate of 0.46 percent was lower than the statewide and Large Counties averages of 0.69 percent and 0.76 percent, respectively.

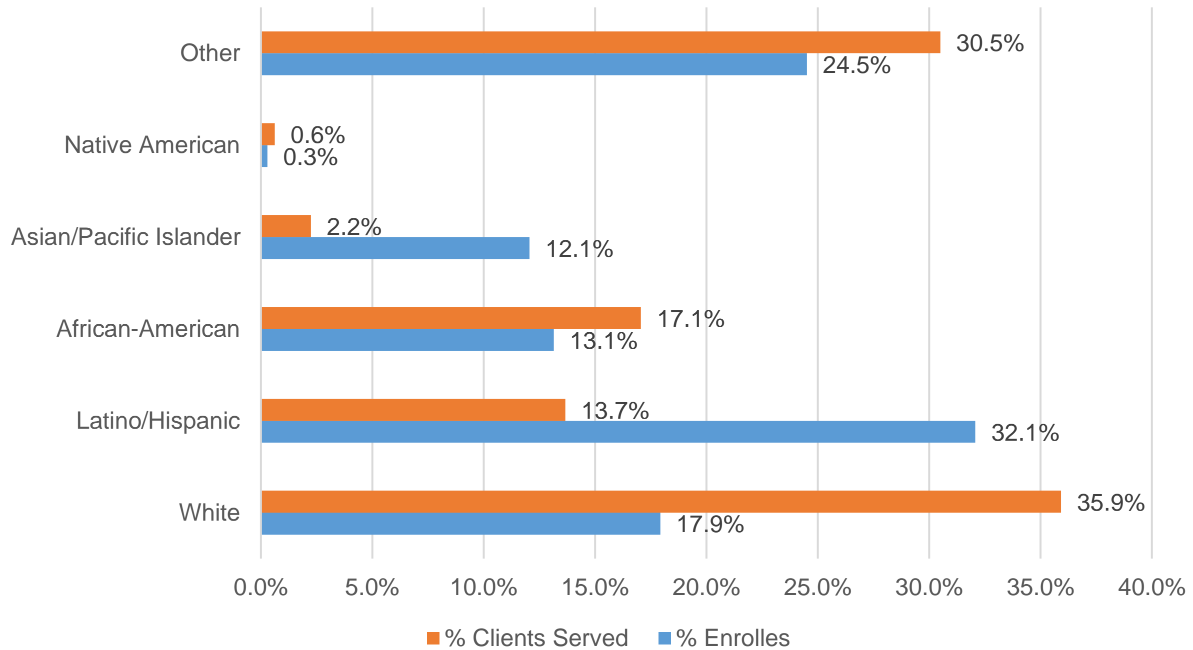
Table 3: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Race/Ethnicity, CY 2020

Contra Costa				Large Counties	Statewide
Race/Ethnicity Groups	**Average # of Eligibles per Month**	**# of Clients Served**	**Penetration Rate**	**Penetration Rate**	**Penetration Rate**
White	37,323	815	2.18%	2.34%	1.96%
Latino/Hispanic	66,772	310	0.46%	0.76%	0.69%
African-American	27,366	387	1.41%	1.53%	1.34%
Asian/Pacific Islander	25,096	51	0.20%	0.17%	0.17%
Native American	598	14	2.34%	2.77%	1.84%
Other	51,034	692	1.36%	1.58%	1.41%
TOTAL	**208,189**	**2,269**	**1.09%**	**1.18%**	**1.03%**

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

In Contra Costa, 32.1 percent of eligible beneficiaries are Latino/Hispanic, but they only received 13.7 percent of DMC-ODS services in CY 2020. 17.9 percent of eligible beneficiaries are White, but this group received 35.9 percent of DMC-ODS services.

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



Penetration Rates and Approved Claim Dollars by Eligibility Category

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.

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

Table 4 shows Contra Costa's penetration rates by DMC eligibility categories. The rates are compared with statewide averages for all actively implemented DMC-ODS counties. Contra Costa clients are mostly eligible for services through ACA (49.4 percent) or having a disability (25.6 percent). The disabled group's penetration rate of 2.4 percent was higher than the statewide average of 1.8 percent.

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

Contra Costa				Statewide
Eligibility Categories	**Average Number of Eligibles per Month**	**Number of Beneficiaries Served**	**Penetration Rate**	**Penetration Rate**
Disabled	25,080	600	2.4%	1.8%
Foster Care	597	12	2.0%	2.3%
Other Child	18,940	65	0.3%	0.3%
Family Adult	40,860	437	1.1%	1.1%
Other Adult	31,682	42	0.1%	0.1%
MCHIP	13,201	28	0.2%	0.2%
ACA	77,678	1,158	1.5%	1.6%

Table 5 shows Contra Costa’s approved claims by DMC eligibility categories. The claims are compared with statewide averages for all actively implemented DMC-ODS counties. Contra Costa’s average approved claims were higher across all eligibility groups.

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

Contra Costa				Statewide
Eligibility Categories	**Average Number of Eligibles per Month**	**Number of Beneficiaries Served**	**Average Approved Claims**	**Average Approved Claims**
Disabled	25,080	600	$5,331	$4,559
Foster Care	597	12	$2,267	$2,037
Other Child	18,940	65	$3,243	$2,492
Family Adult	40,860	437	$5,630	$4,231
Other Adult	31,682	42	$4,676	$3,386
MCHIP	13,201	28	$2,860	$2,748
ACA	77,678	1,158	$6,518	$5,131

Table 6 tracks the initial DMC-ODS service used by clients to determine how they first accessed services and shows the diversity of the continuum of care. Most Contra Costa clients enter the DMC-ODS through NTP/OTP services (48.4 percent) and residential treatment (23.6 percent).

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

DMC-ODS Service Modality	Contra Costa		Statewide	
	#	%	#	%
Outpatient treatment	394	17.3%	33,885	33.1%
Intensive outpatient treatment	179	7.9%	2,679	2.6%
NTP/OTP	1,101	48.4%	40,908	40.0%
Non-methadone MAT	-	0.0%	291	0.3%
Ambulatory Withdrawal	-	0.0%	22	0.02%
Partial hospitalization	-	0.0%	23	0.02%
Residential treatment	536	23.6%	16,620	16.3%
Withdrawal management	63	2.8%	6,790	6.6%
Recovery Support Services	-	0.0%	1,006	1.0%
TOTAL	**2,273**	**100.0%**	**102,224**	**100.0%**

Table 7 shows the percentage of clients served and the average approved claims by service categories. This table provides a summary of DMC-ODS service usage by clients in CY 2020. Most Contra Costa clients received NTP services (40.3 percent) and residential treatment (22.4 percent). Only one percent of clients received non-methadone MAT services from DMC-ODS providers, but Contra Costa's FQHC-based Choosing Change program offers buprenorphine to clients outside of the DMC-ODS.

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

Service Categories	Contra Costa % Served	Statewide % Served	Contra Costa Average Approved Claims	Statewide Average Approved Claims
Narcotic Tx. Program	40.3%	30.7%	$3,866	$4,097
Residential Treatment	22.4%	17.5%	$11,246	$8,846
Res. Withdrawal Mgmt.	3.7%	6.8%	$1,408	$2,057
Ambulatory Withdrawal Mgmt.	0.0%	0.0%	$0	$654
Non-Methadone MAT	1.0%	5.2%	$952	$1,093
Recovery Support Services	0.4%	2.7%	$930	$1,521

Service Categories	Contra Costa % Served	Statewide % Served	Contra Costa Average Approved Claims	Statewide Average Approved Claims
Partial Hospitalization	0.0%	0.0%	$0	$1,926
Intensive Outpatient Tx.	12.6%	6.4%	$3,404	$966
Outpatient Services	19.6%	30.6%	$2,539	$2,037
TOTAL	**100.0%**	**100.0%**	**$6,047**	**$4,894**

IMPACT OF FINDINGS

Latino/Hispanics are the largest beneficiary group but under-represented in the use of DMC-ODS services. This group would benefit from enhanced outreach and engagement efforts.

Most Contra Costa clients receive DMC-ODS services through ACA or disability. The high rate of disabled clients in the DMC-ODS compared to statewide suggests the need for close coordination with physical health and mental health care services, which Contra Costa does do.

Most clients' initial DMC-ODS service is NTP/OTP. On an ongoing basis, 48 percent of clients use NTP services, 24 percent use residential treatment, and 17 percent use outpatient treatment.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is a vital component of engagement, retention, and the ability to achieve desired outcomes. Studies have shown that the longer it takes to engage in treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system, including initial, routine, and urgent services. To successfully provide timely access to treatment, the DMC-ODS must have the infrastructure to track the timeliness and a rapid process to review the metrics regularly by LOC and site. Counties then need to adjust their service delivery system to ensure that standards are being met. CalEQRO uses a number of indicators for tracking, and trending timeliness, including the Key Components and PMs, addressed below.

TIMELINESS IN CONTRA COSTA COUNTY

The DMC-ODS reported timeliness data in aggregate. Further, timeliness data presented to CalEQRO represented both county and county-operated services since most of the services (over 95 percent) are contract-provided in Contra Costa County. In some LOCs, there are some challenges with data collections which shall be described because there is no EHR for the DMC-ODS system, and the only contractors with a system are the methadone providers who use Methasoft.

The development of a systemwide EHR has been a challenge for Contra Costa County for the last eight years, including the time period when Mental Health began managed care services. Now, Contra Costa has made a decision they can no longer rely on the current system for future billing and support for DMC-ODS. This will be discussed in more depth in the information systems sections of the report, but it will have implications for the potential improvement in the future for their ability to improve timeliness reporting. The system is currently manual data entry from multiple contract providers (who provide the source data to the county for initial requests and first billable services), as well as “no shows.” All these key indicators are done in such a way that timely data availability is not a possibility, and accuracy can be compromised. In addition, the ability to make corrections to problem areas is more challenging with these more manual systems.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics

helps the DMC-ODS identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

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

Table 8: Key Component – Timeliness

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

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

- Contra Costa offers first appointments within 7.8 days on average for routine appointments for all levels of care except NTP/OTP, which is within 1 day.
- Contra Costa is working to improve timeliness of data entry of their first face to face contact information which are billable services so that programs know the actual timeliness data in a prompter manner. The measure being tracked here is from request to first clinical service.
- Contra Costa needs to be sure all requests for a clinical service answered by clerical staff when Access clinicians are busy are returned to resolve their requests especially if they are urgent and are tracked for their timeliness.
- Contra Costa with its Transition Team case management has better timeliness and success with transition from one LOC to the next LOC than the statewide average.

PERFORMANCE MEASURES

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

- First Non-urgent Appointment Offered
- First Non-urgent Appointment Rendered
- Non-Urgent MAT Request to First NTP/OTP Appointment
- Urgent Services Offered
- Average Days for Follow-up Post-Residential Treatment
- Withdrawal Management (WM) Readmission Rates Within 30-Days
- No-Shows

In preparation for the EQR, DMC-ODSs complete and submit the Assessment of Timely Access form to identify DMC performance across several key timeliness metrics for a specified time period. For the FY 2021-22 EQR, the DMC-ODS reported its performance for FY 2020-21. Utilizing approved claims data, CalEQRO analyzes DMC performance on withdrawal management readmission and follow-up after residential treatment.

Contra Costa reported a moderate to low rate of meeting timeliness standard in First Non-Urgent Appointment Offered (61 percent), First Non-Urgent Service Rendered (50 percent), Urgent Services Offered (33.4 percent), and 7-Days Follow-up Post-Residential Treatment (14.4 percent).

Due to data entry issues, Contra Costa's Assessment of Timely Access data for FY 2020-21 is incomplete.

Table 9: FY 2021-22 DMC Assessment of Timely Access

FY 2021-22 DMC Assessment of Timely Access			
Timeliness Measure	Average	Standard[2]	% That Meet Standard
First Non-Urgent Appointment Offered	7.8 Days	10-Business Days	61%
First Non-Urgent Service Rendered	8.39 Days	10-Business Days	50%
Non-Urgent MAT Request to First NTP/OTP Appointment	1 Day	3-Business Days	100%
Urgent Services Offered	15.3 Hours	48-Hours	33.4%
Average Days for Follow-up Post-Residential Treatment	9.9 Days	7-Days	14.4%
WM Readmission Rates Within 30 Days	N/A	30-Days	8.27%
No-Shows	16.07%	N/A	N/A

Medi-Cal Claims Data

The following data represents DMC-ODS performance related to methadone access and follow-up post-residential discharge, as reflected in the CY 2020 claims.

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

On average, Contra Costa clients receive their first dose of methadone within a day after completing the assessment, which is similar to the statewide experience. The methadone programs operate daily and accept new referrals daily.

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

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

	Contra Costa			Statewide		
Age Groups	**Clients**	**%**	**Avg. Days**	**Clients**	**%**	**Avg. Days**
Ages 12-17	-	0.00%	n/a	*	n/a	n/a
Ages 18-64	836	78.2%	<1	33,027	80.4%	<1
Ages 65+	233	21.8%	<1	*	n/a	n/a
TOTAL	**1,069**	**100.0%**	**<1**	**41,093**	**100.0%**	**<1**

Transitions in Care

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

In CY 2020, 6.04 percent of Contra Costa clients had a care transition within seven days following residential treatment, which is a lower rate than the statewide experience. However, 24.65 percent of clients had a transition admission following residential treatment if day parameters are not considered, which is a slightly higher rate than the State average of 20.31 percent.

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

	Contra Costa (n= 1,059)		Statewide (n= 49,799)	
Number of Days	**Transition Admits**	**Cumulative %**	**Transition Admits**	**Cumulative %**
Within 7 Days	64	6.04%	3,757	7.54%
Within 14 Days	105	9.92%	5,160	10.36%
Within 30 Days	151	14.26%	6,422	12.90%
Any days (TOTAL)	**261**	**24.65%**	**10,112**	**20.31%**

Residential Withdrawal Management Readmissions

Table 12 measures the number and percentage of residential withdrawal management readmissions within 30-days of discharge. Of 130 Contra Costa clients admitted into residential WM, 14.6 percent were readmitted within 30-days of the discharge compared to the 11.1 percent statewide average for all DMC-ODS counties.

Table 12: Residential Withdrawal Management Readmissions, CY 2020

	Contra Costa		Statewide	
Total DMC-ODS admissions into WM	130		11,647	
	#	%	#	%
WM readmissions within 30-days of discharge	19	14.6%	1,291	11.1%

IMPACT OF FINDINGS

Due to many issues involved with the COVID19 pandemic, Contra Costa experienced multiple delays in timely access to care. The County has attempted to offer interim services while prospective clients wait for admission as a short-term solution.

Contra Costa is in the process of completing entry of FY 2020-21 timeliness data, but preliminary data reflect challenges in meeting most performance standards.

Contra Costa's rates of care transition following residential treatment within 7-days (6.04 percent), 14-days (9.92 percent), or 30-days (14.26 percent) were lower than statewide averages (7.54 percent, 10.36 percent, 12.9 percent, respectively) in CY 2020.

Contra Costa also had a higher residential WM readmission rate within 30-days of discharge when compared to the statewide average.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Interventions for performance improvement.

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

QUALITY IN CONTRA COSTA COUNTY

In the DMC-ODS, the responsibility for Quality Improvement is the responsibility of the QI committee, which includes both an MH and an AODS component which includes specific goals and objectives and does an annual evaluation of those goals as well as a prevention plan related to its federal block grant requirements. There is also a cultural competence plan which was recently updated, and specific requirements. There are four SUD QI staff for core functions, review of programs, evaluation, analytics, PIPs, and technical support of programs. In addition, contract providers also have quality improvement staff and functions related to the Medi-Cal requirements related to training, charting, billing, and quality improvement activities.

The DMC-ODS monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Assessment and Performance Improvement (QAPI) work plan, and the annual evaluation of the QAPI work plan. The QIC, comprised of managers, clinical supervisors, analysts, key contractors, SUD counselors with lived experience, and support staff, is scheduled to meet monthly except for two holiday months or in an emergency. Since the previous EQR, the DMC-ODS QIC met ten times. Of the 27 identified FY 2020-21 QAPI work plan goals, the DMC-ODS met or saw improvements on 74 percent of the goals in the plan.

QUALITY KEY COMPONENTS

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

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

Table 13: Key Component – Quality

KC #	Key Component - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from DMC-ODS Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of an ASAM Continuum of Care	Met
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	Met
3F	ASAM Training and Fidelity to Core Principles is Evident in Programs within the Continuum of Care	Met
3G	Measures Clinical and/or Functional Outcomes of Clients Served	Met
3H	Utilizes Information from Client Perception of Care Surveys to Improve Care	Partially Met

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

- Contra Costa transitions from one LOC to lower LOCs were better than the statewide average.

- Contra Costa's average on discharge ratings with clinical improvement on CalOMS was better than the statewide average.
- Contra Costa's TPS ratings were extremely high, predominately in the 90th percentiles for all but two categories: the high 80th percentiles, including coordination with mental health, which is rare.
- Contra Costa only had two youth complete the TPS, so participants should be improved this year for both youth and Latino clients to reflect their views.
- CalOMS administrative discharge rates, which mean clients left programs without notice was higher than statewide averages, need improvement as this compromises the quality of the data as there is no exit data possible.

PERFORMANCE MEASURES

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

- Beneficiaries served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment.
- High-Cost Beneficiaries (HCB): Because of the cost impacts of the COVID-19 pandemic, this data cannot be reliably interpreted. But Contra Costa has done an excellent job expanding case management and improving timely access for requests.
- ASAM congruence- UCLA data is used to ensure clients are matched to optimal care.
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS Discharge Status Ratings

Diagnosis Data

Table 14 compares the breakdown by diagnostic category of the Contra Costa, and a statewide number of beneficiaries served and total approved claims amount, respectively, for CY 2020. Contra Costa's leading substance use diagnoses were Opioid Use Disorder (53.5 percent), Other Stimulant Abuse (19.1 percent), and Alcohol Use Disorder (17.1 percent).

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

Diagnosis Codes	Contra Costa		Statewide	
	% Served	Average Cost	% Served	Average Cost
Alcohol Use Disorder	17.1%	$9,108	17.6%	$5,936
Cannabis Use	6.7%	$3,149	8.0%	$2,921
Cocaine Abuse or Dependence	2.2%	$8,192	1.8%	$5,769
Hallucinogen Dependence	0.1%	$10,218	0.2%	$6,112
Inhalant Abuse	0.0%	$4,576	0.0%	$8,581
Opioid	53.5%	$4,553	47.4%	$4,788
Other Stimulant Abuse	19.1%	$8,734	23.1%	$5,269
Other Psychoactive Substance	0%	$0	0.1%	$7,114
Sedative, Hypnotic Abuse	0.7%	$8,607	0.5%	$6,077
Other	0.5%	$3,772	1.2%	$2,923
Total	**100%**	**$6,148**	**100%**	**$4,962**

Table 15 shows the number and percentage of clients receiving three or more MAT visits through Contra Costa providers and statewide for all actively implemented DMC-ODS counties. In Contra Costa, most non-methadone MAT services are provided in FQHC clinics outside of the DMC-ODS.

Non-Methadone MAT Services

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

	Contra Costa				Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 12-17	-	0.0%	-	0.0%	*	n/a	*	n/a
Ages 18-64	27	1.4%	18	1.0%	6,698	7.6%	3,227	3.7%
Ages 65+	-	0.0%	-	0.0%	*	n/a	*	n/a
TOTAL	**27**	**1.2%**	**18**	**0.8%**	**7,146**	**7.0%**	**3,397**	**3.3%**

Residential Withdrawal Management with No Other Treatment

Contra Costa served 96 clients in residential WM in CY 2020, and 6.25 percent had three or more episodes with no other treatment. This rate is almost twice the statewide rate of 3.34 percent and suggests that residential WM programs should consider ways to improve how they engage clients in discharge planning and case management to improve the rate of follow-up care and reduce WM readmission rates.

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

	Contra Costa		Statewide	
	# WM Clients	% 3+ Episodes & no other services	# WM Clients	% 3+ Episodes & no other services
TOTAL	96	6.25%	8,824	3.34%

High-Cost Beneficiaries

8.95 percent of Contra Costa clients are considered high-cost based on CY 2020 claims data, which is higher than the statewide rate of 5.42 percent. 203 clients accounted for 34.15 percent of Contra Costa's total claims. This is more difficult to interpret due to rate impacts of COVID-19 on costs overall and particularly on residential treatment.

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

Contra Costa						
Age Groups	**Total Beneficiary Count**	**HCB Count**	**HCB % by Count**	**Average Approved Claims per HCB**	**HCB Total Claims**	**HCB % by Total Claims**
Ages12-17	99	0	0.00%	$0	$0	0.00%
Ages 18-64	1,872	192	10.26%	$23,107	$4,436,484	37.32%
Ages 65+	298	11	3.69%	$22,629	$248,919	16.38%
TOTAL	**2,269**	**203**	**8.95%**	**$23,081**	**$4,685,404**	**34.15%**

Table 18: High-Cost Beneficiaries by Age, Statewide, FY 2020-21

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

ASAM Level of Care Congruence

In CY 2020, Contra Costa showed good congruence between ASAM indicated LOC and referred LOC in initial screening (88.4 percent). Where there were differences, it was mainly due to patient preference. However, no data was available on the initial assessment or follow-up assessment. This showed effort at meeting client care needs in matching care to the assessment. Contra Costa said they did submit full assessment and follow-up assessment data to DHCS, but it was not available at the time of the report from DHCS.

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

Contra Costa ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
CY 2020	**#**	**%**	**#**	**%**	**#**	**%**
If assessment-indicated LOC differed from referral, then reason for difference						
Not Applicable - No Difference	957	**88.4%**	0	0.0%	0	0.0%
Patient Preference	92	8.5%	0	0.0%	0	0.0%
Level of Care Not Available	13	1.2%	0	0.0%	0	0.0%
Clinical Judgement	17	1.6%	0	0.0%	0	0.0%
Geographic Accessibility	0	0.0%	0	0.0%	0	0.0%
Family Responsibility	0	0.0%	0	0.0%	0	0.0%
Legal Issues	0	0.0%	0	0.0%	0	0.0%
Lack of Insurance/Payment Source	1	0.1%	0	0.0%	0	0.0%
Other	2	0.2%	0	0.0%	0	0.0%
Actual Level of Care Missing	0	0.0%	0	0.0%	0	0.0%
TOTAL	**1,082**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**

Initiation and Engagement

Contra Costa's adult and youth clients had good rates of initiating DMC-ODS services in CY 2020, at 93.5 and 79.8 percent, respectively.

Both adult and youth clients also had comparable rates of service engagement to statewide averages at 83.0 percent and 67.6 percent.

Adult rates were better than youth in both categories.

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

	Contra Costa				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Clients with an initial DMC-ODS service	2,184		89		98,320		3,904	
	#	%	#	%	#	%	#	%
Clients who then initiated DMC-ODS services	2,041	93.5%	71	79.8%	87,609	89.1%	3,179	81.4%
Clients who then engaged in DMC-ODS services	1,695	83.0%	48	67.6%	69,099	78.9%	2,230	70.1%

Length of Stay

Table 21 measures how long the system of care can retain clients in its DMC-ODS services and counts the cumulative time that clients were involved in all types of service they received sequentially without an interruption of more than 30-days.

The mean (average) length of stay for Contra Costa clients staying in treatment was 120 days (median 71-days), compared to the statewide mean of 142 (median 88-days). 42.07 percent of clients had at least a 90-day length of stay; 23.65 percent had at least a 180-day stay, and 13.42 percent had at least a 270-day length of stay.

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

	Contra Costa		Statewide	
Clients with a discharge anchor event	2,004		110,817	
LOS for clients across the sequence of all their DMC-ODS services	Mean (Average)	Median (50th percentile)	Mean (Average)	Median (50th percentile)
	120	71	142	88
	#	%	#	%
Clients with at least a 90-day LOS	843	42.07%	54,782	49.43%
Clients with at least a 180-day LOS	474	23.65%	32,644	29.46%
Clients with at least a 270-day LOS	269	13.42%	20,256	18.28%

CalOMS Discharge Ratings

Table 22 displays the rating options in the CalOMS discharge summary form counselors use to evaluate their clients' progress in treatment. The first four rating options are positive. The last four rating options indicate a lack of satisfactory progress for different reasons.

69.2 percent of Contra Costa clients had a positive discharge status in CY 2020, which was a higher rate than the statewide average of 49.9 percent, either completing treatment or leaving before treatment completion but with satisfactory progress.

Table 22: CalOMS Discharge Status Ratings, CY 2020

Discharge Status	Contra Costa		Statewide	
	#	%	#	%
Completed Treatment - Referred	676	31.0%	13,699	18.7%
Completed Treatment - Not Referred	0	0.0%	4,039	5.5%
Left Before Completion with Satisfactory Progress - Standard Questions	245	11.2%	12,675	17.3%
Left Before Completion with Satisfactory Progress – Administrative Questions	586	26.9%	6,059	8.3%
Subtotal	*1,507*	***69.2%***	*36,472*	***49.9%***
Left Before Completion with Unsatisfactory Progress - Standard Questions	53	2.54%	11,751	16.1%
Left Before Completion with Unsatisfactory Progress - Administrative	614	28.2%	24,233	33.1%
Death	1	0.05%	142	0.2%
Incarceration	2	0.1%	551	0.7%
Subtotal	*670*	*30.8%*	*36,677*	*50.1%*
TOTAL	**2,177**	**100.00%**	**73,149**	**100.00%**

IMPACT OF FINDINGS

Over 50 percent of Contra Costa clients served have a diagnosis of an opioid use disorder, and most non-methadone MAT services are provided in FQHC clinics outside of the DMC-ODS. Based on data provided by clinics, over 800 clients had obtained

MAT at the FQHC clinics. Access call center staff routinely route requests for non-methadone MAT to FQHC partners.

Contra Costa's Access Line staff use the ASAM LOC criteria for client screening and referral and enter the information in ccLink, the county's EHR. Client LOC assessments are done by providers during intake appointments. The assessment forms are then faxed to AODS for manual data entry into ccLink to support ASAM LOC State reporting. For reasons unknown, ASAM indicated and referred LOC initial and follow-up assessments data are not available for CY 2020.

Contra Costa has a higher percentage of clients who received more than three episodes of residential WM but with no other treatment. This finding is related to the higher rate of readmissions within 30-days of discharge reported in a previous table. These findings suggest room for improvements in how residential WM programs engage their clients in discharge planning and follow-up case management to connect with new services.

PM results indicate that Contra Costa's System of Care (SOC) is effective—more than the statewide average in initiating and engaging clients once they have begun treatment. These findings support Contra Costa clients' positive outcomes as indicated by provider CalOMS discharge ratings. However, clients' retention in treatment as measured by the length of stay is slightly below the statewide average. CalOMS data can be improved by reducing administrative discharges which are higher than the state averages.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

Each DMC-ODS is required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's quality assessment and performance improvement (QAPI) program, per 42 CFR §§ 438.330 and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create improvement at a member, provider, and/or DMC system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Transition Team Case Management

Date Started: 03/2020

Aim Statement:

a. Will providing intensive CM to persons requesting SUD services who have to wait three or more days for an intake appointment improve successful enrollment by ten percent over baseline?
b. Will providing intensive CM to persons transitioning between one LOC to a lower LOC increase the percentage of successful transitions by ten percent compared to those who do not get support (over baseline)?

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

Target Population: This PIP focused on two populations over its two years using intensive case management engagement and treatment services, first adults waiting three or more days for an access appointment to get into treatment, and the second group was those adult clients who needed assistance to transition to a lower LOC from residential treatment or residential WM usually to outpatient, MAT, recovery support, case management or a combination. Both populations had data indicating problems with engagement in treatment, and barriers to successful access and transitions, indicating a need for a more robust support system to help them enter care and link to care, taking down barriers, and retention in that care.

Validation Information: The DMC-ODS's clinical PIP is in the second measurement phase and considered a high confidence level.

Summary

This PIP identified problems with initial engagement after clients requested services and the need for more support for clients to come to their first appointment and be retained in care. This was identified during the onset of COVID-19. The profile of many of these clients showed risk factors such as co-occurring disorders, often homeless, health complications, fear of the outbreak, and additional complications. Since they were requesting services from Access, a team of case managers was linked to Access and assigned to provide intensive support to remove barriers and assist clients with treatment access and engagement. Services included providing counseling, motivational interviewing, testing if needed, or other supports. Many clients were contacted daily and had long visits or calls with their case managers averaging 40-50 minutes to consider their needs and issues creating barriers to entering SUD treatment. This rich level of support resulted in a significant increase in successful treatment engagement and retention in services with this group of clients requesting care, compared to those who did not get support or refused support.

In the second year of this PIP, the team expanded this type of CM intervention to clients needing help transitioning from a higher to a lower LOCs and making a therapeutic alliance with a new provider and remaining stable in this transition. This same intensive daily support approach was utilized during and for a period after the transition to the new LOCs. Again, the effort of the intervention was a significant increase in retention in the new LOC compared to those who did not have these supportive services. The staff documented the number and type of contacts to make replication possible for others who would do this job or other counties that might attempt to replicate this service.

TA and Recommendations

As submitted, this clinical PIP was found to have a high confidence level because the design and the data collection were consistent. There did not appear to be outside factors influencing the outcomes. The clients who have SUD often need these intensive services to navigate these complex systems and stay motivated when barriers to access arise. Clients with SUD are easily discouraged and often ambivalent about care in terms of the lifestyle changes needed, and so without an advocate, mentor, and support with regular contact, engagement and retention can be lost. Thus, this approach is proving remarkably successful, particularly for dual diagnosis clients and homeless clients who often have fewer support resources and coping skills than most clients to cope with frustrations in the treatment start-up process.

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

- Regular contact to discuss the progress of the case management team and documentation needed of the techniques they were using in their interventions, billing issues or opportunities, unique roles of specialty CM such as perinatal.
- Research related to case management billing issues for various team members and whether these would interfere or be possible to do and still bill for services.
- Documentation of the profiles of clients served.
- How PIP design and success might be applied to youth and other populations needing to be addressed, which had challenges with outreach and engagement.

CalEQRO recommendations for improvement of this clinical PIP include:

- Clarification and documentation of some of the unique case management activities of the perinatal case manager and the criminal justice-oriented case manager, and the individual who worked more with those who were requesting help from the hospital emergency department, so these issues were documented.
- Develop a model that might apply to supporting youth coming into the system who need similar encouragement and supports. Youth do not usually request the SUD often are directed by school counselors, parents, courts, but still, they need support and encouragement.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improvement in MAT Treatment for Alcohol Use Disorders (AUD)

Aim Statement:

a. Will MAT access for AUD clients increase from 17.4 percent to 22.4 percent in FY 2021-22 with the structured training of SUD counselors and education of clients on the benefits of AUD MAT treatment options and opportunities for access to care interventions? Phase one is training for counselors/line staff, and phase two is client education and empowerment/training on choices and benefits for AUD treatment. Education related to symptoms/ side-effects of withdrawal, health benefits, and recovery with the goal of a 28.74 percent increase if 22.4 percent of the clients can receive the MAT medications.
b. Potential phase three of this PIP is intensive engagement with prescribing clinicians, clinics, and pharmacists as needed with supports related to increased access or other interventions (will evaluate as needed).

Target Population: Adult clients with a primary or secondary diagnosis of AUD

Validation Information: The DMC-ODS's non-clinical PIP is in the Implementation Phase and is considered as Moderate Confidence Status.

Summary

After completing a data review and finding only 2.4 percent of 1152 clients with AUD in FY 2019-20 had any experience with MAT treatments for AUD despite the benefits of MAT for AUD, Contra Costa leadership conducted a survey of staff and clients to identify potential reasons for this low utilization of MAT. The results indicated a low understanding of the benefits of MAT. Many believed that the clients did not need or would not benefit from MAT treatment. Based on this survey, it was decided that some intensive training and education for both staff, clients, and the public was needed to educate them as to the potential health benefits of these medications related to withdrawal symptoms, cravings that help clients sustain their recovery, and reduce their desire for alcohol, and the damage that alcohol takes on their body which can be avoided with reduced use. Also, some of the medications that can help stabilize brain chemistry and improve mental health coming out of withdrawal.

Outcome studies are clear that MAT can make a significant difference in sustained recovery from AUD and severe damage to the body and help with successful treatment. MAT is an entitlement and part of the treatment that each patient has the right to receive under the Medi-Cal program. Clients need to know the benefits and risks of all the treatments. So, the PIP design starts with an intervention of required basic AUD training of the counseling staff who do initial assessments into the programs and need to be identifying AUD and offering MAT service as one of many options to clients with AUD.

Clients have the right to know this treatment is available to them as part of their care package and have many benefits for their health and wellness. Thus, the PIP will also make available sessions to clients. Also, literature and videos should be available to provide education and information to clients so they can easily access MAT as part of their care and have prescribers available and counselors.

Finally, it is also important to make access easy to have engagement and coordination of the pharmacy and prescribing staff available as needed to the treatment programs in this multi-pronged approach to support choice and empowerment of clients with the best science and treatments for their AUD.

It is anticipated this will be a two to three-year PIP in total to completely shift the system to make all these elements align, including with the primary care clinics and psychiatry, as well as change staff attitudes against medications which seem to still exist in some of the community volunteer organizations and line SUD staff.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because the design is in compliance with guidelines and a solid research foundation was done with the baseline survey, and a curriculum was developed on AUD, which can be used with staff at all the DMC programs beginning with the residential programs and working through all LOCs. All of these will be documented with required training, literature for clients and options for referral to outpatient medication, and discussion in WM of how to access medicines as part of treatment to make the process less complicated. The method for measuring the success of the PIP Is to see an increase in the percentage of clients being prescribed MAT for AUD, either naloxone in some form, Vivitrol, gabapentin, acamprosate, or any FDA approved medication. This will be tracked in a new pharmacy report available monthly to see if the percentage increase to the goal at the end of the first year of training. It will be tracked by program referring, prescriber, etc. Pharmacy data is available to the administration through health plans for Medi-Cal clients.

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

- Linkage to other PIPs and programs working specifically with AUD MAT expansion projects with their EDs, primary care, and DMC-ODS programs.
- Linkage to MAT expansion materials and trainings on AUD MAT.
- Linkage to SAMHSA materials on AUD treatment and MAT, and ED Bridge consultation on AUD clinical issues.
- Refinement of goals and PMs for the PIPs to be more realistic for first year based on experience of other counties.

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

- More focus on clients and peers presenting to peers on MAT experience.
- Support for non-AA support groups for those on MAT as part of treatment process.
- Requirement of MAT literature at all sites and as part of the intake treatment process for those with opioid or alcohol diagnosis
- More regular data feedback loops on prescribing patterns to track engagement and success of trainings.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN CONTRA COSTA COUNTY

California DMC-ODS EHRs fall into two main categories: those managed by the county IT staff and those operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. Currently, the DMC-ODS does not have an EHR and uses ShareCare as its practice management system. Contra Costa has released an RFI to solicit vendor solutions for a DMC-ODS EHR.

Approximately five percent of the DMC-ODS budget is dedicated to supporting the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving DMC-ODS control and another county department. The IT budget for FY 2020-21 was also five percent.

The DMC has 79 named users with log-on authority to ccLink, the EHR for Contra Costa Health Services (CCHS), including 31 county-operated staff and 48 contractor-operated staff. There is no SUD data in ccLink, but users could view physical health and mental health data of DMC-ODS clients who are associated with CCHS. Support for the users is provided by five full-time equivalents (FTE) IS technology positions that also support Mental Health services. Currently, only one position is unfilled.

As of the FY 2021-22 EQR, no contract providers have access to directly enter data into ccLink due to 42 CFR Part 2 concerns. Line staff have direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the DMC-ODS IS as reported in the following table:

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

	Submittal Method	Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between DMC IS	☐ Real Time ☐ Batch	%
☐	Electronic Data Interchange (EDI) to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	%
☒	Electronic batch file transfer to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	15%
☒	Direct data entry into DMC IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	70%
☒	Documents/files e-mailed or faxed to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	10%
☒	Paper documents delivered to DMC IS	☐ Daily ☐ Weekly ☐ Monthly	5%
			100%

Beneficiary Personal Health Record

- The 21st Century Cures Act (Cures Act) of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. All DMC-ODS clients who are linked to CCHS have access to MyChart, an online patient portal in ccLink.

Interoperability Support

The DMC is not a member or participant in an HIE. Healthcare professional staff use secure email, RightFax, and the use of secure folders to share information with contract providers.

IS KEY COMPONENTS

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

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

Table 24: Key Component – IS Infrastructure

KC #	Key Component – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Not Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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

- Elements of the ASI were combined with the county's ASAM LOC assessment form, and the ASI was officially retired after July 1, 2021. This has eased the paperwork burden placed on contract providers to complete the ASAM assessment and ASI forms.
- A Face Sheet that highlights SUD treatment episodes a client has received in the DMC-ODS along with demographics and insurance information was created and released to contract providers in January 2021.
- A SUD Data Quality Workgroup with strong contract provider participation meets regularly to promote the use of data in QA work.
- Contra Costa does not have an EHR. Clinical documentation such as progress notes and treatment plans are kept in paper charts.
- Tools needed to measure many aspects of the DMC-ODS performance, such as client progress through treatment or their transition through the continuum of care, are either lacking or require workarounds.

IMPACT OF FINDINGS:

Ninety-seven percent of DMC-ODS services in Contra Costa are provided by community-based organizations (CBOs). However, the DMC-ODS' programs charts of record are paper.

CBOs enter client admissions, service encounters, and CalOMS data directly in a practice management system. This often means double data entry of the same data in the agency's information system as well as the county system.

CBOs are required to submit a number of paper forms/reports to AODS via secure email or fax, and information from these forms is entered manually into the CCHS EHR for analyses and reporting. These workflow processes are error-prone, inefficient, and a burden to CBOs.

In the absence of an EHR, Contra Costa relies on reports produced from a number of disparate systems/databases to monitor capacity, measure performance, and identify service needs.

VALIDATION OF CLIENT PERCEPTIONS OF CARE

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

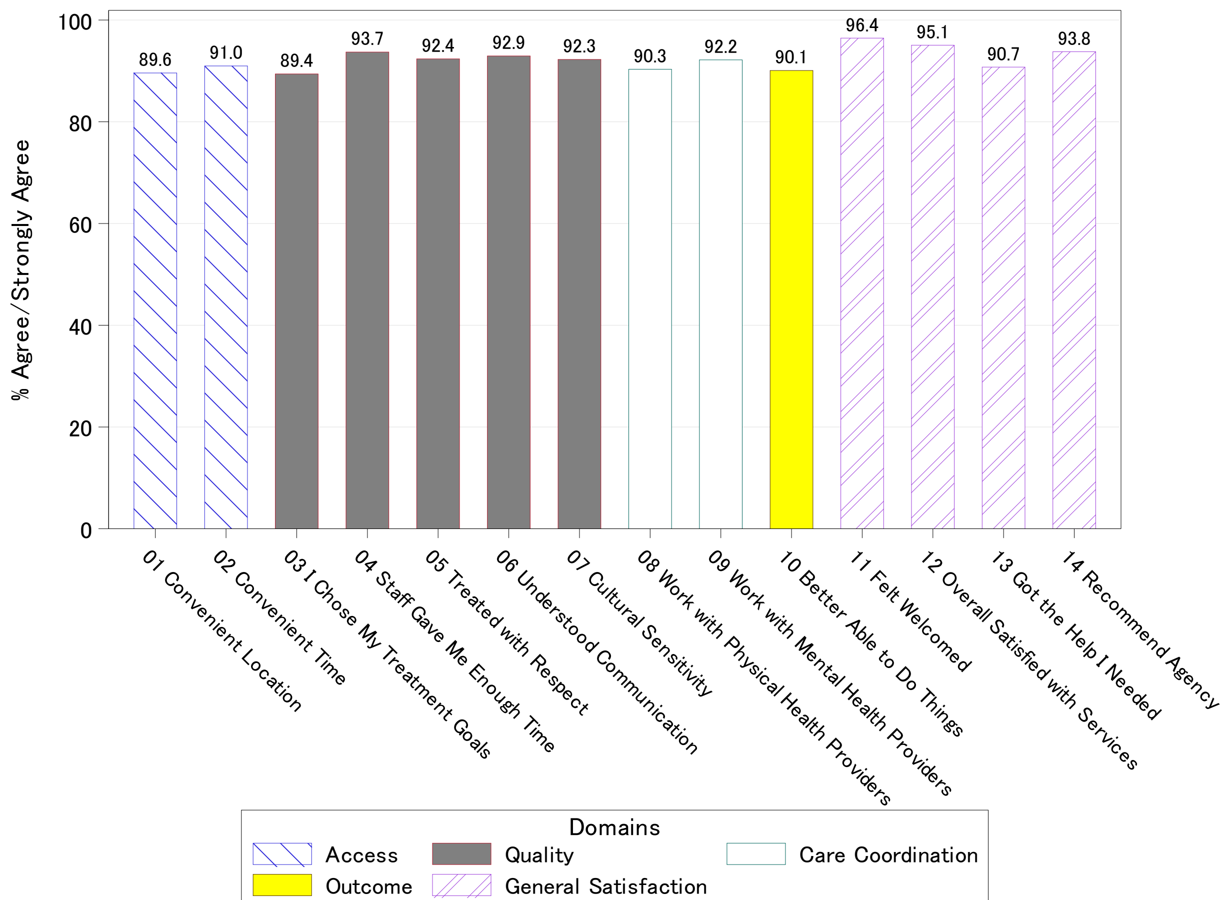
TREATMENT PERCEPTION SURVEY

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

Contra Costa clients rated most TPS questions positively, and high scores were noted across all five domains. TPS results were discussed at a Contra Costa SOC meeting in March 2021 and shared with each provider.

There is not a youth version because there were not enough youth surveys completed to provide a valid sample.

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



CONSUMER FAMILY MEMBER FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with adult clients, containing an average of 6-9 participants each.

CONSUMER FOCUS GROUP ONE

CalEQRO requested a diverse adult outpatient group from a variety of outpatient programs. The focus group was held by telehealth video and included four participants. All clients were currently participating in clinical services from the DMC-ODS outpatient programs. All were in the 25 to 59-year-old age group and spoke English. The group included one African American woman, two Caucasian women, and one Caucasian man. All had begun treatment in the past year. Three had begun treatment in residential and then transferred to outpatient services. The waiting time for two of the clients was approximately one month between the two LOCs, and the third person got in right away. The other individual went directly into outpatient after two weeks wait with case management and outpatient support in the interim by the Transition Team.

Participants were first facilitated through a group process, and discussion was encouraged. The facilitators further explained that the goal of the session is to understand the clients' experiences and generate recommendations for improving the care experience.

Participants described their experience as the following:

Clients found the program topics helpful and relevant and the counselors responsive. They said going on to outpatient was important to their recovery and staying clean and sober as they went back into the community. One client commented, "If I had not had outpatient and the support, I would have been drinking again by now." Another client reported, "They are my lifeline…following the directions they give me is critical, and now I have a more balanced life with meaning today."

Recommendations from focus group participants included:

- Counselors are awesome, and they have a lot of cases. It would be great if they had more time for each person.
- Individual mental health counseling is also needed at the programs and SUD treatment to work more on depression, anxiety, and relationship issues.
- Better medication monitoring at residential treatment is needed per clients who went through residential treatment. It was reported that a few clients are hiding medications and trading them, and it was frightening when they were supposed to be clean and sober. Counselors were not making sure the clients had taken the medications they were given.
- We need more help getting housing and jobs as part of the recovery process - for safe and affordable housing. The clean and sober housing here is too expensive, up to $1000 for a shared bedroom. We need more housing for families with children too. We need to be able to be with our children.

CONSUMER FAMILY MEMBER FOCUS GROUP TWO

CalEQRO conducted a women's perinatal residential group with ten clients (DMC-ODS beneficiaries) in active treatment. The focus group was a telehealth video conference in English. One client was bilingual, with Spanish as her primary language. She participated and said she understood the questions and information and responded to questions posed by the facilitator. There were three African American women, two Latinx, and five Caucasian women. Various lengths of time were reported for admission to the residential program. Three entered quickly after calling the Access Center. One was "picked up by someone" and after her COVID-19 test was admitted. Two reported two weeks for admission. Two reported rapid entry after WM from alcohol poisoning. One came from Drug Court and noted it was quick once the court process had occurred. Three transferred from jail after one, three, and four weeks, respectively.

Summary of perinatal residential group findings:

All clients reported that the program was helping them function better and cope with their cravings and the stress of their addictions and also traumas that led them to use. One client remarked, "I am also learning how to be a better parent; learning reMoming is important." The counselors bring new activities into the treatment that makes learning more exciting and fun. Several clients said, "Counselors here pay attention to us, ask how we are doing, notice when we are stressed and feeling bad, and get to know us as people and don't judge us." Another critical view shared was that the counselors had been where they were and understood the difficulties of their journey and were easy to relate to and gave solid advice. Others said they were welcomed back even if they had

been discharged if they had a difficult day or were struggling. “These people care about us and want us to make it. Staff are solid therapeutic partners and are there for us”.

Recommendations from focus group participants included:

- It would be helpful to have some mental health help as well as SUD counseling. We have those needs as well, and they can make a difference. Anxiety and depression, and other things are part of why we began using.
- We need regular childcare so we can go to the group without having to have our children present. There is not always childcare during group time.
- We did not get information on MAT and had to ask about it or how to get help with transportation to participate or continue participating in it. It is essential too.
- It would be helpful to have more creative activities in the program like art and music and journaling to make it more personal and individual.
- More materials in Spanish from the entry and throughout the program are needed.
- Help early and often to plan on housing transitions since housing for moms with children is so hard to find. I do not want to go back to the streets.

IMPACT OF FINDINGS

The programs are having positive impacts on beneficiaries and particularly the counseling staff. There are some needs for MH support as well as SUD support, and while some may be mild and moderate, it would be good to examine how many may also have histories or cases with the public mental health system as well for more intensive needs. As many as 30 percent in some counties do have records in the public mental health system with more serious needs.

Highlights of strengths and challenges for improving client input into the care process and experience included:

- TPS surveys were incredibly low for youth and Latino clients this year, making it difficult to determine their satisfaction, and it is important to make an effort to make youth and Latino participation in the TPS survey process a priority this year.
- Ratings on TPS of clients who completed the survey were in the 90th percentile except for participation in treatment plans and having a convenient location.

These two areas may be worth focusing on, particularly in additional focus groups or surveys or identifying if this is an issue for specific programs or sites.

- Clients report little or no information readily available to them at treatment admission regarding the potential benefits of MAT and a high level of stigma in the community groups against clients who use MAT. Having literature in public and at all access points and in programs on the potential benefits of MAT would be beneficial. It would be good to ensure training their staff to readily provide this information to clients at admission for those with opioid or alcohol disorders, or in general to reduce the general belief that MAT is not part of legitimate treatment.
- Child supervision is a requirement of all Perinatal programs, and this should be a program performance issue for all the perinatal contractors. Children were in the group because there was no childcare.

REPORT CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the Contra Costa DMC-ODS's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for quality improvement. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective DMC-ODS managed care system.

STRENGTHS

1. Contra Costa was able to expand access in numbers of unduplicated clients served, added a new youth provider who provides outpatient services, including MAT in a remote area of the county, and reduced the number of zip codes with NA challenges from three to one by adding new services.
2. Contra Costa, in a time with limited staff resources due to COVID-19, developed and was awarded two important grants to expand services. One to youth in Antioch bridging prevention and treatment services. This is another remote area of the county with service challenges. Also, they received a large grant for SUD treatment and discharge planning staff within the detention medical services program to link persons with SUD to treatment within the institution, but also in transitions into the ASAM continuum of care, including to recovery residence programs such as Oxford house which is an EBP. This showed a strong commitment to expanding access to these vulnerable populations.
3. To maintain the health and safety of staff and clients and timely access to care, Contra Costa AOD in partnership with Public Health, instituted hands-on interventions for all treatment and support staff in the DMC-ODS and clients. These included scheduling rapid vaccine access, ongoing COVID-19 and TB testing access, sending nursing staff to vaccinate clients and staff onsite when needed, as well as providing quick testing kits for all residential programs. Rapid tests allowed residential programs to test daily to avoid outbreaks of staff and residents. They also have provided personal protective equipment (PPE), remote training technology resources and are now planning for booster injections for those who qualify, both staff and clients, including those who are still in need of project room key housing. Without this health and safety quality effort, timely access to programs would have been compromised due to the highly infectious nature of the Delta variant, which has particularly impacted congregate settings.
4. As part of a long-term effort to improve quality and coordination, Contra Costa has released an RFI related to a new data system for the DMC-ODS program related to billing, care management, and EHR capacity. While this effort will take time to be

completed, it has been needed to address important quality of care, management, and coordination issues for some time.

5. Contra Costa has established a number of initiatives to address the expansion of services to the Latino population, including development and support of their existing bilingual staff, expand these services within the county with the Latino Commission, and offering some bilingual only SUD treatment groups to build capacity in areas where there currently are none and work with contractors to transition these to them as they get established, and other community activities.

OPPORTUNITIES FOR IMPROVEMENT

1. Communications with contractors to work jointly on system problems such as hiring challenges, COVID-19 stressors, and other issues needed attention as they felt unheard on many important concerns. This was requested in a recent session related to future planning with CalAIM system changes and included in new computer system changes by contract providers. Both major initiatives present opportunities for improvement and streamlining systems as well.
2. The DMC-ODS services are provided primarily by contract providers (over 97 percent) who work with the county as the managed care entity. Sunsetting the Sharecare system and implementing CalAIM in a positive and integrated fashion will be complex but enormous if all the providers are included in the EHR. The inclusion of the contract network is significant for the success of any managed care system. For quality to be optimized, there needs to be seamless coordination between the network providers and the county in real-time using the EHR.
3. Bilingual staffing throughout the contract and county LOCs continue to need expansion. The AOD Director identified a number of positive strategies. These included new services linked to the Latino Commission and optimizing new opportunities through peers, starting bilingual groups for contractors to support, and other creative efforts discussed. Expanded penetration rates with the Latino community are essential, and Contra Costa's goals in this area are optimistic and need continued support.
4. Outpatient capacity is stressed for a variety of reasons. As compared to other counties, it is a lower percentage of your overall DMC-ODS continuum of care. Focus group participants who made the transition to outpatient from residential were grateful and felt it made a great deal of difference in their long-term recovery.
5. Mental Health treatment support is needed at the DMC treatment programs as a resource for clients with co-occurring needs, both mild and moderate, and those with more severe conditions.

6. Oxford house-model resources for clients with children is needed and in general to support adults in recovery.
7. Perinatal contractors need adequate childcare for parents to participate in the clinical groups without their children present.

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR. They are intended as TA to support the DMC-ODS in its continuous quality improvement efforts and to improve beneficiary outcomes:

1. It is recommended that outpatient services and recovery services be evaluated related to capacity and demand to consider current and future needs and incorporate them into an updated QI plan and continuum of care for FY 2022-23.
2. Contra Costa should continue its multi-pronged approach to expanding Latino and youth services access with the Latino Commission, with La Familia, support of current bilingual staff, the addition of supported bilingual groups, tracking bilingual Access requests, supporting the New Beginnings (Nuevos Comienzos) program at the Family Justice Center, and expanded use of bilingual peers.
3. Implement expanded communication and planning activities with contract providers. Contra Costa can work on shared problems areas, expected computer system changes, clarify areas of misinformation such that they understand the many changes are state-driven, not generated by Contra Costa, and prepare for CalAIM in partnership with their network providers. These efforts will provide new opportunities to improve the care system.
4. For measurement of outcomes and quality, expand Latino and youth participation in TPS. Also, consider ways to reduce administrative discharges in CalOMS, which compromises the validity of the data overall. These efforts will improve the usefulness of both these tools in evaluating quality and outcomes related to SUD systems.
5. Improve timeliness data collection to be as automated as possible so that feedback to providers and QI is timely and relevant to take action upon. If possible, eliminate manual data entry of the timeliness data coming in from contractors.
6. Make MAT documentation available at all service sites through the MAT expansion program in Spanish and English and require programs to share with new admissions with primary opioid or alcohol use disorders who may benefit. www.californiamat.org/toolkit_resource

7. Youth SUD assessment and treatment could be expanded county-wide in coordination with Mental Health, including in Juvenile Hall, to prevent further substance use and recidivism.

ATTACHMENTS

ATTACHMENT A: CalEQRO Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT E: County Highlights

ATTACHMENT A: CALEQRO REVIEW AGENDA

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

Table A1: CalEQRO Review Sessions – Contra Costa DMC-ODS

Table A1: CalEQRO Review Sessions - Contra Costa DMC-ODS
Opening session – Changes in the past year, current initiatives, the status of previous year's recommendations (if applicable), baseline data trends and comparisons, and dialogue on results of performance measures
Quality Improvement Plan, implementation activities, and evaluation results
Cultural Competency Plan and Activities
Information systems capability assessment (ISCA)/fiscal/billing
General data use staffing, processes for requests and prioritization, dashboards, and other reports- California Overdose Dashboard, MAT Expansion Activities,
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
PIPs
Health Plan, primary and specialty health care including MAT and Mental Health coordination with DMC-ODS
Medication-assisted treatments (MATs) Choosing Change Data, Trends, Pharmacist
Criminal justice coordination with DMC-ODS including youth
Clinic managers group interview – contracted
Continuum of Care and ASAM fidelity, Network Changes,
Clinical line staff group interview – county and contracted
Recovery support services group interview including staff with lived experience – county and contracted
Client/family member focus groups such as adult, youth, special populations, and/or family
Timeliness of Services, Network Adequacy, Grievances
Access call center interview of line staff, supervisor, review of data, key metrics

Table A1: CalEQRO Review Sessions - Contra Costa DMC-ODS
Key stakeholders and community-based service agencies group interview
Exit interview: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rama Khalsa, Ph.D. Lead Reviewer

Sue Nelson, Ph.D., Second Reviewer

Caroline Yip, IS Reviewer

Luann Baldwin, CFM Consultant

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

Sites for Contra Costa's DMC-ODS Review

DMC-ODS Sites

Contra Costa County Behavioral Health and Recovery Services

All sessions were conducted on the zoom platform due to a recent COVID-19 outbreak in one of the facilities and staff preparations for booster administration.

Contract Provider Sites

Project Reach was the site for the zoom telehealth session for the adult focus group.

Perinatal Residential treatment site with the ten adult clients was the site for the other focus group via a zoom video session.

Table B1: Participants Representing Contra Costa

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Aguirre	Priscilla	Quality Improvement Coordinator	Contra Costa Behavioral Health
Allen	Michelle	Director of Contract Compliance	WestCare
Artola	Elizabeth	Substance Abuse Counselor	REACH Project, Inc.
Aswad	Tom	CFO, Co-Founder & Treasurer	Support4Recovery
Beath	Lori	Client Services Liaison	Contra Costa Public Defender's Office
Bernstein	Marsha	Substance Abuse Counselor	Contra Costa Behavioral Health
Bertram	Lynn	Medical Director-Discovery House	Contra Costa Behavioral Health
Blum	Steve	Acting Program Manager-Behavioral Health-Juvenile Hall 8	Contra Costa Behavioral Health
Blunt	Sonya	Program Supervisor	Contra Costa Behavioral Health
Brown	Mitch	Substance Abuse Counselor	Contra Costa Behavioral Health
Calloway	Vern	Information Technology Manager	Contra Costa Health Services Information Technology
Campos	Jaime	Executive Director	Bi-Bett
Carofanello	Nick	Accountant	Contra Costa Health Services
Church	Robert	Deputy Director	WestCare
Conry	Leonard	Substance Abuse Counselor	J. Cole Recovery Homes
Crandell	Ed	Executive Director	J. Cole Recovery Homes
Crossman	Ed	Clinical Director	WestCare

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Down	Adam	Mental Health Project Manager	Contra Costa Behavioral Health
English	Rodney	Substance Abuse Counselor	WestCare/Richmond Health & Wellness
Farrar	Jesse	Substance Abuse Counselor	Contra Costa Behavioral Health
Fernandez	Antonia	Substance Abuse Counselor	Contra Costa Behavioral Health
Field	Stephen	Behavioral Health Medical Director	Contra Costa Behavioral Health
Fischer	Michael	Project Manager	Contra Costa Health, Housing, Homeless Division
Galdamez	Fadua	Community Health Worker/Latino Outreach	Contra Costa Behavioral Health
Gallagher	Ken	Research & Evaluation Manager	Contra Costa Behavioral Health
Garrett	James	Lead Counselor	J. Cole Recovery Homes
Goode	Lashondra	Substance Abuse Counselor	Contra Costa Behavioral Health
Guillory	Patrice	Director	Contra Costa County Office of Re-entry & Justice
Hahn-Smith	Steve	Informatics Chief	Contra Costa Behavioral Health
Hall	Keith	Substance Abuse Counselor	Contra Costa Behavioral Health
Hill-Howard	Barbara	Substance Abuse Counselor	Contra Costa Behavioral Health
Haverty	Denise	Substance Abuse Counselor	Contra Costa Behavioral Health
Jacob	Jean	Planner/Evaluator	Contra Costa Behavioral Health

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Jarrar	Aous	Substance Abuse Counselor	Contra Costa Behavioral Health
Kalaei	Susan	Pharmacist	Contra Costa Behavioral Health
Kekuewa	David	Health Services System Analyst	Contra Costa Behavioral Health
Kendall	Vincent	Substance Abuse Counselor	Bi-Bett/Diablo Valley Ranch
Kersten	Melissa	Mental Health Clinical Specialist-Quality Assurance/Quality Improvement	Contra Costa Behavioral Health
Klopf	Jodi	Clinical Director	Harmonic Solutions
Legree	Toni	Substance Abuse Counselor	Contra Costa Behavioral Health
Liu	Allison	Planner/Evaluator	Contra Costa Behavioral Health
Loch	Oeum	Substance Abuse Counselor	Contra Costa Behavioral Health
Luu	Matthew	Behavioral Health Deputy Director	Contra Costa Behavioral Health
MacCaskie	Edwin	Substance Abuse Counselor	Ujima Family Recovery Services/West Outpatient
Madison	Kuumba	Executive Director	Harmonic Solutions
Marchetti	Mickie	Executive Director	REACH Project, Inc.
Martinez	Susan	Substance Abuse Counselor	Contra Costa Behavioral Health
Matal Sol	Fatima	Program Chief-Alcohol & Other Drugs Services	Contra Costa Behavioral Health
McCray	Dennis	Vice President	Center Point

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Messerer	Mark	Program Manager-Alcohol & Other Drugs Services	Contra Costa Behavioral Health
Mims	Pat	Director	Reentry Success Center
Munoz	Dora	Substance Abuse Counselor	Contra Costa Behavioral Health
Musawwir	Angelene	Social Worker	Contra Costa Public Defender's Office
Neilson	Jersey	Planner/Evaluator	Contra Costa Behavioral Health
Nybo	Erik	Business Intelligence Developer	Contra Costa Health Services
O'Neill	Robin	Program Manager-West County Adult Behavioral Health	Contra Costa Behavioral Health
Ornelas	Fabiola	Substance Abuse Counselor	Contra Costa Behavioral Health
Pedraza	Chris	Project Manager-Behavioral Health	Contra Costa Behavioral Health
Pena	Jorge	ShareCare and PSP/InSyst Support Analyst	Contra Costa Health Services Information Technology
Pormento	Alicia	Accountant	Contra Costa Health Services
Razon	Danelyn	Accountant	Contra Costa Health Services
Reynolds	Susanne	Substance Abuse Counselor	Bi-Bett/Frederic Ozanam Center
Rice	Megan	ccLink Behavioral Health Project Manager	Contra Costa Behavioral Health
Richardson	Michelle	Program Manager-Alcohol & Other Drugs Services	Contra Costa Behavioral Health

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Robbins-Laurent	Nadine	Regional Vice President	BayMark Health Services
Santiago-Nederveld	Catania	Substance Abuse Counselor	Contra Costa Behavioral Health
Schank	Rita	Executive Director	Ujima Family Recovery Services
Seastrom	Trisha	Program Manager- Alcohol & Other Drugs Services	Contra Costa Behavioral Health
Shelton	Cleadus	Vice President-CA Operations	WestCare
Shipe	Jayme	Prevention Coordinator	Contra Costa Behavioral Health
Spikes	Chet	Assistant Director, Business Systems	Contra Costa Health Services Information Technology
Stewart	Harrison	Program Supervisor- Alcohol & Other Drugs Services Discovery House	Contra Costa Behavioral Health
Tavano	Suzanne	Behavioral Health Director	Contra Costa Behavioral Health
Temeltas	Ates	Assistant IT Director, Clinical Systems	Contra Costa Health Services Information Technology
Todd	Zachariah	Substance Abuse Counselor	Contra Costa Behavioral Health
Webb	Darren	Substance Abuse Counselor	Contra Costa Behavioral Health
Wilson	Gertrude	Program Director	West Care/Richmond Health & Wellness
Wilson	Patrick	Chief Information Officer & Director of Information Technology	Contra Costa Health Services Information Technology

Table B1: Participants Representing Contra Costa			
Last Name	**First Name**	**Position**	**Agency**
Zesati	Genoveva	Workforce Education & Training/Ethnic Services Coordinator	Contra Costa Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
X High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	With an intensive “assertive community treatment” (ACT) type case management approach, the team engagement clients successfully requesting services and linked them to treatment providers (goal one), and also increased successful transitions in care from one LOC to a lower LOC enhancing continuity, stability, and LOS compared to those that did not use the transition team

General PIP Information
DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Contra Costa County
PIP Title: Transition Team Case Management Clinical PIP
PIP Aim Statement: **a.** Will providing intensive CM to persons requesting SUD services who have to wait three or more days for an intake appointment improve successful enrollment by 10 percent over baseline? ` **b.** Will providing intensive CM to persons transitioning between one LOC to a lower LOC increase the percentage of successful transitions by 10% compared to those who do not get support (baseline)?

General PIP Information
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17) * ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): all diagnoses qualifying for SUD services

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Members were only required to communicate with CM barriers or fears related to treatment, needs related to treatment and allow for a thorough assessment, and answer the question, how often can I contact you to offer support until we can get you into the program you need?
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Providers are the case managers who, as CM and SUD counselors, will provide CM services and brief treatment if needed, additional assessment of needs, identify barriers to SUD engagement in treatment such as needing COVID-19 or TB tests and arrange for them, childcare supports, transportation, Medi-Cal benefits, etc. and work with the person if needed daily until they are in the program and feeling comfortable and engaged in care, help them with what to expect, etc. This is a highly active community-based approach.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include recent programs, practices, or infrastructures, such as new patient registries or data tools) The system changed to link this team of CMs with new scopes of work to Access for clients waiting 3-days or more or with special needs and directed them to use the ACT type approach to care with the clients and help remove barriers to treatment even its daily contact was needed. Document in chart even if not billable, do what it takes to remove barrier to treatment and engagement.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	A statistically significant change in performance (Yes/No) Specify P-value
Percent of Client Admissions to Treatment Programs after requesting services from Access with Transition Team Support	**2020**	89 admissions 36.8%	**2021**	**896**	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 XOther (specify): The percentage difference in admission rate for the Transition team group with intensive, extended individualized calls and services was 30.99%, with a point differential of 17.49% between 65.19% and 47.7%
Percent of Clients transitioning from higher to lower LOC with Transition Team Contact & Support (compared to not)	2020	207	**2021**	167	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 79.64% transitioned compared to 66.45%. 13.19% difference in points. The actual % difference is 18.06%

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☒ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Team with CM methods shows impacts at two critical points where clients are often lost to care. Documentation and refinement of the model to off this service to as many clients as possible requesting services like Riverside, even those you offer services to who do not show up rapidly, might be a good follow-up PIP to see if these clients could be engaged. Their more intensive daily contact model and length of time in conversation and relationship-building barrier removal were essential to their success, it appears. It would be helpful to have more insights from staff and clients on why their help made a difference at this critical time to share with other counties and expand to as many clients as possible. You could also measure the discharge status of these clients to see if it is better than others.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
X High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	With the “intensive “assertive community treatment” (ACT) type case management approach, the team engagement clients successfully requesting services and linked them to treatment providers (goal one), and increased successful transitions in care from one LOC to a lower LOC, enhancing continuity and stability and LOS compared to those that did not use the transition team

General PIP Information
/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Contra Costa County
Non-Clinical PIP Title: Medication-Assisted Treatment for Alcohol Use Disorders
PIP Aim Statement: a. Will MAT access for AUD clients increase from 17.4% to 22.4% in FY 2021-22? With SUD counselors' training and clients' education of the benefits of AUD MAT treatment options and opportunities for access to care interventions? Phase one training for counselors, phase two client education, sessions on choices and benefits for symptoms and health benefits and recovery. (28.74% increase) b. Potential phase three intensive engagement with clinics and pharmacists as needed with supports related to increased access or other interventions (will evaluate as needed).

General PIP Information
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17) * ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age thresholds for children, specify age range here:
Target population description, such as specific diagnosis (please specify): all diagnoses qualifying for SUD services AUD diagnoses 1152 in the program, and only 2.4%% had an opportunity to try any MAT approved for AUD

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Members will be given literature on AUD MAT when admitted to any Contra Costa SUD program to be developed by the medical director and staff and consultation as needed with clinical staff and peers with experience with AUD MAT and others. Members will be given literature on AUD MAT when admitted to any Contra Costa SUD program to be developed by the medical director and staff and consultation as needed with clinical staff and peers with experience with AUD MAT and others.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Phase One of the project is all SUD programs will get intensive training per survey that is needed on AUD medications, options, and benefits, including symptom reliefs, brain recovery, withdrawal issues, and cravings. Administration options and outcomes related to AUD medication benefits. The survey indicates little knowledge and much stigma related to MAT for AUD and the need for re-orientation and training with staff, especially SUD counselors, LPHAs. To AUD medication benefits. Phase One of the project is all SUD programs will get intensive training per survey that is needed on AUD medications, options, and benefits, including symptom reliefs, brain recovery, withdrawal issues, and cravings. Administration options and outcomes related
System experience was that it took time to overcome stigma related to opioid use disorder MAT and see real benefits and outcomes and reduction of stigma and encouragement of clients and staff to use as EPB and tool and treatment and this same effort is needed with AUD medication and much less is understood about the biology and issues with alcohol use disorder, risks, benefits, options. Training, materials, literature, and physicians and other prescribers understand the benefits and several types of administrations. Presentations from two phenomenally successful counties may be options as well.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	A statistically significant change in performance (Yes/No) Specify P-value
Percent of Clients with AUD to get access to MAT, now extremely low, only 2.4 percent of 1152	**2020**	201 out of 1152 had any MAT			☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No Concept and implementation just starting

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: Measure each training, keep content consistent, cover all medications, have client speak with AUD experience with Vivitrol/naltrexone/gabapentin if possible, very powerful for SUD counselors who can be very negative towards meds supports, if not a familiar clinician with experience, make materials available to clients staff online if possible, tracking participants, may need more than once per program, do the procedure for review with clients on the literature on AUD on admission, roleplay video is helpful if you can get from SAMHSA, used to have one with simple introduction of topic health benefits, cravings, withdrawal improvements, etc. Staff need supports, not familiar topic, the medical director plays a key role in encouraging the use of MAT. Provide a sample of new data report on prescriptions, do at least monthly and call for video consults, use San Mateo for technical questions, a great resource, and excellent staff experience on this topic. Judy Martin, MD in SF, also did AUD PIP and may also have suggestions and be a valuable resource for treatment or measurement issues.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CalOMS Living Status at Admission, CY 2020

Admission Living Status	Contra Costa		Statewide	
	#	%	#	%
Homeless	522	27.4%	21,737	27.9%
Dependent Living	424	22.3%	19,900	25.5%
Independent Living	959	50.3%	36,372	46.6%
TOTAL	1,905	100.0%	78,009	100.0%

Table D2: CalOMS Legal Status at Admission, CY 2020

Admission Legal Status	Contra Costa		Statewide	
	#	%	#	%
No Criminal Justice Involvement	1,751	91.9%	49,154	63.0%
Under Parole Supervision by CDCR	8	0.4%	1,676	2.1%
On Parole from any other jurisdiction	2	0.1%	1,023	1.3%
Post release supervision - AB 109	33	1.7%	21,128	27.1%
Court Diversion CA Penal Code 1000	0	0.0%	1,122	1.4%
Incarcerated	109	5.7%	384	0.5%
Awaiting Trial	2	0.1%	3,496	4.5%
TOTAL	1,905	100.0%	77,983	100.0%

Table D3: CalOMS Employment Status at Admission, CY 2020

Current Employment Status	Contra Costa		Statewide	
	#	%	#	%
Employed Full Time - 35 hours or more	200	10.5%	8,939	11.8%
Employed Part Time - Less than 35 hours	126	6.6%	5,819	7.8%
Unemployed - Looking for work	593	31.1%	23,736	29.7%
Unemployed - not in the labor force and not seeking	986	51.7%	39,515	50.6%
TOTAL	**1,905**	**100.0%**	**78,009**	**100.0%**

Table D4: CalOMS Types of Discharges, CY 2020

Discharge Types	Contra Costa		Statewide	
	#	%	#	%
Standard Adult Discharges	766	**35.2%**	33,835	45.5%
Administrative Adult Discharges	1,203	**55.3%**	31,361	42.2%
Detox Discharges	194	8.9%	7,879	10.6%
Youth Discharges	14	0.6%	1,297	1.7%
TOTAL	**2,177**	**100.0%**	**74,372**	**100.0%**

ATTACHMENT E: COUNTY HIGHLIGHTS

This past year Contra Costa received a Board of Corrections grant for $500,000 for expansion of SUD treatment in the criminal justice population integrated into the community care system, including its evidence-based practice housing program with Oxford House and MAT and the DMC-ODS continuum of care services. This was done in the middle of the COVID-19 pandemic and a year where the County also had several wildfire events to address as part of its emergency response for the community with evacuations and loss of housing and other resources.