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

CONTRA COSTA FINAL REPORT

☐ MHP

☒ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 17-19, 2024

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EXECUTIVE SUMMARY

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

DMC-ODS INFORMATION

Review Type — Virtual

Date of Review — January 17-19, 2024

DMC-ODS Size — Large

DMC-ODS Region — Bay Area

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	4	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	4	1	1
Quality of Care	8	5	3	0
Information Systems (IS)	6	6	0	0
TOTAL	**24**	**18**	**5**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Decrease the Readmission Rate to Residential Withdrawal Management (WM)	Clinical	03/2022	Second Remeasurement	Moderate confidence
Improve Follow-up Rates After Emergency Department (ED) Visits for Individuals Experiencing Alcohol and Other Drug Abuse or Dependence (FUA)	Non-Clinical	03/2023	Planning	High confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Youth ☐ Residential ☒ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	6
2	☐ Youth ☐ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☒ Other	5
3	☐ Youth ☒ Residential ☐ Outpatient ☐ MAT/NTP* ☐ Perinatal ☐ Other	7

*Medication Assisted Treatment (MAT), Narcotic Treatment Program (NTP)

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

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

- The DMC-ODS reorganized its management team into functional areas to promote more leadership by subject matter expertise and has begun reviewing area-specific service data with the new SmartCare electronic health record (EHR).
- The implementation and expansion efforts in the Hispanic/Latino services with bilingual staff support is a positive shift in addressing a historically underserved population.
- The DMC-ODS expanded mobile enhanced services, including recovery support services (RSS) before, during, and after treatment through the transition team, recovery coaches, mobile crisis, and peer support specialists.
- The DMC-ODS expanded options for direct access to care by adding key Access-linked staff for detention, juvenile hall, psychiatric emergency services (PES), hospitals, perinatal residential; further, a family navigator and certified peers were also added.

- Policy and program expansions were implemented to address persons missing in treatment (MIT), particularly persons with significant substance use disorder (SUD) needs, including homeless individuals and monolingual members.
- The Contra Costa County Health system structure, including county operations and integration with the Health Plan, behavioral health, hospitals, and primary care, has greatly enhanced coordination and data exchange. This is a positive model for improving care coordination for members.

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

- There are opportunities to debrief and continue to partner with contract providers to educate and clarify California Advancing and Improving Medi-Cal (CalAIM) changes, specifically CalAIM Payment Reform. There were reported payment delays, reconciliation delays, and lack of clarity in seeing different rates within SmartCare for the services provided.
- There are delays in accessing mental health (MH) treatment for members in DMC-ODS residential and outpatient programs with psychiatric needs.
- California Outcomes Measurement System (CalOMS) administrative discharges (dropouts from programs before completing treatment) are high, accounting for seven out of ten admissions. There is also a high level of lack of treatment completion in CalOMS.
- Completion of multiple high-priority projects to add functionality within the SmartCare system are reportedly impacted due to staffing constraints. These include but are not limited to provider network data updates, CalOMS data reporting, and aggregation of American Society of Addiction Medicine (ASAM) data, which may impact staff and management decisions.
- There are critical residential and outpatient programs currently unavailable for youth and monolingual female adults, specifically in residential treatment levels of care (LOC).

Recommendations for improvement based upon this review include:

- The DMC-ODS needs to enhance communications for system contractors with more engagement and debriefing related to the new rate model, payment reform implementation challenges, CalAIM requirements, and to discuss delays impacting this year's contracts.
- Improving timely access to MH treatment services is needed for those members in SUD outpatient and residential treatment who have co-occurring disorders requesting treatment.
- Analysis and actions are needed to reduce administrative discharges in CalOMS by identifying those at risk of service withdrawal and enhancing engagement in discharge planning.

- Additional information technology (IT) resources are needed for transitions for key projects related to SmartCare, the interface with the Epic MH EHR, CalAIM initiatives, and workflows required by the provider network.
- A plan for adding vital DMC-ODS services is needed for monolingual women and youth residential treatment.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for Contra Costa DMC-ODS by BHC, conducted a virtual review on January 17-19, 2024.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

DMC-ODS CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING DMC-ODS OPERATIONS

After the COVID-19 pandemic, the DMC-ODS continued to have some staffing impacts and member illnesses but managed these in coordination with County Public Health.

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.

- Implementation of a DMC-ODS EHR for both county and contract providers began on July 1, 2023. It was selected to enhance care coordination with the Epic EHR in use by the mental health plan (MHP) and County health systems.
- There was an addition of community-based monolingual Spanish services by the DMC-ODS staff in coordination with community agencies.
- Behavioral Health, including the DMC-ODS, expanded mobile services with key teams and new recovery support models to assist with engagement, motivation for treatment, and aftercare.
- Implementation of the new reimbursement model through payment reform occurred and the DMC-ODS educated the community on the potential impacts of this new CalAIM change.
- The County implemented a mobile crisis team with both MH and SUD staff and coordinated community engagement.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the county has either:

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

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

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

Recommendations from FY 2022-23

Recommendation 1: Contra Costa should continue to take meaningful steps to address its lack of an EHR for the DMC-ODS, provide more opportunities to ensure IS and data are accessible by providers, and prioritize efforts in data collection for timeliness and access to services, reporting, and aggregated assessment of quality and outcomes.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS implemented the SmartCare EHR on July 1, 2023, under the California MH Services Authority (CalMHSA) EHR initiative.
- Medi-Cal services within the DMC-ODS have successfully been claimed through the new EHR, with many contract providers either directly entering service data or electronically submitting batch files.
- Access and functionality are in place for contract providers to directly enter clinical documentation into the SmartCare EHR, which provides a more complete data set for analysis and reporting needs.

Recommendation 2: Develop a plan and timeline to develop an EHR for the DMC-ODS program inclusive of contract agencies.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- A timeline for the new EHR was developed for implementation and training into FY 2023-24.
- Contract providers maintain system licenses and have full access to all existing functionality within the EHR, including clinical documentation and claim submission.

Recommendation 3: Expand RSS to all LOCs and to facilitate enhanced client care coordination, working with DHCS to optimize billing options. Strong consideration should be given to introducing a peer support service model in RSS.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS expanded mobile RSS and added recovery coaches to support members' early engagement, motivation to stay in treatment, and aftercare support needs. Members in focus groups noted these services as immensely helpful.
- The DMC-ODS expanded peer support counselors and had 12 certified peer counselors and many others working on this credential. There are peers in county positions as well as contract providers. More expansion is planned for 2024.

Recommendation 4: The DMC-ODS should improve access to youth services and perinatal services by formally engaging existing and new partnerships with allied social and juvenile service agencies and enhance youth and perinatal service delivery by establishing clear protocols for case management, care coordination and other support services.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Perinatal services have been enhanced with new bilingual staff positions and a family advocate who is now in the maternity hospital area. Both of these changes assist mothers who are discharged from the hospital transition into treatment. The support includes mobile staff who have direct admission capabilities.
- Youth services expanded in Juvenile Hall by adding medication services, as well as outpatient and discharge planning services. There are coordinated efforts with prevention staff, new school-based services, and families.
- Bilingual support for youth and families also improved in schools with new staff and mobile support with a new family advocate position.
- This recommendation was not carried forward even though bilingual supports are improving with a new committee focused on this goal.

Recommendation 5: Increase monitoring on recovery residences and focus on quality, support, and coordination of care.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The DMC-ODS redesigned screening, standards, and support services for the members in the recovery residential sites and other community housing providers.
- Oversight efforts include monitoring for increased treatment, vocational support, and monitoring of members at risk for relapse, providing relapse prevention, and effecting transitions into independent living.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE DMC-ODS

SUD services are delivered by both county-operated and contractor-operated providers in the DMC-ODS. Regardless of payment source, approximately 2.5 percent of services were delivered by County-operated sites, and 97.5 percent were delivered by contractor-operated sites. Overall, approximately 87 percent of services provided were claimed to Medi-Cal.

The DMC-ODS has a toll-free Access Line available to Plan members 24 hours, 7 days per week that is operated by county and contractor staff; members may request services through the Access Line as well as through the following system entry points: outpatient, WM, RSS sites, and residential, where they are linked to Access screening staff by phone. Also, there are now special program-specific staff who can do direct admissions into treatment. These staff are assigned to the PES, Juvenile Hall, the adult detention program, hospital ED, perinatal units, and schools. While many individuals call the Access number to link to treatment, the addition of new staff who are mobile and field-based is assisting special populations (i.e., homeless, those in custody and in hospitals, etc.) to directly link to care. The DMC-ODS is adding a scheduling module that links to all sites for screening and admission appointments next year.

In addition to clinic-based SUD services, the DMC-ODS provides telehealth services to youth and adults. In FY 2022-23, the DMC-ODS reports having provided telehealth services to 2,566 adults, 186 youth, and 248 older adults, across 7 County-operated sites and 29 contractor-operated sites. Among those served, 356 members received telehealth services in a language other than English.

NETWORK ADEQUACY

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

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

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

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

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

Alternative Access Standards				
The DMC-ODS was required to submit an AAS request due to time and distance requirements	☒ Yes ☐ No			
AAS Details	**Opioid Treatment**		**Outpatient SUD Services**	
	Adults (age 18+)	**Youth (age 12 -17)**	**Adults (age 18+)**	**Youth (age 12-17)**
# of zip codes outside of the time and distance standards that required AAS request		6		
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)		6		
Distance and driving time between the nearest network provider and zip code of the member furthest from that provider for AAS requests		41.8 miles 45 minutes		
Approximate number of members impacted by AAS or allowable exceptions		22,272		
The number of AAS request approved and related zip code(s)		AAS was approved for youth NTP/OTP services in 20 zip codes.		
Reasons cited for approval		Additional network provider for youth and transportation when needed.		
The number of AAS requests denied and related zip code(s)		0		
Reasons cited for denial		n/a		

- The DMC-ODS received an approved AAS for youth opioid treatment services.

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

Out-of-Network (OON) Access	
The DMC-ODS was required to provide OON access due to time and distance requirements	☒ Yes ☐ No
OON Details	
Contracts with OON Providers	
OON Access for Plan Members	
The DMC-ODS ensures OON access for members in the following manner:	☐ The DMC-ODS has existing contracts with OON providers. ☒ Other: Single case agreements when needed.

- Single-case agreements are available for members' unique needs where network providers are unavailable.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- There was a large expansion of bilingual services in the community with new positions to address service needs of the monolingual members. A committee was formed to enhance and plan for further expansion of these efforts.
- Integration and coordination of care are extraordinarily strong within the Contra Costa Health system because of its unique legal structure with the MCP, MHP, DMC-ODS, hospital, and primary care delivery all under one legal entity.
- While positive service access is available at many LOCs, youth do not have access to residential treatment or WM.

ACCESS PERFORMANCE MEASURES

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

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

The Statewide PR is 0.95 percent, with a statewide average approved claim amount of $5,998. Using PR as an indicator of access for the DMC-ODS, the PR rate for the DMC-ODS (1.07 %) indicates better access to care across all age groups than similar size counties for members. This rate was an improvement over the prior year.

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

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

Age Groups	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Ages 12-17	35,236	122	0.35%	0.29%	0.25%
Ages 18-64	177,604	2,315	1.30%	1.29%	1.19%
Ages 65+	34,052	214	0.63%	0.56%	0.49%
Total	**246,892**	**2,651**	**1.07%**	**1.04%**	**0.95%**

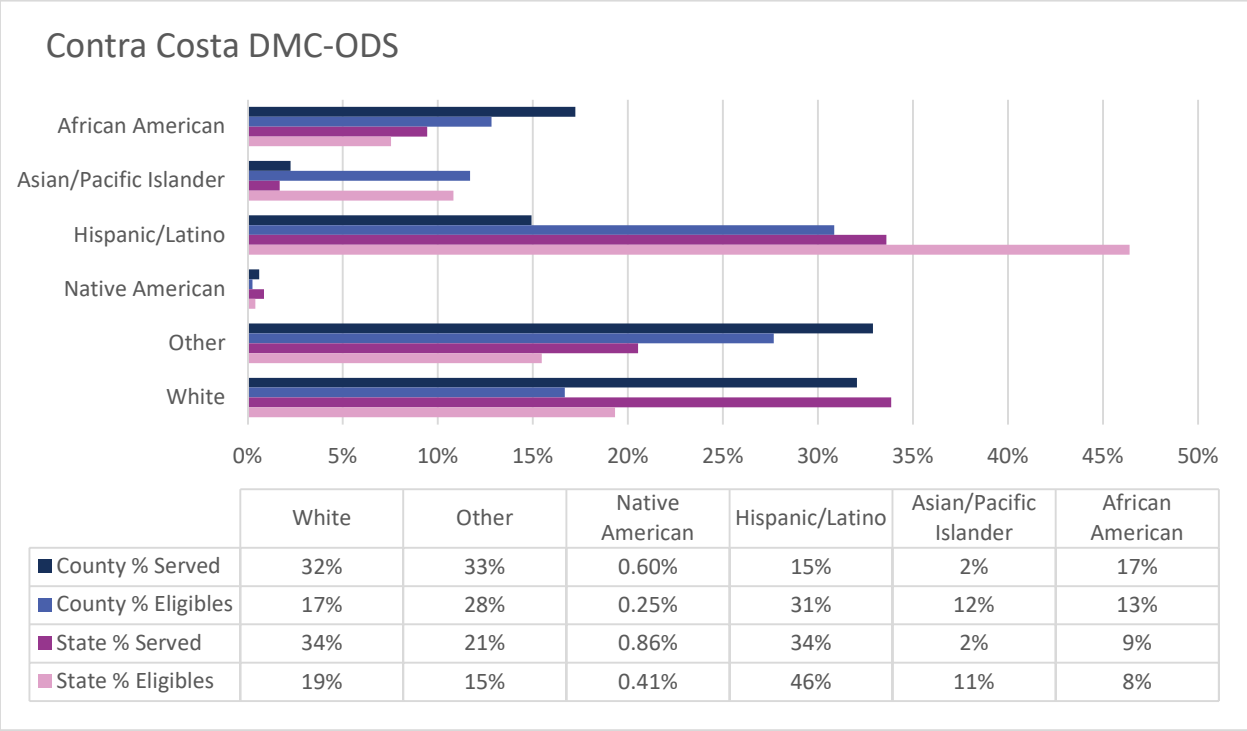
- The DMC-ODS primarily served adults between 18 and 64, with a PR of 1.30 percent within that age group. PRs for all age groups are higher than the corresponding PRs of large counties and statewide. Youth and older adult members had significantly higher PRs than the statewide averages.

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

Racial/Ethnic Groups	# Members Eligible	# Members Served	County PR	Same Size Counties PR	Statewide PR
African American	31,665	457	1.44%	1.29%	1.19%
Asian/Pacific Islander	28,883	60	0.21%	0.15%	0.15%
Hispanic/Latino	76,183	396	0.52%	0.74%	0.69%
Native American	628	16	2.55%	2.34%	2.01%
Other	68,336	872	1.28%	1.34%	1.26%
White	41,200	850	2.06%	1.89%	1.67%

- Contra Costa remains above the statewide PRs for all racial/ethnic groups except the Hispanic/Latino group. Asian/Pacific Islander members had a higher PR (0.21 percent) than similar size counties and statewide (both at 0.15 percent).

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
County % Served	32%	33%	0.60%	15%	2%	17%
County % Eligibles	17%	28%	0.25%	31%	12%	13%
State % Served	34%	21%	0.86%	34%	2%	9%
State % Eligibles	19%	15%	0.41%	46%	11%	8%

- The most significant gaps between percentages of eligibles and members accessing services are seen in the Hispanic/Latino and Asian/Pacific Islander racial/ethnic groups, both of which are proportionally underrepresented in the system. African American, White, and the Other categories are proportionally overrepresented, as occurs statewide. The DMC-ODS has a larger percentage of Other members than is seen statewide.

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

Eligibility Categories	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Affordable Care Act (ACA)	102,470	1,588	1.55%	1.53%	1.42%
Disabled	24,518	443	1.81%	1.51%	1.37%
Family Adult	53,435	506	0.95%	1.03%	0.94%
Foster Care	500	<11	-	2.08%	1.84%
Maternal Child Integrated Health Program (MCHIP)	14,105	-	-	0.20%	0.18%
Other Adult	29,827	42	0.14%	0.10%	0.09%
Other Child	22,610	84	0.37%	0.32%	0.27%

- The primary eligibility categories for members served in Contra Costa are Disabled, ACA, and Family Adult. Contra Costa shows a higher Disabled PR than comparisons.
- Foster Care (FC) shows a slightly higher PR than statewide but the number is small; both FC and MCHIP categories are not displayed due to the low number of FC members served.

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

Eligibility Categories	County AACM	County Size Group AACM	Statewide AACM
ACA	$8,294	$5,742	$6,216
Disabled	$6,969	$5,393	$5,707
Family Adult	$6,498	$5,180	$5,296
Foster Care	$2,446	$2,578	$2,716
MCHIP	$3,314	$3,692	$3,594
Other Adult	$4,995	$3,880	$4,075
Other Child	$3,134	$3,427	$3,194
Total	**$7,612**	**$5,607**	**$5,998**

- AACMs are higher than the large county and statewide averages in all adult eligibility categories and are lower than statewide averages for youth eligibility categories.

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

County			Statewide	
Service Categories	**#**	**%**	**#**	**%**
Ambulatory Withdrawal Mgmt	0	0.00%	56	0.04%
Intensive Outpatient	533	14.55%	14,422	9.58%
Narcotic Treatment Program	968	26.43%	37,134	24.67%
Non-Methadone MAT	53	1.45%	7,782	5.17%
Outpatient Treatment	750	20.48%	46,441	30.85%
Partial Hospitalization	0	0.00%	13	0.01%
Recovery Support Services	81	2.21%	6,400	4.25%
Res. Withdrawal Mgmt	496	13.54%	10,429	6.93%
Residential Treatment	781	21.33%	27,841	18.50%
Total	**3,662**	**100.00%**	**150,518**	**100.00%**

- The plurality of members receiving services were in NTP services (26.43 percent), although the rate decreased from the prior EQR (30.5 percent). This reflects a slightly higher proportion of NTP than statewide (24.67 percent).
- Outpatient service utilization increased from the prior EQR. It was the next most accessed modality at 20.48 percent (compared to 30.85 percent statewide), followed by residential treatment at 21.33 percent (compared to 18.5 percent statewide).

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

Service Categories	County AACM	County Size Group AACM	Statewide AACM
Ambulatory Withdrawal Mgmt	$0	$234	$484
Intensive Outpatient	$4,486	$1,207	$1,729
Narcotic Treatment Program	$4,286	$4,279	$4,526
Non-Methadone MAT	$3,007	$1,601	$1,660
Outpatient Treatment	$2,547	$2,304	$2,547
Partial Hospitalization	$0	$2,802	$2,802
Recovery Support Services	$1,243	$1,660	$1,669
Res. Withdrawal Mgmt	$1,669	$2,278	$2,392
Residential Treatment	$13,624	$10,379	$10,178
Total	**$7,612**	**$5,607**	**$5,998**

- The AACMs by service category for Contra Costa are higher than the large county and statewide averages for intensive outpatient, non-methadone MAT, and residential treatment.
- The AACMs increased for all modalities except outpatient services and residential WM compared to the previous year.

IMPACT OF ACCESS FINDINGS

- Contra Costa has an effective 24-hour Access team with new staff in critical sites to make direct admissions to SUD programs. The sites for new staff include PES, Juvenile Hall, adult detention, perinatal hospital sites, and the EDs. These newly expanded staff are helping with more rapid access and direct engagement of members needing screening and engagement.
- Youth residential and monolingual female WM residential continue to need projects for access.
- New services at 0.5 LOC and with new CalAIM medical necessity requirements have allowed for more rapid engagement and placement into treatment and expansions in youth services for at-risk populations.
- There are also new mobile recovery coaches and certified peer counselors helping members navigate access and admission issues and assisting with motivation and engagement.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 9: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered MAT Appointment	Met
2C	Urgent Appointments (appts not in hours, only days)	Partially Met
2D	Follow-Up Appointments after Residential Treatment	Met
2E	WM Readmission Rates	Met
2F	No-Shows/Cancellations	Not Met

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

- Non-urgent requests to first offered MAT appointments improved in reporting in that the DMC-ODS put in place a monitoring system at the NTPs for daily

requests and offered appointments, even though the programs are open seven days per week.

- The County provided data indicates that just 18.9 percent of members receive timely follow-up services after discharge from residential treatment.
- Contra Costa reported limited ability to track no-shows. The new SmartCare system will allow Access and others to book available assessment appointments into specific LOCs. This is not currently in place but is a planned enhancement for 2024.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the DMC-ODS reported in its submission of the ATA, representing access to care during the 12-month period of FY 2022-23. Table 10 and Figures 2-4 display data submitted by the DMC-ODS; an analysis follows. These data represent the entire system of care.

For time to first offered non-urgent NTP/OTP appointment, the DMC-ODS reports this is not tracked as NTP providers offer same-day screening by policy. The Access Line does not provide appointment times to NTP programs but provides locations and information to callers.

Urgent services during the time period were tracked in units of days instead of the number of hours,. “Urgent” is defined within the DMC-ODS as WM services only, which is limited in its usefulness. The DMC-ODS did not report an average time to service for this metric, although the percentage of appointments meeting the standard was reported.

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

DMC-ODS-Reported Data

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

Timeliness Measure	Average/Rate	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.4 Business Days	10 Business Days*	90.2%
First Non-Urgent Service Rendered	6.7 Business Days	10 Business Days**	79.9%
Non-Urgent MAT Request to First Offered NTP/OTP Appointment	***	3 Business Days*	***
Urgent Services Offered (requirement is hours)	2 days	48 Hours**	98.3%
Follow-up Services Post-Residential Treatment	18.5 Days	7 Days	18.9%
WM Readmission Rates Within 30 Days	8.8%	n/a	n/a
No-Shows (partial data)	26.1%	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** DMC-ODS-defined timeliness standards in days not hours as required due to computer limitation. ***DMC-ODSs did not report data for this measure			
For the FY 2023-24 EQR, the DMC-ODS reported its performance for the following time period: FY 2022-23			

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

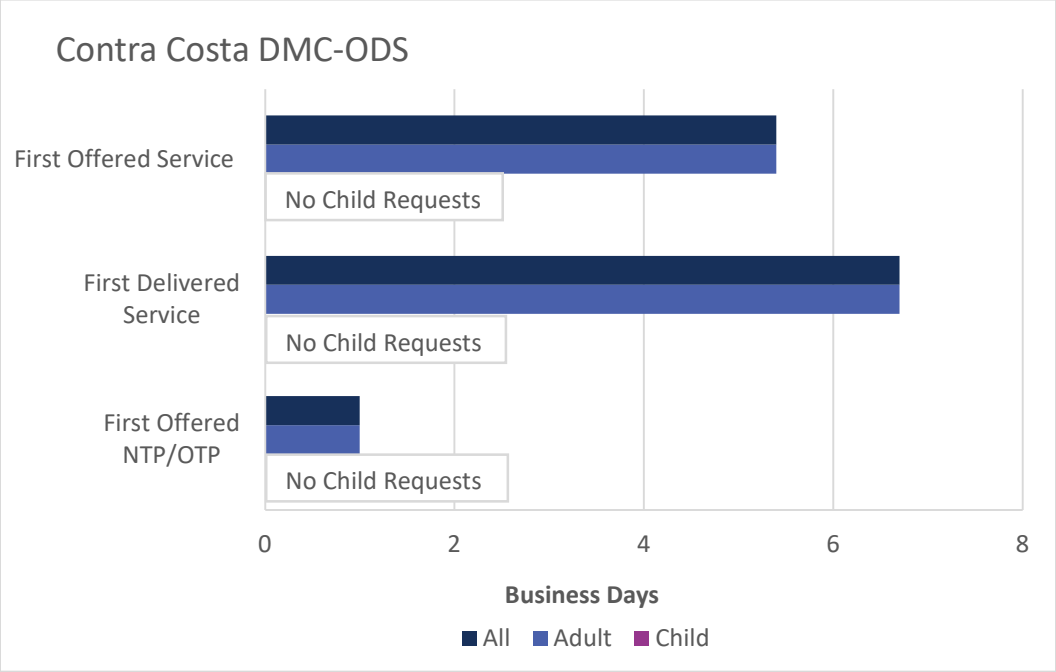
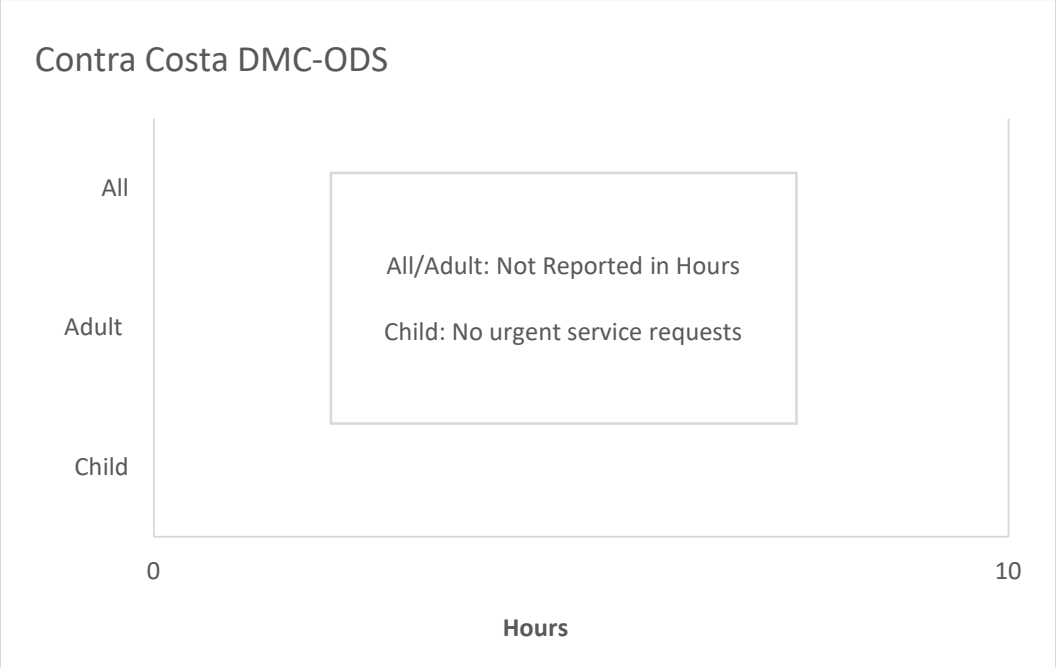
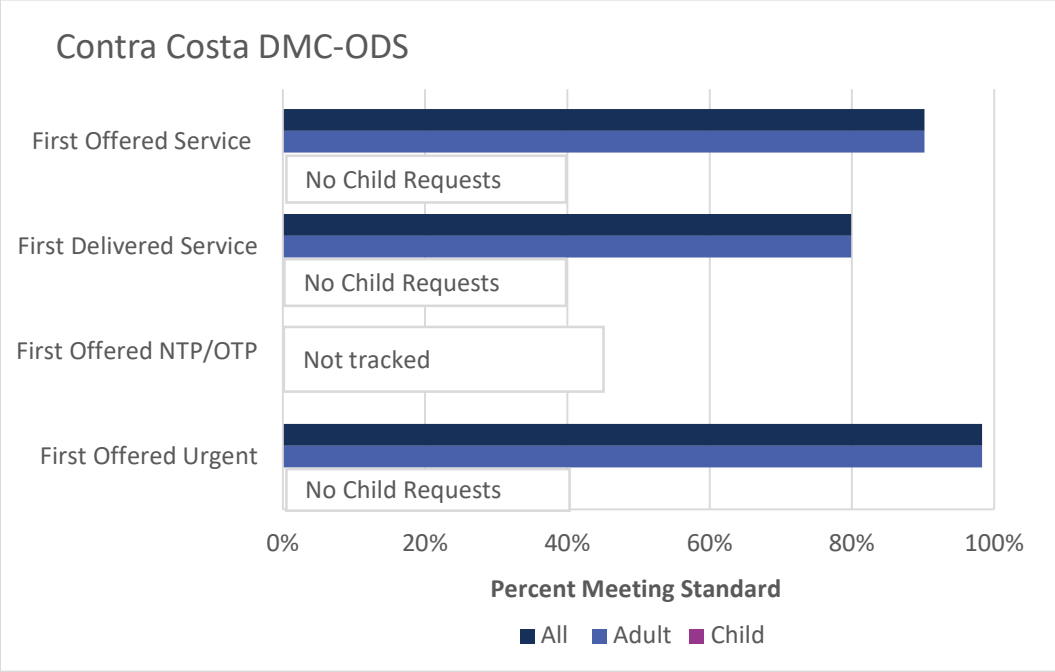


Figure 3: Wait Times for Urgent Services



See description below on urgent WM services requests and admissions. The requirement is for hours, but the computer data can only record days at this time.

Figure 4: Percent of Services that Met Timeliness Standards



Contra Costa did track actual NTP/OTP service delivered and these were within the three day requirement. For urgent conditions which are defined as members needing WM, the data was tracked from request to admission into WM services and averaged two days. There were 474 requests which were offered urgent services and 466 were admitted within two days resulting in a 98.3 percent compliance.

Timeliness from Medi-Cal Claims Data

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

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

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

County				Statewide		
Age Groups	# of Members	%	Avg. Days	# of Members	%	Avg. Days
12 to 17	0	0.00%	N/A	15	0.04%	12.60
18 to 64	825	88.52%	2.24	31,839	87.46%	3.59
65+	107	11.48%	0.16	4,551	12.50%	0.56
Total	**932**	**100.00%**	**2.00**	**36,405**	**100%**	**3.19**

- On average, members in the DMC-ODS receive their first dose of methadone in 2.00 days, which is lower and more expedient than the statewide average of 3.19 days, even as Contra Costa's rate increased slightly from the prior year's average of 1.76 days.

Transitions in Care

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

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

	County N = 771		Statewide N = 27,232	
Number of Days	Transition Admits	Cumulative %	Transition Admits	Cumulative %
Within 7 Days	98	12.71%	3,243	11.91%
Within 14 Days	153	19.84%	4,515	16.58%
Within 30 Days	184	23.87%	5,706	20.95%

- The DMC-ODS discharged 771 members from residential treatment, which was a decrease of 45.8 percent from the prior year. Of members discharged, 23.87 percent had a follow-up service within 30 days, higher than the statewide rate of 20.95 percent.
- Timely transitions to follow-up service improved in CY 2022 and now exceeds the statewide rate in each measured time period. Both DMC-ODS and statewide rates indicate that overall, nearly eight of ten members do not receive billable follow-up services within 30 days of discharge.

Residential Withdrawal Management Readmissions

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

County			Statewide	
Total DMC-ODS admissions into WM	670		13,062	
	#	#	#	%
WM readmissions within 30 days of discharge	65	9.70%	1,148	8.79%

- The DMC-ODS had 670 members admitted into residential WM in CY 2022. The readmission rate in the DMC-ODS decreased from the prior year to 9.7 percent. However, it remains slightly higher than the statewide readmission rate of 8.79 percent.

IMPACT OF TIMELINESS FINDINGS

- The DMC-ODS has improved timeliness with NTP/OTPs related to first service and meets DHCS standards for all methadone within the three day requirement. Members requesting services with the NTP/OTP can access this service six days per week without an appointment. Walkin services are encouraged.
- For urgent services, as notes they were recorded as days and averaged related to members in withdrawal and needing WM services. 98.3 percent were admitted to the WM residential program within an average of two days. However, the requirement is to record this measure in hours and the new computer system Smartcare will be able to do this when it is fully functional.
- Contra Costa could do more to effect timely transitions for members leaving residential treatment to follow-up services and tracking urgent service needs.
- Timeliness of access for DMC-ODS members requesting MH treatments and psychiatry were reported to be far over the 10 business day standard and needing improvement in the focus groups and by the MHP.
- Monitoring no-show services is critical for efficiency and tracking engagement and retention. This scheduling and tracking capacity should be added as part of the SmartCare implementation to allow for this monitoring and improvements.

QUALITY OF CARE

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

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

QUALITY IN THE DMC-ODS

In the DMC-ODS, the responsibility for QI is coordinated by a QI committee for the two branches of Behavioral Health, though they maintain separate QI goals, plans, and evaluations. Compliance is a separate component under Behavioral Health's quality team but is also coordinated with the DMC-ODS and MH QI programs. There is Health Agency oversight of all QI as well. The unique structure of County-directed and operated services from the MCP, a county hospital, county primary care clinics, and behavioral health has created an integrated environment to enhance the coordination of complex member needs. Quality is viewed as a continuous process across all sectors of the Health Agency system of care.

The DMC-ODS monitors its quality processes through the QI Committee (QIC), the QAPI work plan, and the annual evaluation of the QAPI work plan. The QIC is comprised of clinical staff from each section, contract providers, analytics staff, and the medical director. There are participants with lived experience as well. The QIC is scheduled to meet monthly. Since the previous EQR, the DMC-ODS QIC met 12 times. Of the 14 identified FY 2022-23 QAPI work plan goals, they met ten goals and partially met four. Challenges included workforce vacancies and complex administrative challenges in the transition of the data system and payment reform, straining administrative support resources and data access in many areas.

QUALITY KEY COMPONENTS

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

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

Table 14: Quality Key Components

KC #	Key Components – Quality	Rating
3A	QAPI are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Partially 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 Members Served	Partially Met
3H	Utilizes Information from the TPS to Improve Care	Met

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

- MAT treatment access and prevention services are both delivered and well-coordinated with key stakeholders, including public health, hospitals, health plans, and primary care settings. For example, the DMC-ODS reports having over 1,000 members on MAT in the primary care clinics operated by the County in a unique program called Choosing Change. This project includes member participation in SUD programs for counseling in coordination with MAT from primary care sites.
- The DMC-ODS had implemented the ASAM data capture in a way that is not easy to track or submit to DHCS, and thus, the report does not reflect accurate information on assessments and follow-up assessments. This will be corrected in SmartCare when this module is ready to upload the ASAM data later this year.

QUALITY PERFORMANCE MEASURES

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

- Members served by Diagnostic Category
- Non-methadone MAT services
- Residential WM with no other treatment

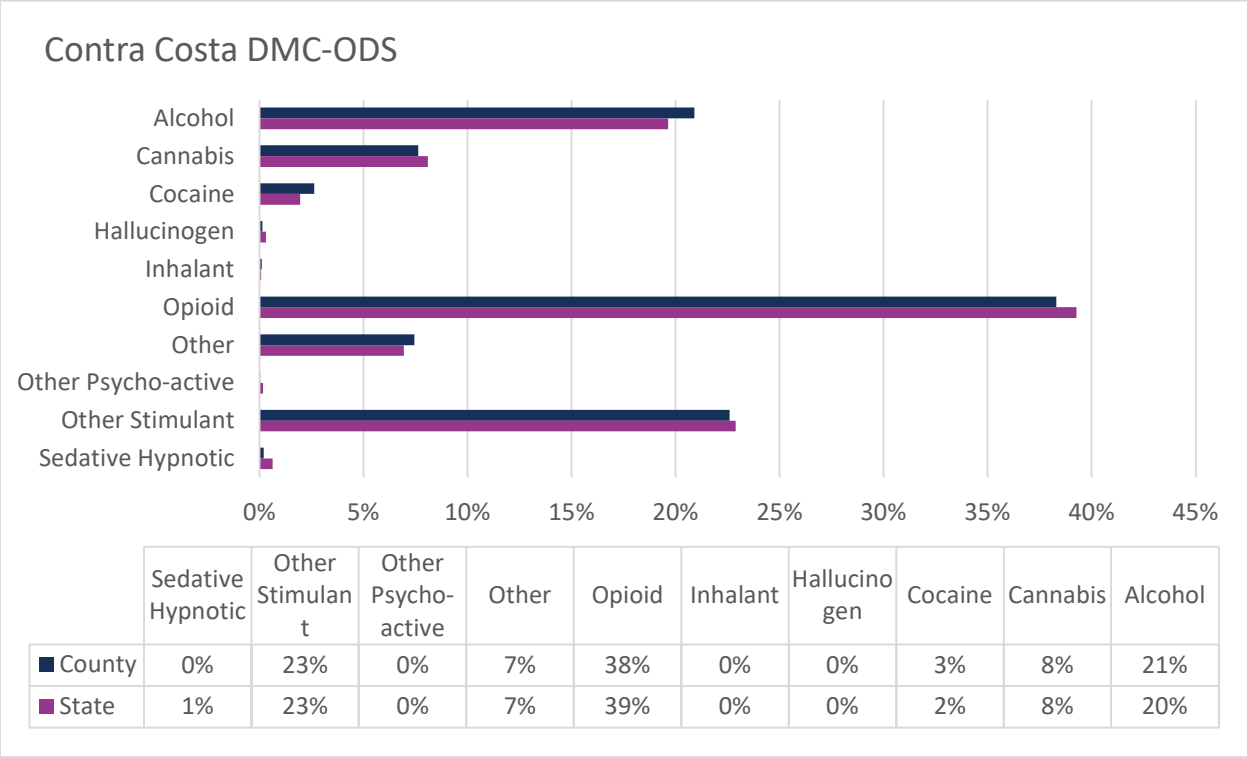
- High-Cost Members (HCM)
- ASAM congruence
- Initiation and Engagement
- Length of Stay (LOS)
- CalOMS admission versus discharge for employment and housing status
- CalOMS Legal Status at Admission
- CalOMS Discharge Status Ratings

Diagnosis Data

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

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

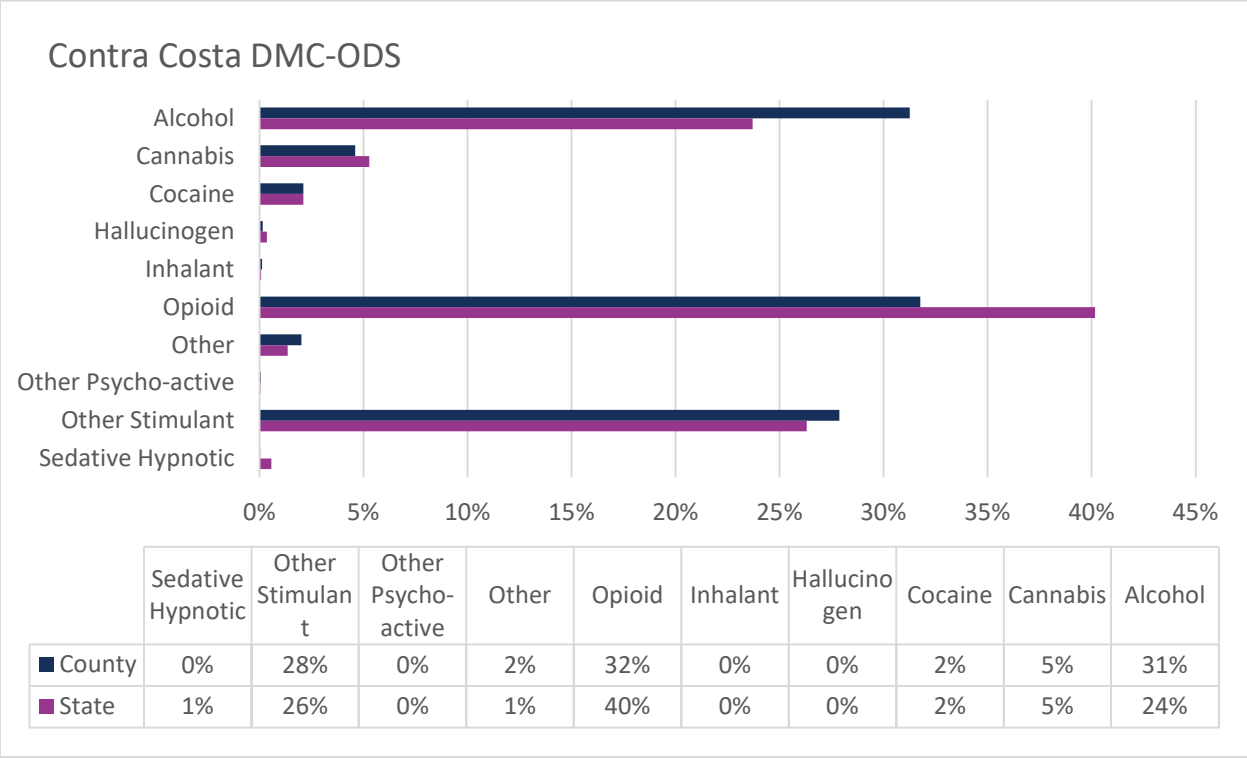
Figure 5: Percentage of Plan Members by Diagnosis Code, CY 2022



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0%	23%	0%	7%	38%	0%	0%	3%	8%	21%
State	1%	23%	0%	7%	39%	0%	0%	2%	8%	20%

- In the DMC-ODS, 38 percent of members receiving services were diagnosed with an opioid use disorder (OUD), followed by other stimulants as the subsequent most common diagnosis (23 percent).
- The primary diagnostic pattern in Contra Costa DMC-ODS is comparable to the statewide diagnostic pattern.

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



	Sedative Hypnotic	Other Stimulant	Other Psycho-active	Other	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
County	0%	28%	0%	2%	32%	0%	0%	2%	5%	31%
State	1%	26%	0%	1%	40%	0%	0%	2%	5%	24%

- OUD is the dominant diagnostic category and accounts for 32 percent of claims, closely followed by alcohol at 31 percent.
- The proportion of approved claims for members decreased for OUD (from 40 to 32 percent), now below the statewide rate (40 percent). Claims remained static for members with other stimulant use diagnosis, and claims increased for members with alcohol use diagnosis (from 25 to 31 percent) of overall claims.

Non-Methadone MAT Services

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

County					Statewide			
Age Groups	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services	At Least 1 Service	% At Least 1 Service	3 or More Services	% 3 or More Services
Ages 0-17	<11	-	<11	-	24	0.56%	13	0.30%
Ages 18-64	49	2.12%	48	2.07%	7,473	7.96%	3,881	4.13%
Ages 65+	<11	-	<11	-	428	5.78%	173	2.34%
Total	**53**	**2.00%**	**51**	**1.92%**	**7,925**	**7.13%**	**4,051**	**3.66%**

- The DMC-ODS had substantially lower initiation and engagement in non-methadone MAT compared to the statewide rates. Member numbers for youth and older adult utilization were suppressed due to low numbers.

Residential Withdrawal Management with No Other Treatment

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

	# Members with 3+ Episodes WM & No Other Services	% Members with 3+ Episodes WM & No Other Services
County	16	3.25%
Statewide	205	2.00%

- The DMC-ODS had 16 members receiving three or more WM services with no other treatment, while exceeding the statewide rate only represents 3.25 percent of members served.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. In SUD treatment, this may reflect multiple admissions to residential treatment or residential WM. HCMs may be receiving services at a LOC not appropriate to their needs. HCMs, for the purposes of this report, are defined as those who incur SUD treatment costs higher than two standard deviations above the mean, which for CY 2022 equates to claims of $17,188 or more.

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

	Total Members Served	HCM Count	HCM % by Count	Average Approved Claims per HCM	HCM Total Claims	HCM % by Total Claims
County	2,651	243	9.17%	$28,119	$6,832,876	33.86%
Statewide	105,657	5,724	5.42%	$24,551	$140,532,204	21.84%

- 243 HCMs served by the DMC-ODS accounted for 33.86 percent of total claims for CY 2022.
- The DMC-ODS rate of HCMs (9.17 percent) is above the statewide rate (5.42 percent).

ASAM Level of Care Congruence

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

ASAM LOC Referrals	Initial Screening		Initial Assessment		Follow-up Assessment	
	#	%	#	%	#	%
Not Applicable /No Difference	1,162	86.27%	33	76.74%	0	0.00%
Patient Preference	77	5.72%	<11	-	0	0.00%
LOC Not Available	-	-	0	0.00%	0	0.00%
Clinical Judgment	36	2.67%	0	0.00%	0	0.00%
Geographic Accessibility	0	0.00%	0	0.00%	0	0.00%
Family Responsibility	<11	-	0	0.00%	0	0.00%
Legal Issues	0	0.00%	0	0.00%	0	0.00%
Lack of Insurance/Payment	0	0.00%	0	0.00%	0	0.00%
Other	0	0.00%	0	0.00%	0	0.00%
Actual LOC Missing	54	4.01%	<11	-	0	0.00%
Total	1,347	100.00%	43	100.00%	0	0.00%

- The DMC-ODS reported a high congruence of LOC referrals with ASAM findings at initial screening. At the same time, the counts substantially dropped for the initial assessment and were not reported for follow-up assessment.
- The patient preference category was the primary reason the assessment-indicated LOC differed from referral.

Initiation and Engagement

An effective system of care helps people who request treatment for their addiction to both initiate treatment services and then continue further to become engaged in them. Table 20 displays the results of measures for two early and vital phases of treatment-initiation and then engaging in treatment services. Research suggests that those who can engage in treatment services will likely continue their treatment and enter into a recovery process with positive outcomes. The method for measuring the number of Plan members who initiate treatment begins with identifying the initial visit in which the member's SUD is identified. Based on claims data, the "initial DMC-ODS service" refers to the first approved or pending claim for a member that is not preceded by one within the previous 30 days. This second day or visit is what, in this measure, is defined as "initiating" treatment.

CalEQRO's method of measuring engagement in services is at least two billed DMC-ODS days or visits that occur after initiating services and that are between the 14th and 34th day following initial DMC-ODS service.

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

	County				Statewide			
	# Adults		# Youth		# Adults		# Youth	
Members with an initial DMC-ODS service	2,483		122		99,855		4,026	
	#	%	#	%	#	%	#	%
Members who then initiated DMC-ODS services	2,270	91%	95	78%	83,830	84%	3,286	82%
Members who then engaged in DMC-ODS services	1,752	77%	58	61%	63,753	76%	2,202	67%

- Adult members had higher rates of initiation and engagement in services compared to statewide rates, while youth initiation and engagement are below statewide rates.

Length of Stay

Examining Plan members' LOS in services provides another look at engagement in services and completion of treatment. Table 21 presents the number of members who were discharged from treatment in CY 2022, defined as having zero claims for any DMC-ODS services for 30+ days, the average and median LOS for members, and results indicating what proportions of members had accessed services for at least 90, 180, and 270 days, as well as statewide comparisons for reference.

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

	County		Statewide	
Members discharged from care. (no treatment for 30+ days)	3,248		139,688	
LOS for members across the sequence of all their DMC-ODS services	Average	Median	Average	Median
	128	67	158	90
	#	%	#	%
Members with at least a 90-day LOS	1,385	43%	69,919	50%
Members with at least a 180-day LOS	800	25%	43,096	31%
Members with at least a 270-day LOS	485	15%	27,677	20%

- The average LOS for DMC-ODS members was 128 days (median 67 days), which was substantially shorter than the statewide average of 158 (median was 90 days).
- 43 percent of members had at least a 90-day LOS, 25 percent had at least a 180-day stay, and 15 percent had at least a 270-day LOS. The proportions of members retained for each measured period were lower than statewide. Thus, more Contra Costa members have a LOS less than 90 days than statewide.

CalOMS Data

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

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

	County		Statewide	
Admission Legal Status	**#**	**%**	**#**	**%**
No Criminal Justice Involvement	2,099	93.29%	56,511	65.47%
Under Parole Supervision by California Department of Corrections and Rehabilitation (CDCR)	17	0.76%	1,649	1.91%
On Parole from any other jurisdiction	<11	-	1,427	1.65%
Post-release supervision - AB 109	60	2.67%	19,933	23.09%
Court Diversion CA Penal Code 1000	0	0.00%	1,312	1.52%
Incarcerated	71	3.16%	446	0.52%
Awaiting Trial	<11	-	5,038	5.84%
Total	**2,250**	**100.00%**	**86,316**	**100.00%**

- A high rate of members in treatment, 93.29 percent, were reported to have no criminal justice involvement, which is substantially higher than the statewide proportion of 65.47 percent.

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

Discharge Status	County		Statewide	
	#	%	#	%
Completed Treatment – Referred	954	31.58%	19,232	21.62%
Completed Treatment - Not Referred	0	0.00%	5,687	6.39%
Left Before Completion with Satisfactory Progress - Standard Questions	363	12.02%	12,302	13.83%
Left Before Completion with Satisfactory Progress – Administrative Questions	1,119	37.04%	7,046	7.92%
Subtotal	*2,436*	*80.64%*	*44,267*	*49.76%*
Left Before Completion with Unsatisfactory Progress - Standard Questions	24	0.79%	15,497	17.42%
Left Before Completion with Unsatisfactory Progress - Administrative	549	18.17%	28,288	31.80%
Death	<11	-	166	0.19%
Incarceration	<11	-	740	0.83%
Subtotal	*585*	*19.36%*	*44,691*	*50.24%*
Total	**3,021**	**100.00%**	**88,958**	**100.00%**

- More than 80 percent of discharges in the DMC-ODS were considered satisfactory discharges (80.64 percent), quite favorable compared to 49.76 percent statewide. The majority of members were rated “Left Before Completion with Satisfactory Progress – Administrative Questions.” DMC-ODS members were substantially more likely to be discharged with that rating than statewide (37.04 percent vs. 7.92 percent statewide).
- 31.58 percent of members were discharged and completed treatment and were referred to follow-up treatment. In comparison, the statewide rate of members completing treatment and referred is 21.62 percent.

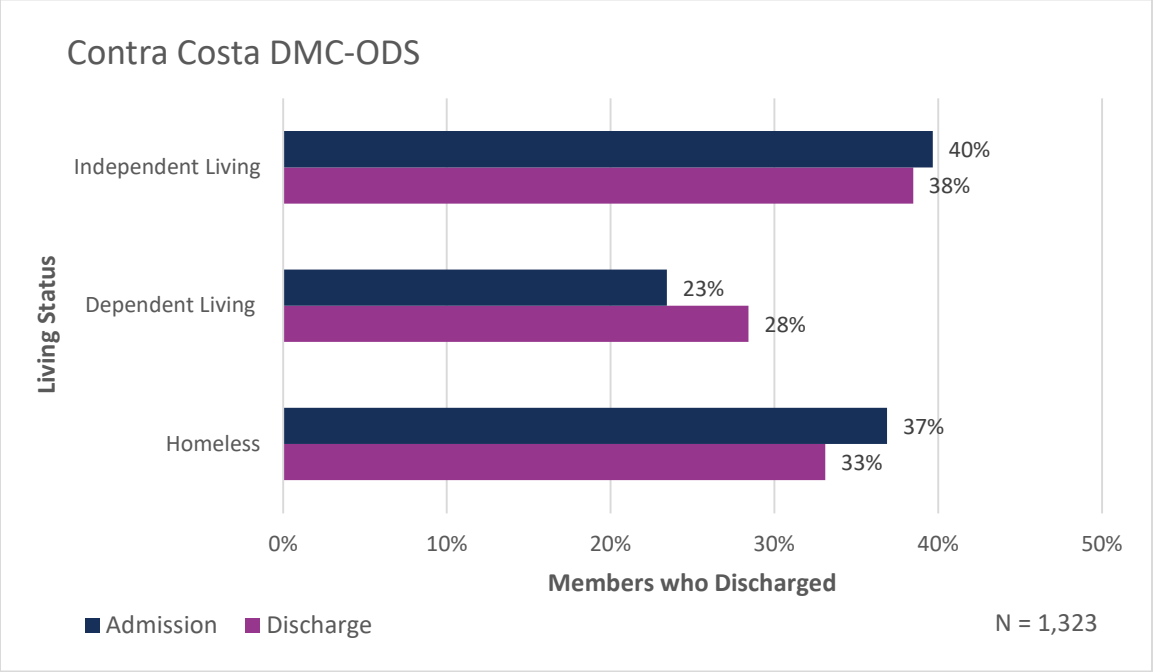
Table 23: Contra Costa DMC-ODS CalOMS Types of Discharges, CY 2022

Discharge Types	County		Statewide	
	#	%	#	%
Standard Adult Discharges	1,037	34.33%	44,306	49.81%
Administrative Adult Discharges	1,680	55.61%	36,240	40.74%
Detox Discharges	286	9.47%	7,075	7.95%
Youth Discharges	18	0.60%	1,337	1.50%
Total	**3,021**	**100.00%**	**88,958**	**100.00%**

- The DMC-ODS experienced a 44 percent increase in total discharges since the prior EQR.
- Administrative adult discharges were the primary discharge type at 55.6 percent, which increased from the prior year when the administrative discharge rate was 53 percent, and remained above the statewide rate of 40.7 percent.

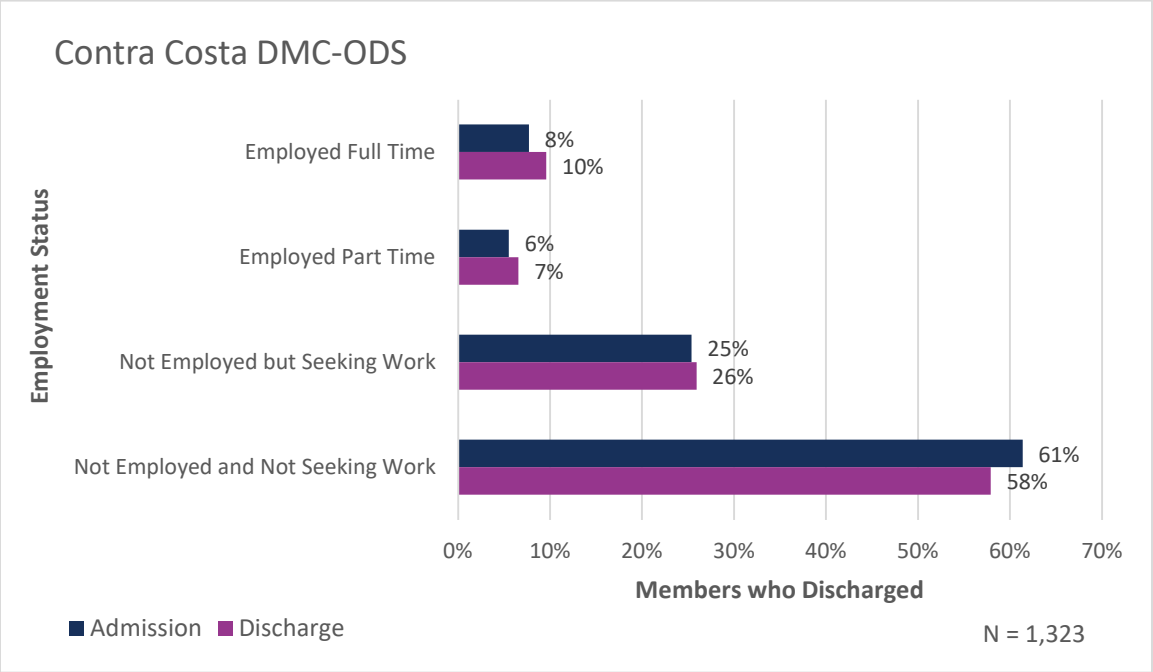
The data presented in Figures 7 and 8 reflect the percent change at discharge from admission for both living status and employment status. Both questions are asked in relation to the prior 30 days.

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



- The plurality of members (40 percent) was in independent living at admission, a substantial decrease from the CY 2021 CalOMS data, which was at almost 52 percent for that CY.
- There is a positive change in living status between admission and discharge for many members, showing improvement in housing stability at discharge.

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



- In CY 2022, there were slight improvements in member employment between admission and discharge. There was a slight increase in both full-time and part-time employment.

IMPACT OF QUALITY FINDINGS

- There were several improvements related to expanding services in a new youth MAT provider called “Let's Recover.” A number of programs (Mobile crisis, recovery support, and outpatient) were providing expanded mobile services, and this positively impacted members, as reported in focus groups.
- The new EHR enhanced the quality of communication and coordination between MH, hospitals, primary care, and the DMC-ODS, as expressed by key stakeholders. This included faster direct admission into the DMC-ODS programs, especially after urgent or ED events.
- The QAPI was broad and detailed in terms of SUD data-driven goals and activities. There were some additional staff to help with enhanced capacity in the range of services being delivered and participating in QI.
- More IT staff are needed to address the systems that are still not able to report to DHCS (CalOMS, ASAM, TPS). Many of the new CalAIM goals and requirements were integrated into the plan.
- Communication, training, and active engagement appear to still be needed and enhanced with the amount of system change, particularly payment reform and the EHR conversion, especially in the provider network.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Decrease the Readmission Rate to Residential Withdrawal Management (WM)

Date Started: 03/2022

Aim Statement: "Through the provision of additional materials, additional WM guidelines, and enhanced transition planning and case management in WM, will the readmission rate of members to WM decrease by two percentage points (from 10 percent to 88 percent)? Will the members' enrollment rate to SUD treatment within seven days of discharge from residential WM increase to 60 percent?"

Target Population: Adults 18 years and older with any diagnoses of SUDs. The profile was predominantly alcohol, opioid, and stimulant-related diagnoses similar to the overall county diagnostic profile. Ages ranged from 18 to 69, with the largest group being 30 to 39-year-olds. There were 87 females and 230 males in the baseline group. All four adult sites for residential WM were included. The largest ethnic group was white at

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

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

45 percent, followed by Latino/Hispanic at 24 percent, followed by African American at 19 percent. All other groups were under 3 percent.

Status of PIP: Second remeasurement phase

Summary

The focus of the PIP was improving engagement, early discharge planning, and follow-up services for treatment after the episode of WM. A variety of workflow improvements were utilized to enhance these processes. These included new protocols for prompt discussion of options for treatment with the Access team after assessment of the members' needs and stages of change/motivation. New case management and warm handoff requirements were also added to facilitate a smooth transition to treatment services after WM. PMs included tracking readmission rates, admission rates to treatment after discharge, and how rapid the admission was.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence because the analysis of the problem was thorough, and the design of interventions involved not only reviewing research but also the WM providers to engage and motivate them to make changes in service associated with successful transitions. While data showed modest improvements, the new services and systems communication did appear to be changing the experiences of care for many members as well as the skills of the WM staff in delivering more effective care.

The TA provided during this PIP implementation focused on the results of similarly designed PIPs from other counties.

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

- Continue to enhance early engagement with members with motivational interviewing and discussions on discharge planning options in partnership with the Access team, which can track available openings at different LOCs.
- Utilize the new EHR to enhance communication and coordination by adding the scheduling option, which would allow members to leave with a firm admission date and have a warm handoff whenever possible.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improve Follow-up Rates After Emergency Department (ED) Visits for Individuals Experiencing Alcohol and Other Drug Abuse or Dependence (FUA)

Date Started: 03/2023

Aim Statement: “For Medi-Cal beneficiaries with ED visits for SUD at Contra Costa Regional Medical Center, the implemented intervention should increase the percentage of follow-up SUD services with the Plan within 7 and 30 days by 5 percentage points by March 31, 2025.”

Target Population: The population includes all members 16 and older who visit the specified ED for SUD.

Status of PIP: Planning phase

Summary

The goal of the PIP is to improve engagement and treatment access for members presenting at the Contra Costa Regional Medical Center within 7 and 30 days of discharge. The interventions include staffing at the ED with SUD expertise and new workflows to support admissions to treatment with the 24-hour Access team. These interventions are to be achieved through facilitating the linkage to treatment when the member is present in the ED. There is also a component of additional support for warm handoffs based on needs, such as transportation with new recovery coaches.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence due to the integrated supervision of the PIP and data exchange between the Epic hospital system and the SmartCare DMC-ODS program and Access Team. Also, the DMC-ODS completed a thorough review of the root causes for the current admission rates to treatment after an ED visit.

The DMC-ODS was encouraged to work closely with CalMHSA, hospital staff, and the QI team to design the PIP with data available between the EDs and the DMC-ODS treatment system.

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

- Use enhanced data capacity to coordinate care engagement and admissions in real-time, linking Epic software and SmartCare as soon as possible.
- Provide monthly reports of results by drug type, area of the county the member lives in, which programs they are referred and connected to; and breakdown also by ethnic group and especially note monolingual clients and homelessness as characteristics.

INFORMATION SYSTEMS INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE DMC-ODS

The EHRs of California's DMC-ODSs are generally managed by the county, DMC-ODS IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the DMC-ODS is SmartCare by Streamline, which was implemented as part of the CalMHSA semi-statewide EHR initiative and has been in use since July 2023. Currently, the DMC-ODS is actively implementing the new system, which requires heavy staff involvement to fully develop.

Approximately 2 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 allocated to the DMC-ODS but managed by county Health IT.

The DMC-ODS has 269 named users with log-on authority to the EHR, including approximately 54 county staff and 215 contractor staff. Support for the users is provided by 5.3 full-time equivalent (FTE) IS technology positions. Currently, all positions are filled. In the prior EQR, the DMC-ODS reported 13.25 FTE supporting both MH and DMC-ODS systems, although the DMC-ODS did not have a clinical EHR in place prior to implementing SmartCare. The DMC-ODS now has a breakdown of dedicated IS FTEs supporting the DMC-ODS system and new EHR.

As of the FY 2022-23 EQR, contract providers have access to directly enter clinical data into the DMC-ODS' EHR. The majority of contract providers also utilize electronic batch file transfer. Contractor staff that has direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

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

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between DMC-ODS IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to DMC-ODS IS	☐ Daily ☐ Weekly ☒ Monthly	65.23%
Direct data entry into DMC-ODS IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	34.77%
Documents/files e-mailed or faxed to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to DMC-ODS IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Plan Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The DMC-ODS does not currently have a functioning PHR and anticipates it will be over two years before one will be implemented.

Interoperability Support

The DMC-ODS is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The DMC-ODS does not currently engage in electronic exchange of information with any entities.

INFORMATION SYSTEMS KEY COMPONENTS

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

Table 25: IS Infrastructure Key Components

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

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

- The DMC-ODS successfully launched the SmartCare EHR on July 1, 2023, with integrated use by contract providers and County DMC-ODS staff. This is the first complete EHR implemented to support the Contra Costa DMC-ODS system of care. Primary features, including clinical documentation and claiming for services, are functioning; other EHR components, including reporting and aggregation of ASAM data, are not currently available.
- Regarding investment in IT infrastructure and resources, the DMC-ODS has adjusted staffing to account for the new EHR within the DMC-ODS but appears understaffed in IS support positions, with 5.3 FTE approved. Data analytics approved positions are similar in scale at 4 FTE; however, County data analytics positions were at a 25 percent vacancy rate at the time of the review.
- The DMC-ODS has decided to require contract providers to enter service data and clinical documentation either directly into the SmartCare EHR or send data through a batch file transfer. Multiple contract providers use the SmartCare EHR as the primary system, while other providers may maintain a separate system with duplicated or supplemental information outside the SmartCare system. The DMC-ODS is not currently a member or a participant of an HIE.
- The system updates related to payment reform were substantial as the DMC-ODS simultaneously implemented a new EHR for the entire system of care. Newly established rates were reportedly received late, which required contract updates for providers. This led to late contracts and impacts on timely claims and reimbursement for services for both the County and contract providers in FY 2023-24. The DMC-ODS is continuing to address this at the time of the review.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

Table 26 shows the amount of denied claims by denial reason, and Table 27 shows approved claims by month, including whether the claims are either adjudicated or

denied. This may also indicate if the DMC-ODS is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

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

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible	3,226	$524,002	71.55%
Other Healthcare coverage must be billed first	7,189	$150,446	20.54%
Late claim submission	59	$20,897	2.85%
Service location not eligible	185	$19,107	2.61%
Duplicate/same day service without modifier or other info needed for adjudication	66	$11,955	1.63%
National Provider Identifier (NPI) issue	81	$4,683	0.64%
Other	6	$1,054	0.14%
Missing valid diagnosis	1	$227	0.03%
Total Denied Claims	**10,813**	**$732,371**	**100.00%**
Denied Claims Rate		**3.45%**	
Statewide Denied Claims Rate		**3.64%**	

- The top three denial reasons account for $695,345 and almost 95 percent of the denied claims amount.
- The DMC-ODS denied claims rate is slightly below the statewide denial rate.

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

Month	# Claim Lines	Total Approved Claims
Jan-22	24,299	$1,561,296
Feb-22	22,523	$1,578,130
Mar-22	25,851	$1,928,647
Apr-22	25,545	$2,053,782
May-22	25,466	$1,960,404
Jun-22	24,035	$1,836,161
Jul-22	24,410	$1,820,763
Aug-22	25,065	$1,654,462
Sep-22	24,121	$1,520,661
Oct-22	23,895	$1,570,371
Nov-22	23,107	$1,510,060
Dec-22	23,566	$1,517,062
Total	**291,883**	**$20,511,801**

- The DMC-ODS had a relatively stable volume of claim lines across CY 2022.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The new functionality for contract providers to directly enter clinical data within the county EHR is a new strength in obtaining timely and aggregated data.
- There are currently system limitations in SmartCare that are impacting the ability to provide timely reports for staff and management. The DMC-ODS reports the vendor just recently provided access to the system data warehouse feature, which may allow staff to develop customized reporting while waiting for further development of the system in coordination with CalMHSA. Additionally, staff reports multiple EHR development projects that are pending with staff based on priority levels.

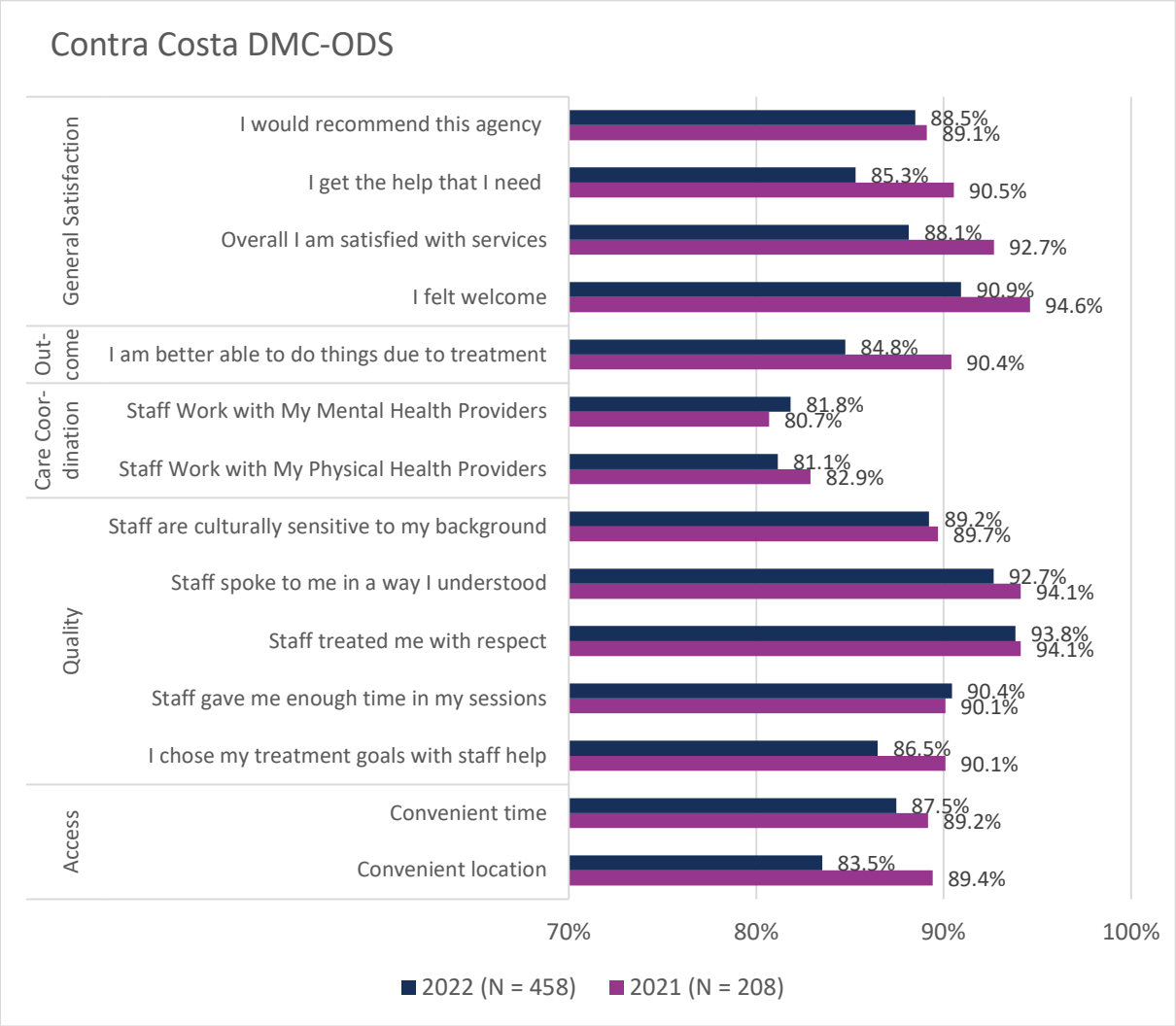
VALIDATION OF PLAN MEMBER PERCEPTIONS OF CARE

TREATMENT PERCEPTION SURVEYS

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-ODSs administer these surveys to members annually in the fall and submit the completed surveys to DHCS. As part of its evaluation of the statewide DMC-ODS Waiver, the University of California, Los Angeles (UCLA) evaluation team analyzes the data and produces reports for each DMC-ODS.

The DMC-ODS made a significant effort to collect TPS this year with both electronic and onsite paper participation with incentive cards. The goal was a much more complete TPS feedback report with all LOCs represented, and the numbers, including youth, increased significantly. There were also providers and LOCs who had not been well represented in TPS before who participated. With this increase in participation, the ratings in many cases reflected some lower ratings this year than the prior year but may be more reflective of the members' experience because of larger numbers. Participation in 2022 was 208 members, and in 2023 it was 485 members.

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



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

- Improvements were achieved in care coordination with MH providers, and the staff gave me enough time in my sessions, which is a quality rating.
- Other ratings were lower, but data by LOC and provider site were much more complete than the previous year, providing focused opportunities for improvement on which the DMC-ODS is engaging providers.

PLAN MEMBER/FAMILY FOCUS GROUPS

Plan member and family (PMF) focus groups are an essential component of the CalEQRO review process; feedback from those who receive services provides

important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and PMF involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested three 90-minute focus groups with Plan members (DMC-ODS members) and/or their families. Groups were request to include five to eight participants each.

Plan Member/Family Focus Group One Summary

CalEQRO requested a diverse group of adult Plan members who initiated services in the preceding 12 months. The focus group was held at Options Recovery Services and included six participants. All Plan members participating receive outpatient clinical services from the Options Recovery Services and other SUD and housing services in the DMC-ODS.

The male and female members present were positive about the program and their counselors, and some had recovery coaches as well. They felt staff were responsive and had good skills, and many had personal experience with SUD. There were some suggestions to diversify and update parts of the curriculum to focus more on individual and family engagement and therapy sessions. Some had asked for MH treatment and psychiatry, but after assessment, there were exceptionally long waits, and some members were still waiting. In January 2024, transportation was reportedly disrupted for those with Anthem Blue Cross, and the county transportation service, which is linked to the Health Plan, was not working as well for access to services.

Recommendations from focus group participants included:

- “Our families need to understand this is a disease, and there are now tools to recover, including MAT.”
- Improve timeliness for MH treatment after assessments.
- Make the transportation service as excellent and flexible as possible to meet the needs of members accessing treatment.
- One member lived in a remote area and asked to have telehealth sessions available sometimes.
- “Tell staff how thankful I am for what I am getting in treatment.”

Plan Member/Family Focus Group Two Summary

CalEQRO requested a diverse group of adult Plan member-consumers who initiated services in the preceding 12 months and participated in RSS. The focus group was held by video conference and included five participants. All Plan members receive clinical services from the DMC-ODS recovery support programs and have recovery coaches.

Every member had nothing but praise to share about their treatment and support experiences from their recovery coaches. They expressed appreciation for help with life skills, jobs, community connections, applications for benefits, and similar services. One representative quote was, “Having a recovery coach has been key to my moving on to the next step in success.” Another said, “Help with family issues and the legal system are so helpful to have, and this helps make success possible.”

Areas of challenge, similar to other groups, were access to MH treatment and medications, wanting more support with family education, and continuing to build on independent living skills in housing.

Recommendations from focus group participants included:

- Better access is needed to MH treatment and medications in a timely way, especially for those who have been on medication and need refills.
- “The county should help me maintain this relationship with the coach. It has been so helpful in housing, jobs, relationships, and communication.”

Plan Member/Family Focus Group Three Summary

CalEQRO requested a diverse group of adult Plan members in the county-operated residential treatment program. The focus group at Discovery House included seven participants. All Plan members participating are currently receiving clinical services from the DMC-ODS.

Members described the program in generally favorable terms related to medication transitions from detention, counselor skills and support, coordinating to access sober living with outpatient service upon completion, and positive experiences with alumni groups and individuals. Several members requested more physical activities and continued help with vocational issues and housing. This group also asked about family involvement and education so they could reconcile and have support.

Recommendations from focus group participants included:

- “More groups and helpful activities to best use our time here.”
- Peers in the facility for staff and volunteers would be helpful.
- Individuals with special diets for diabetes need to have diet-appropriate meals as the resident cooks do not usually know how to prepare these or have many options.
- “We need more contact with alums and aftercare groups before we leave.”

Summary of Member Feedback Findings

Key themes for the member groups included needing more access to MH treatment, involvement and education for family members, and the success of the recovery

services coaches as a key support for transitions in care and successful community integration.

There was a steep rise in the number of TPS responses in the 2023 administration, more than double the number in 2022, which should assist the DMC-ODS by having more comprehensive qualitative data regarding member satisfaction.

CONCLUSIONS

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

STRENGTHS

1. The DMC-ODS reorganized its management team into functional areas to promote more leadership by subject matter expertise and has begun reviewing area-specific service data with the new SmartCare EHR. (Quality)
2. The implementation and expansion efforts in the Hispanic/Latino services with bilingual staff support is a positive shift in addressing a historically underserved population. (Access)
3. The DMC-ODS expanded mobile enhanced services, including RSS, before, during, and after treatment, utilizing the transition team, recovery coaches, mobile crisis, and peers. (Access, Quality)
4. The DMC-ODS expanded options for direct access to care by adding key Access-linked staff for adult detention, juvenile hall, PES, hospital, perinatal, and adding a family navigator and certified peers. (Access)
5. Policy and program expansions were added to address persons MIT populations, including those with significant SUD needs, especially homeless individuals and monolingual members. (Access, Quality)
6. The Contra Costa Health system structure, including county operations and integration with the Health Plan, behavioral health, hospitals, and primary care, has greatly enhanced coordination and data exchange. This is a positive model for improving care coordination for members. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. There are opportunities to debrief and continue to partner with contract providers to educate and clarify CalAIM changes, and specifically payment reform. There are reported payment delays, reconciliation delays, and a lack of clarity in seeing different rates within SmartCare for the services provided. (Quality, IS)
2. There are delays in accessing MH treatment (not assessments) for those in DMC-ODS residential and outpatient programs with co-occurring MH needs. (Access)

3. CalOMS administrative discharges (dropouts from programs before completing treatment) were high, accounting for nearly seven out of ten adult discharges. There was also a high level of lack of treatment completion shown in CalOMS, though many were rated to have shown successful progress. (IS, Quality)
4. Completion of multiple high-priority projects to add functionality within the SmartCare system are reportedly impacted due to staffing constraints. These include, but are not limited to, provider network data updates, CalOMS data reporting and aggregation of ASAM data, which may impact staff and management decisions. (IS)
5. There are key residential and outpatient programs currently unavailable for youth and monolingual female adults, specifically in residential treatment. (Access)

RECOMMENDATIONS

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

1. The DMC-ODS needs more engagement and debriefing with contractors related to the new rate model and payment reform implementation challenges, CalAIM requirements, and delays impacting this year's contracts. (Quality, IS)
2. Consider staffing and service improvements needed to reduce delays in accessing ASAM recommended treatments and include timely access to MH treatment services for DMC-ODS members as well. (Access, Quality)
3. Analysis and actions are needed to reduce administrative discharges in CalOMS by identifying those at risk of service withdrawal and enhancing engagement in discharge planning. (IS, Quality)
4. Additional IT resources are needed for transitions for critical SmartCare projects, Epic MHP EHR interface, CalAIM initiatives, and workflows required by the provider network and appointment modules. (IS)
5. A plan for access to clinically significant DMC-ODS services is needed for monolingual women and youth needing residential treatment. (Access)

EXTERNAL QUALITY REVIEW BARRIERS

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

The DMC-ODS did not identify any barriers to this review.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from DMC-ODS Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions - Contra Costa DMC-ODS
Opening session – Significant changes in the past year, current initiatives, and status of previous year's recommendations, baseline data trends and comparisons, and dialogue on results of PMs
Access to Care, Timeliness of Services, and Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the DMC-ODS NA
Validation and Analysis of the DMC-ODS Health IS
Validation and Analysis of Member Satisfaction with three focus groups
Fiscal/Billing Review related to data integrity
QI Plan, implementation activities, and evaluation results
General data use- staffing, processes for requests and prioritization, dashboards, and other required reports.
DMC-specific data use: TPS, ASAM LOC Placement Data, CalOMS
Disparities: cultural competence plan, implementation activities, evaluation results
Health Plan, primary and specialty health care coordination with DMC-ODS
Medication-assisted treatments
MH coordination with DMC-ODS
Criminal justice coordination with DMC-ODS
Senior managers group interview – contracted network providers
Clinical line staff group interview – county and contracted
Key stakeholders and community-based service agencies group interview
Closing session: questions and next steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rama Khalsa, PhD, Lead Quality Reviewer
Eric McMullen, Quality Reviewer
Joel Chain, IS Reviewer
Diane Mintz, Senior Consumer/Family Member Consultant

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

All sessions were held via video conference.

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

Last Name	First Name	Position	County or Contracted Agency
Abloogalook	Tonia	Admin/Data J. Cole Recovery Homes	Contracted Agency- J. Cole House Recovery Homes
Aguirre	Priscilla	Quality Management Program Coordinator	Contra Costa County
Alexander	Scott	Utilization Review Program Supervisor	Contra Costa County
Allen	Michelle	Westcare Director of Contract Compliance	Contracted Agency- Westcare
Amaya	Daniel	Pueblos Del Sol Program Coordinator	Contracted Agency- Pueblos Del Sol
Ament	Jason	Substance Abuse Counselor	Contracted Agency-Bi-Bett: Diablo Valley Ranch
Anaya	Tiffany	Lead Counselor	Contracted Agency- Reentry Success Center
Ang	JR	Director of Patient Finance Services	Contra Costa County
Avila	Orlando	Youth Substance Abuse Counselor	Contra Costa County
Barcelo	Nicholas	Medical Director Contra Costa Health Plan	Contra Costa County
Beath	Lori	Public Defender Client Success Specialist	Contra Costa County
Benavidez	Mario	Substance Abuse Counselor	Contra Costa County
Bernstein	Marsha	Program Supervisor	Contra Costa County
Bilgi	Tejasi	La Familia Deputy Chief Clinical Officer	Contracted Agency- La Familia
Blunt	Sonya	Program Supervisor	Contra Costa County
Brand-Lockshin	Julie	Treatment Center Director	Contracted Agency-BAART
Brown	Mitch	Lead Counselor	Contra Costa County
Bruggeman	Jennifer	MH Program Manager	Contra Costa County
Calloway	Vernon	Health Services IT Manager	Contra Costa County
Campos	Sofia	Planner/Evaluator	Contra Costa County
Carofanello	Nick	Health Services Finance, Accountant	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Cedermaz	Heather	Health Care for the Homeless Medical Director	Contra Costa County
Chavez	Rudy	Business Intelligence Consultant	Contra Costa County
Christensen-Gibbons	Ian	Let's Recover Head of Operations	Contracted Agency- Let's Recover
Church	Robert	Deputy Administrator	Contracted Agency- Westcare
Coletto	Sy	Juvenile Hall Substance Abuse Counselor	Contra Costa County
Conroy	Leonard	Substance Abuse Counselor	Contracted Agency- J. Cole House Recovery Homes
Cristofani	Gary	Substance Abuse Counselor	Contra Costa County
Dold	Amanda	MH Program Chief Mobile Crisis	Contra Costa County
Dorigatti	Phillip	Substance Abuse Counselor	Contra Costa County
Down	Adam	MH Project Manager	Contra Costa County
Farrar	Jesse	Substance Abuse Counselor	Contra Costa County
Ferguson-Manly	Fe	Ujima Program Coordinator	Contracted Agency- Ujima
Fernandez	Antonia	Substance Abuse Counselor	Contra Costa County
Field	Stephen	Behavioral Health Medical Director	Contra Costa County
Fitzpatrick	Lisa	Regional Director, Operations	Contracted Agency- Baymark
Galdamez	Fadua	Community Health Worker	Contra Costa County
Gallagher	Ken	Research and Evaluation Manager	Contra Costa County
Garofalo	Catherine	Substance Abuse Counselor	Contracted Agency-Ujima: La Casa
Garrett	James	Substance Abuse Counselor	Contra Costa County
Giles	Amber	Program Manager	Contra Costa County
Guitarte	Rizza	Detention Discharge Manager	Contra Costa County
Gulino	Nick	Executive Director	Contracted Agency- Let's Recover
Gutierrez	Cynthia	MH Clerk	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Hahn-Smith	Steven	Behavioral Health Informatics Chief	Contra Costa County
Hall	Keith	AB 109 Substance Abuse Counselor	Contra Costa County
Haverty	Denise	Youth Substance Abuse Counselor	Contra Costa County
Hernandez	Gilberto	Substance Abuse Counselor	Contra Costa County
Hill-Howard	Barbara	Substance Abuse Counselor	Contra Costa County
Islas	Cristina	Substance Abuse Counselor	Contra Costa County
Johnson	Kennisha	MH Program Chief of Housing Services	Contra Costa County
Jones	Vickie	Substance Abuse Counselor	Contra Costa County
Keefer	Ronda	Substance Abuse Counselor	Contracted Agency-Wollam
Kekuewa	David	System Analyst	Contra Costa County
Kersten	Melissa	QI Coordinator	Contra Costa County
Liu	Mariana	Contracts Analyst	Contra Costa County
Loenicker	Gerold	MH Program Chief	Contra Costa County
Lopez	Deyanara	Secretary-Advanced Level	Contra Costa County
Macias	Peter	Substance Abuse Counselor	Contracted Agency-Options For Recovery
Martinez	Susan	Program Supervisor	Contra Costa County
Mata	Melissa	Substance Abuse Counselor	Contra Costa County
Matal Sol	Fatima	Program Chief	Contra Costa County
McElroy	Terri	Program Manager	Contracted Agency- Reach Project
McKeown	Jessica	Substance Abuse Counselor	Contracted Agency-Wollam House
Mekuria	Sefanit	Public Health Medical Director	Contra Costa County
Melendez	Christina	Program Manager	Contracted Agency- Center for Human Development
Messerer	Mark	Program Manager	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Monterrosa	Maritza	Parent Navigator	Contra Costa County
Moore	Greg	Program Director	Contracted Agency- REACH Project
Mosesman	Yolanda	Substance Abuse Counselor	Contracted Agency-Ujima East
Munoz	Dora	Substance Abuse Counselor	Contra Costa County
Ny	Faye	Health Services Reimbursement Accountant	Contra Costa County
Nybo	Erik	Business Intelligence Developer	Contra Costa County
Oliveira	Phoebe	Choosing Change Program Manager	Contra Costa County
Orlando	Stephanie	Substance Abuse Counselor	Contra Costa County
Orme	Betsy	Adult and Older Adult MH Program Chief	Contra Costa County
Ornelas	Fabiola	Substance Abuse Counselor	Contra Costa County
Ortiz	Pearl	Substance Abuse Counselor	Contra Costa County
Pedraza	Christopher	Behavioral Health Services Project Manager	Contra Costa County
Pena	Jorge	Sharecare Support Analyst	Contra Costa County
Pendergast	Michael	Lead Counselor	Contracted Agency- J. Cole House Recovery Homes
Perez	Shiley	Program Supervisor	Contracted Agency- La Familia
Peterson	Todd	Health Services Planner Evaluator	Contra Costa County
Philbin	Agueda	SUD Counselor	Contracted Agency- REACH Project
Pierre	Natalie	Westcare Residential Assurance Director	Contracted Agency- Westcare
Rahimzadeh	Ziba	Director of Provider Relations and Credentialing	Contra Costa County
Razon	Danelyn	Finance, Accountant	Contra Costa County
Recinos	Jessica	Prevention Coordinator	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Reynolds	Susanne	J. Cole House Lead Counselor	Contracted Agency- J. Cole House Recovery Homes
Rice	Megan	Behavioral Health Services Informatics	Contra Costa County
Sanding	Mariella	MEDs Coalition Coordinator	Contracted Agency-Bay Area Community Resources (BACR)
Santiago-Nederveld	Catania	Substance Abuse Counselor	Contra Costa County
Scannel	Marie	Forensic MH Chief	Contra Costa County
Schank	Rita	Ujima Executive Director	Contracted Agency- Ujima
Schilling	Lisa	Quality Officer	Contra Costa County
Segura-Melendez	Eduardo	Substance Abuse Counselor	Contracted Agency-Bi-Bett: Pueblos Del Sol
Shah	Bhumil	Associate Chief Information Officer	Contra Costa County
Skallet	Maria	Detention Nursing Educator	Contra Costa County
Smith	Brittney	Interim Program Coordinator	Contracted Agency- Frederic Ozanam Center
Spikes	Chet	Assistant Director, Business Systems	Contra Costa County
Stevenson	Michael	Lead Counselor	Contracted Agency- Diablo Valley Ranch
Tavano	Suzanne	Director of Behavioral Health Services	Contra Costa County
Temeltas	Ates	Assistant Director, Clinical Systems	Contra Costa County
Tighe	Tommy	Chief of Mental Health	Contra Costa County
Todd	Zachariah	Program Supervisor	Contra Costa County
Townsend	Justin	Youth Substance Abuse Counselor	Contra Costa County
Tuipulotu	Jennifer	MH Consumer Empowerment Program Coordinator	Contra Costa County
Tupper	Stacey	MH Project Manager	Contra Costa County
Webb	Darren	Program Supervisor	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
White	Katy	MH Program Manager	Contra Costa County
Wilder	Toni	Bi-Bett Interim Program Coordinator	Contracted Agency- Bi-Bett
Williams	Ulrika	Treatment Center Director	Contracted Agency-BAART
Woodward	Brandon	Substance Abuse Counselor	Contracted Agency-REACH Project
Zesati	Genoveva	Workforce Education and Training/Ethnic Services Coordinator	Contra Costa County

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The focus of the PIP was decreasing readmissions within 30 days to residential WM programs which were somewhat higher than statewide and similar size counties in 2022 when the PIP began. The other goal was to improve transitions to other LOCs. A series of interventions were implemented with modest results.
General PIP Information	
MHP/DMC-ODS Name: Contra Costa	
PIP Title: Decrease the Readmission Rate to Residential Withdrawal Management (WM)	
PIP Aim Statement: "Through the provision of materials, additional WM guidelines, and enhanced transition planning and case management in WM, will the readmission rate of members to WM decrease by two percentage points (from 10% to 88 percent)? Will the members' enrollment rate to SUD treatment within two days of discharge from residential WM increase to 60 percent?"	
Date Started: 03/2022	
Date Completed: 03/2024	
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 a different age threshold for children, specify the age range here:	

Target population description, such as specific diagnosis (please specify): Adults 18 years and older with all diagnoses of SUDs. The profile was predominantly alcohol, opioid, and stimulant-related diagnoses similar to the overall county diagnostic profile. Ages ranged from 18 to 69, with the largest group being 30-39-year-olds. There were 87 females and 230 males in the baseline group. All four adult sites for residential WM were included. The largest ethnic group was white at 45 percent, followed by Latino/Hispanic at 24 percent, followed by African American at 19 percent. All other groups were under 3 percent.

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 engaged in enhanced discharge planning and care coordination activities, including warm handoffs to the next LOC.

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 had new expectations and requirements for engagement in discharge planning, evaluation of needs, and care coordination of members with new protocols.

MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):

System changes included EHR enhancements to improve facilitated discharge planning, documentation related to planning transitions in care, and engaging Access Line support by the second day to identify step-down treatment options meeting the member's ASAM-assessed treatment needs.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Readmission rate to WM Program within 30 days of discharge. Goal 8 %	10%	36/361	☐ Not applicable—PIP is in planning or implementation phase, results not available	41/476 8.6%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Enrollment rate to SUD treatment within 2 days of discharge from WM. Goal 50 %	49.3%	178/361	☐ Not applicable—PIP is in planning or implementation phase, results not available	224/476 47.1%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. Enrollment rate to SUD treatment within 7 days of discharge from WM. Goal 60%	56.2%	203/361	☐ Not applicable—PIP is in planning or implementation phase, results not available	269/476 56.5%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP: 1. Continue to enhance early engagement with members with motivational interviewing and discussions on discharge planning options in partnership with the Access Team, which can track available openings at different LOCs.

2. Utilize the new EHR to enhance communication and coordination by adding the scheduling option, allowing members to leave with a firm admission date and have a warm handoff whenever possible.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	This PIP was established with the goal of enhanced successful transitions to treatment of members presenting for Alcohol and other drug abuse or dependence (FUA) at an ED. The interventions focused on discharge planning and engagement as well as data exchange and onsite support for the members to motivate and assist them in follow-up with treatment.
General PIP Information	
MHP/DMC-ODS Name: Contra Costa	
PIP Title: Improve Follow up Rates After Emergency Department (ED) Visits for Individuals Experiencing Alcohol and Other Drug Abuse or Dependence (FUA)	
PIP Aim Statement: "For Medi-Cal Members with ED visits for SUD at Contra Costa Regional Medical Center, the implemented interventions should increase the percentage of follow-up SUD treatment services with the DMC-ODS Plan within 7 and 30 days of discharge by 5 percent by March 31, 2024"	
Date Started: 03/2023	
Date Completed: 3/2025 (to be completed, not currently complete)	
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 a different age threshold for children, specify the age range here: 16 and over.	

Target population description, such as specific diagnosis (please specify): The population includes members 16 and older. The diagnostic profile of the baseline data set, which continues to be similar in the PIP, included 49.9% diagnoses with Alcohol-related disorders, 31.8% with stimulant-related disorders, 14.6% psychoactive substance use-related disorders, and 11.1 % opioid-related disorders. All other diagnoses were 8 % or less. There were 65% male and 35% female members presenting at the ED. In terms of ethnic mix, there were 40% white, 24 % Latino/Hispanic, 19 % African American, and all other groups were between 7%-1%. The largest age group was 31-40 years of age. The smallest groups were those over 70 and under 21. The initial interventions will be focused on the Contra Costa County hospital system to test the interventions, and if successful, they will be expanded to Kaiser, Sutter, and John Muir Hospitals.

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 have new expanded care coordination in the ED and after discharge by staff with support for access to treatment.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

There are new staff and workflow requirements in the ED and after to link members to services and provide education, direct admissions support, and support tools as needed, such as transportation.

MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):

Hospital and the DMC-ODS programs are both county-operated or directed and these will be linked using Epic and Sharecare to make communication on urgent and routine members needs in the ED clear to key support staff, admissions/access, and treatment providers.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	A statistically significant change in performance (Yes/No) Specify P-value
PM 1. 7-day follow-up rate after ED visit related to alcohol and drug use for admission to SUD treatment program. Goal: 24.4%	1/31/22-9/1/22	94/485 19.4%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	A statistically significant change in performance (Yes/No) Specify P-value
PM 2. 30-day follow-up services rate after ED visit related to alcohol and other drug use to admission to treatment. Goal 34.5%	1/31/22-9/1/22	143/485 29.5%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP: 1. Use enhanced data capacity to coordinate care engagement and admissions in real-time, linking Epic and SmartCare as soon as possible. 2. Provide monthly reports of results by drug type, area of the county the member lives in, which programs they are referred and connected to, and breakdown also by ethnic group and especially note monolingual clients and homelessness as characteristics.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM DMC-ODS DIRECTOR

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